

**Office of Consumer Information and Insurance Oversight**

**State Planning and Establishment Grants for the  
Affordable Care Act's Exchanges**

**Final Project Report**

**Date: April 27, 2012**

**State: Vermont**

**Project Title: State Planning and Establishment Grant for the Affordable Care Act's Exchanges**

**Project Quarter Reporting Period: Quarter 4 (10/01/2011-12/31/2011)**

**Grant Contact Information**

Primary Contact Name: Betsy Forrest  
Primary Contact Number: 802-879-5918  
Primary Contact Email Address: betsy.forrest@state.vt.us

Secondary Contact Name: Lindsey Tucker  
Secondary Contact Number: 802-872-7523  
Secondary Contact Email Address: lindsey.tucker@state.vt.us

Website (if applicable): <http://dvha.vermont.gov/administration/health-benefits-exchange>

Award number: HBEIE100009-01-00

Date submitted: January 30, 2012

**Project Detail**

Vermont has completed its planning work in the nine core areas as described below. With the assistance of its contractor, Bailit Health Purchasing, and Bailit's subcontractors, Vermont completed the following tasks:

- Completed background research on the uninsured and underinsured, the current private insurance market, and the effects of "churning" on beneficiaries of public health care programs
- Conducted focus groups or private interviews with a wide range of stakeholders, including uninsured individuals, small employers, private insurance companies, insurance brokers, and advocates for low-income Vermonters
- Established an Exchange Advisory Committee, which met monthly throughout the grant period

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- Completed an integration study and executed Memoranda of Understanding between the Department of Vermont Health Access (DVHA) and the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) and the Department for Children and Families (DCF)
- Passed comprehensive authorizing legislation that establishes the Exchange as a division within DVHA
- Reviewed current business function infrastructure and identified areas which could be enhanced to serve the Exchange, as well as areas requiring new development
- Completed a first estimate of development and operational costs of the Exchange, including a report of financing options
- Participated in the early innovator project, the New England States' Collaborative for Insurance Exchange, as well as conducted an extensive internal planning process to chart a clear path for implementation of the Exchange IT infrastructure
- Established an initial staffing plan for the Exchange Division within DVHA and hired a Deputy Commissioner for the Exchange
- Created an initial Exchange design document and detailed work plan
- Applied for and received a Level 1 Establishment grant for the next phase of Exchange development and implementation.

Most reports and documents discussed below can be found on DVHA's Exchange web page:  
<http://dvha.vermont.gov/administration/health-benefits-exchange>.

**Core Areas**

• **Background Research.**

*Uninsured and underinsured*

Bailit, through its subcontractor Market Decisions, completed an analysis of the uninsured and underinsured using data from Vermont's 2009 Household Health Insurance Survey.

Key findings:

- In late 2009, 7.6% of all Vermont residents were uninsured. This represents a total of 47,460 residents.
- In late 2009, 27.9% of all Vermont residents under the age of 65 were underinsured. This represents a total of 160,406 residents.
- The percentage of adults lacking health insurance coverage was highest among those age 18 to 24 (17%) and those aged 25 to 34 (16%).
- Lacking health insurance coverage is strongly correlated with family income.
- Under current state health insurance programs, more than half (53%) of the uninsured adults aged 18 to 64 were eligible for coverage through a state health care program.
- Under the guidelines in the Patient Protection and Affordable Care Act (PPACA), 85% (37,295) of uninsured adults ages 18-64 would be eligible for coverage under the expanded Medicaid program or eligible for some level of premium assistance (tax credits) to assist in purchasing health insurance through the health exchange. Thirty-one percent of uninsured adults would be eligible for Medicaid while the remaining 54% would be eligible for tax credits.

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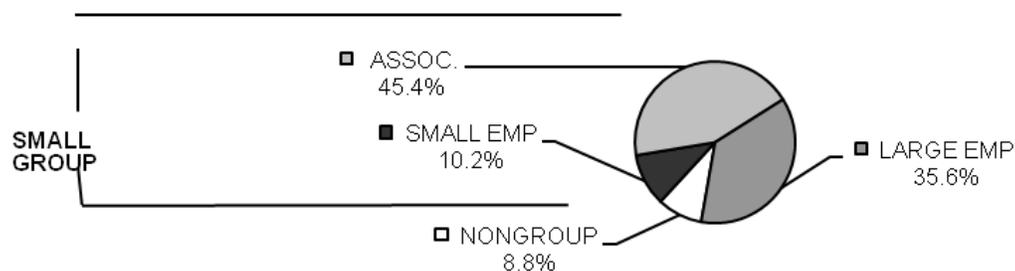
Link to full report: <http://dvha.vermont.gov/administration/hbe-uninsured-underinsured-report-03032011.pdf>

*Current insurance market*

In 2011 Vermont completed a study of the current insurance market.

Key findings:

- In 2009, out of a total of 621,270 Vermont residents, 57.3% (355,380) had private insurance as their primary source of coverage, including insured group plans (233,535 lives), insured non-group plans (16,521 lives including Catamount Health Insurance), and self-funded employer plans (105,302 lives including the Federal Employees Health Benefit Plan).
- Approximately 95,182 of Vermonters (15.3%) were enrolled in the federal Medicare program and over 17% of Vermonters (109,353 individuals) were enrolled in the state Medicaid program, including the Vermont Health Access Plan.
- The private commercial insurance market is clearly dominated by a small number of insurers in Vermont. These same insurers have consistently been part of the insurance market in Vermont for many years.
- Based on a review of claims from 2007 to 2009, total expenditures by insurers and members have increased substantially.
- Vermont insurance law is largely as, or more protective than, the standards set in the ACA.
- The small group market includes both association plans and small employers. In 2009, the largest insured market segment was associations.
- Plan designs have changed over time in Vermont. Specifically, in recent years there have been increasing offerings and take-up rates of high deductible health plans coupled with health savings accounts, more preferred provider organizations (PPOs), and more focus on prescription drug cost sharing.
- Under Vermont law, both small group and non-group plans must be community rated and sold on a guaranteed-issue basis.



As a result of these and other findings from the study, the following decisions were made:

- Vermont will merge its individual and small group markets.
- Vermont will retain its definition of small employer to include employers with 50 or fewer employees.

- Vermont will require all individuals and small businesses to purchase insurance through the Exchange.

Link to full report: <http://dvha.vermont.gov/administration/hbe-insurance-market-report-revised-10-10-11.pdf>.

#### *Assessment of churning*

An evaluation of the impacts of churning was completed. DVHA supplied Bailit's subcontractor, the University of New England, with the total number of individual episodes of eligibility for Catamount Health premium assistance for four years, 2007-2010. UNE also reviewed existing literature on the issue of churning and interviewed other states that have taken steps to mitigate its effects. The final report did not reveal any surprises, and there appears to be no "silver bullet" that will eliminate the effects of churn, although there are some recommendations that might slightly reduce the negative impacts on families and the State.

Link to full report: <http://dvha.vermont.gov/administration/hbe-churn-final-report-8-11-11.pdf>.

#### • **Stakeholder Involvement.**

Vermont through its Exchange contractor conducted the following formal stakeholder research:

- Focus groups of uninsured and underinsured Vermonters
- Interviews with consumer advocacy organizations
- Interviews with Vermont's three largest insurance companies
- Survey of small businesses
- Interviews with insurance brokers/agents.

#### Key findings:

- Many of the uninsured may not completely understand their current options for state sponsored insurance.
- Many of the uninsured think that health insurance is a poor value because they are healthy.
- For many, income was insufficient to pay even for subsidized insurance.
- Since the underinsured see their insurance bills and their health care bills, they are more savvy shoppers than those who have no insurance.
- The underinsured do not expect the ACA to address their needs and problems with the cost of health care or the cost of insurance.
- Most small businesses (82%) knew very little about the ACA or its requirements for an Exchange.
- Most small businesses said they would not need the services of a broker if comprehensive information on plans is available online.
- Insurance agents had mixed opinions about the effect the ACA would have on their businesses. Some thought that if the ACA focused primarily on the uninsured, it would have little effect.
- Insurance agents see themselves as already performing the role of navigators.
- Non-profits that currently work with the uninsured worried that policy makers would underestimate the difficulty of enrolling the uninsured.

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- Non-profits thought that one-on-one assistance would be necessary for most of the under- and uninsured.

As a result of these and other findings, these decisions were made:

- Vermont will develop a robust navigator program that will provide one-on-one assistance throughout the state.
- Vermont will develop a formal navigator certification process, which will include training.
- Vermont will implement a comprehensive outreach and education plan targeting uninsured and underinsured individuals, as well as small businesses.

Links to formal stakeholder reports:

<http://dvha.vermont.gov/administration/hbe-stakeholder-study-uninsured-focus-group-report.pdf>

<http://dvha.vermont.gov/administration/hbe-underinsured-focus-group-report-5-18-11.pdf>

<http://dvha.vermont.gov/administration/hbe-stakeholder-study-non-profit-interview-report.pdf>

<http://dvha.vermont.gov/administration/hbestakeholder-study-small-business-survey-report.pdf>

<http://dvha.vermont.gov/administration/hbe-insurance-brokers-report-5-15-11.pdf>

In addition to the research described above, Vermont established an Exchange Advisory Group that has met 11 times over the last year. The advisory group consists of representatives from the following organizations, with many other stakeholders attending on a regular basis:

- House Health Care Committee
- Senate Health and Welfare Committee
- Vermont Campaign for Health Care Security (non-profit)
- Legal Aid and Health Care Ombudsman Office
- Vermont Chamber of Commerce
- Lake Champlain Chamber of Commerce
- Vermont Medical Society
- Vermont Association of Hospitals and Health Systems
- Bi-State Primary Care Association
- Vermont Insurance Agents Association
- Blue Cross Blue Shield of Vermont
- MVP Health Care
- Cigna
- Delta Dental
- Vermont Association for Mental Health
- Vermont State Employees Association
- National Education Association
- Vermont Businesses for Social Responsibility
- Vermont Retail Association

The advisory group has received information on, and provided input to, all aspects of Exchange planning and development.

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Link to minutes, slide decks, and other documents from advisory group meetings:

<http://dvha.vermont.gov/administration/minutes-documents-from-exchange-advisory-board-meetings>.

In addition to formal advisory group meetings, members of the Administration have met informally with numerous individuals, organizations, and companies with a stake in health care reform. Examples of these stakeholders include the following, although this is not a complete list:

- UVM College of Medicine
- Northern Counties Healthcare
- Vermont League of Cities and Towns
- Voices for Vermont's Children
- Johnson State College
- Working Vermont/VTNEA
- VT Federation of Nurses and Health Professionals
- Vermont Human Resource Association
- IBM (large employer)
- IHI (Institute for Healthcare Improvement)
- Central Vermont Chamber of Commerce
- Brandon Rotary Club
- Fletcher Allen Health Care
- Downs, Rachlin, & Martin (law firm representing issuers)
- Health Care for All
- VT Public Interest Research Group
- American Cancer Society
- American Heart Association
- American Civil Liberties Union
- VT Workers Center
- AARP
- Planned Parenthood
- Coalition of VT Elders
- VT Grocers Association
- Business Resource Services
- VT Automobile Dealers Association

Input from stakeholders has been invaluable to Vermont's Exchange development process and has influenced every decision made thus far on the design of the functions of the Exchange and on the composition of the insurance market external to the Exchange. For example, consumer advocates were unanimous in their opinion that too many plan choices would be confusing to consumers; as a result, Vermont has decided to limit the number of plan design options available on the Exchange.

• **Program Integration.**

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The work of DVHA has been closely integrated with the work of other Vermont State agencies in order to carry out all of the responsibilities involved in planning for the Exchange. During the first year of planning for the Exchange, there were several State work groups including health insurance operations; insurance market planning; administrative simplification; integration of public health, quality initiatives, and wellness programs into the Exchange; and integration between Medicaid and Exchange eligibility, health insurance operations, and technology. In addition, there were monthly core team meetings of work group leaders to ensure coordination among the work groups, and quarterly meetings of the Governor's Health Care Cabinet. Staff from DVHA, working with its other State agency partners, BISHCA and DCF, has begun to produce business process documentation. This work will continue in even greater detail under the Establishment Grant planning phase.

DVHA currently has in place Memoranda of Understanding with BISHCA (the insurance department), and DCF (the department that determines Medicaid eligibility) that ensure ongoing cooperation and delineate the roles and responsibilities of each department during the Exchange development stage. New memoranda will be put in place for the operational phase of the Exchange.

Link to integration report: <http://dvha.vermont.gov/administration/hbe-integration-report-10-03-11.pdf>.

Attached: MOUs with BISHCA and DCF

• **Resources & Capabilities.**

Vermont is currently engaged in gap analyses, through Level 1 Establishment funds, in the areas of IT, call center, staffing levels, and financial management. Reports in these areas will be available within the next 60 days.

• **Governance**

Act 48, which was passed by the legislature and signed by the governor in 2011, authorizes the establishment of an Exchange within DVHA and assigns it the following goals:

- 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
- to improve quality of health care.

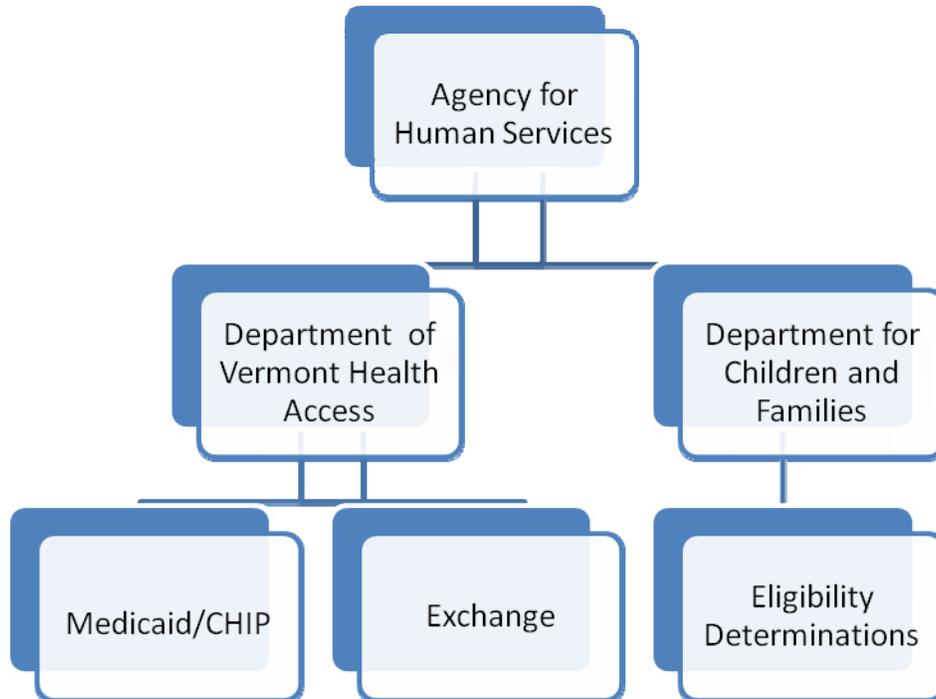
The Exchange is to be administered by DVHA in consultation with an advisory committee (Joint Medicaid/Exchange Advisory Committee) and headed by a new DVHA Deputy Commissioner who will manage the Exchange Division in DVHA. The advisory committee must meet at least

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ten times a year and will advise the State on both Medicaid and the Exchange to ensure optimal integration of those programs.

The Exchange Deputy Commissioner position was filled in December 2011, and recruitment for additional Exchange staff is now underway.



- **Finance.**

Vermont conducted a preliminary analysis of the business functions of the Exchange, including financial management. Financial infrastructure and practices currently in place in Vermont's State health care programs were examined with a particular focus on the Catamount Health premium assistance program, and to a lesser extent, the State Employees Health Insurance Plan. Various finance and business functions necessary for the operation of the Exchange were outlined, and potential options and responsible parties were identified to perform each function. Cost estimates for the performance of the financial and business functions were also provided. The cost estimates were preliminary in nature, and further work will need to be conducted once decisions are made on the various processes for the Exchange. However, this preliminary work lays down the foundation for future work in this area and will be extremely useful in the planning and implementation work that continues during the Establishment Grant process.

In developing the cost estimates, information was sought from various agencies in Vermont, including DVHA, DCF, BISHCA, and the Vermont Department of Labor (DOL).

Cost estimates will be refined during the Level 1 Establishment grant work, and a financial sustainability option will be chosen.

Links to financial function reports:

<http://dvha.vermont.gov/administration/hbe-examination-of-current-financial-systems-03-21-11.pdf>

<http://dvha.vermont.gov/administration/hbe-matrix-of-exchange-functions-3-25-2011.pdf>

<http://dvha.vermont.gov/administration/hbe-financial-functions-report-08-30-11.pdf>

- **Technical Infrastructure.**

Vermont has recently decided to join with Oregon in further developing its model for the Exchange. There are many synergies between the two states' visions for the Exchange, including the decision to use the Oracle suite as the infrastructure for the Exchange build, as well as for the eventual addition of other assistance programs.

Vermont has had various informal discussions with Oregon IT staff and intends to send a team to Oregon in the near future to jointly formulate a work plan. Rhode Island has also joined these discussions.

Vermont is currently working with KPMG to complete a thorough IT gap analysis; results will be available within four to six weeks.

- **Business Operations.**

DVHA, with help from Bailit, developed a proposal for necessary staffing levels for the Exchange Division for FFY 12. The additional positions needed to develop the Exchange were included, and approved, in the Level 1 Establishment grant application. Vermont expects to revise this staffing plan when it submits its Level 2 Establishment grant application in 2012.

A Level 1 Establishment Grant contract is in place to provide assistance to Vermont in the following business operations areas:

- Specifications for call center changes
- Design of financial functions
- Recommendations on program integrity improvements
- Recommendations for staffing levels and Exchange organization chart
- Design for SHOP function
- Recommendations for individual and employer responsibility determinations
- Review of business process flows for enrollment
- Analyses of impacts on private insurance market
  - Market impact of employer decisions to drop coverage
  - Market impact of employer decisions to self-insure and recommendations for mitigating trend
  - Survey of benefits offered in existing high-deductible plans in the Vermont small group health insurance market and their relation to federal cost-sharing requirements
- Recommendations on risk-leveling programs

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- Design of certification process for Qualified Health Plans (QHPs)
- Process for customer satisfaction surveys
- Recommendations on QHP plan designs (cost-sharing at various metal levels)

• **Regulatory or Policy Actions.**

Act 48, which authorizes Vermont’s Exchange, was passed and signed into law in 2011. Here is the link to the act: <http://www.leg.state.vt.us/DOCS/2012/ACTS/ACT048.PDF>.

Act 48 provides a framework for the Health Benefit Exchange and articulates goals, governance structure, and functions. Another health care reform bill, H.559, was passed by the House earlier in 2012 and has now been passed by the Senate. H.559 would retain the definition of “small employer” as an employer with 50 or fewer employees, merge the individual and small group markets in 2014, and require all individual/small group products to be sold through the Exchange (no external market for comprehensive health plans).

**Needs Assessment**

• **A budget of projected funding needs through Federal Fiscal Year 2014**

The document, “Analysis of Exchange Financial Functions Final Report,” which was developed under the Exchange Planning Grant, contains Vermont’s best estimates thus far on the funding needs for the Exchange. A copy of the document can be found here: <http://dvha.vermont.gov/administration/hbe-financial-functions-report-08-30-11.pdf>. These cost estimates will be refined during the Level 1 Establishment Grant work in 2012.

Vermont, through its Level 1 Exchange grant contractors, is currently engaged in gap analyses for IT, call center, and financial management functions.

• **An accounting of number of personnel needed**

Vermont’s Level 1 Establishment grant contained funds for the following positions, the need for which was developed during the planning grant process:

Position Title
Director, Health Care Reform
Health Care Policy Analyst
Executive Staff Assistant
Deputy Commissioner
Health Care Policy Analyst (private market)
Health Access Policy & Planning Chief
Communications Director
Exchange Project Director
Director, Health Care Affordability
Change Management Director
Exchange Project Director (Integration)
Exchange Project Director (Public Health & Wellness)

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Exchange Project Director (Basics)
Grants Management Specialist
Contract and Grants Administrator
Financial Administrator I
Financial Specialist II
Executive Office Manager
Project Manager
Executive Staff Assistant
AHS Information Systems Security Director
Senior Sys Dev - SOA QA Interrogator
Systems Developer II
Systems Developer II
Enterprise Business Analyst
Database Administrator
Information Management Officer
Project Coordinator (Insurance Dept)
Director, QHP Certification
Data Analyst
Data Analyst
Business Analyst
Business Analyst

Later in 2012 Vermont will be developing estimates of additional staff needed for the operational stage of the Exchange.

**• A list and description of contracts you plan to award and when you plan to do so (if available)**

The following contracts have been executed to assist Vermont with Level 1 Establishment grant tasks:

**Wakely Consulting Group**

- Specifications for call center changes
- Design of financial functions
- Plan for financial sustainability
- Recommendations on program integrity improvements
- Recommendations for staffing levels and Exchange organization chart
- Design Exchange evaluation process
- Draft Level 2 grant application
- Design for SHOP function (Small Business Health Options)
- Recommendations for individual and employer responsibility determinations
- Review of business process flows for enrollment
- Analyses of impacts on private insurance market

- Market impact of employer decisions to drop coverage
- Market impact of employer decisions to self-insure and recommendations for mitigating trend
- Survey of benefits offered in existing high-deductible plans in the Vermont small group health insurance market and their relation to federal cost-sharing requirements
- Recommendations on risk-leveling programs
- Design of certification process for Qualified Health Plans (QHPs)
- Process for customer satisfaction surveys
- Recommendations on QHP plan designs (cost-sharing at various metal levels)

**Pacific Health Policy Group**

- Development of integration plan
- Development of administration simplification strategy

**GMMB Inc.**

- Design of navigator program
- Development of strategic plan for outreach and education

**University of Massachusetts**

- Design for a quality rating system for QHPs
- Recommendations for wellness programs

**Bailit Health Purchasing**

- Design and implementation of payment reform pilot projects

- **An assessment of the information technology builds and systems changes required to establish an operational Exchange**

Vermont is currently working on an IT gap analysis with KPMG, who is a subcontractor under Wakely Consulting Group.

**Technical Assistance**

Vermont will likely have many technical assistance needs, the specific nature of which may become clearer after the Planning Review with CMS in May 2012.

**Final Project Work Plan**

Vermont's work plan, which was developed under the Exchange planning grant, is attached. The work plan will be further refined as work under the Level 1 Establishment grant progresses.

**Final Evaluation Report**

Vermont's contract with Wakely Consulting Group, using Level 1 Establishment funds, includes the development of an Exchange evaluation plan. Attached is a preliminary list of the data needs for the evaluation. A report containing goals, indicators, and a reporting template is due from Wakely at the end of April 2012.

### **Exchange Deliverables**

The following press release was issued earlier this month:

**Press release, April 9, 2012**

**FOR IMMEDIATE RELEASE**

**Monday, April 9, 2012**

**Williston, Vermont**

### **VERMONTERS EXPRESS HIGH INTEREST IN USING HEALTH BENEFIT EXCHANGE**

*Want a place to compare health insurance plans and prices*

**WILLISTON** – Three out of four (75 percent) Vermonters say they are interested in using “an online health insurance exchange” to compare and purchase health insurance, according to a Department of Vermont Health Access (DVHA) survey. After learning more about the “online health insurance exchange,” that number grows to 86 percent who say they would be interested in using the website if they are uninsured in 2014.

This “online health insurance exchange,” also known as the Vermont Health Benefit Exchange (Exchange), will launch a new website in the Fall of 2013 where individuals, families and small businesses in Vermont can search for health insurance, compare plans side-by-side and enroll. The website will feature plans from private carriers as well as public programs, like Medicaid and Dr. Dynasaur. The Exchange will also create a Navigator program – giving Vermonters access to assistance online, in-person and over the phone.

Vermont has received funding from the federal government to establish the Exchange and plan its implementation, including the entire cost of fielding this survey. As part of that funding, Vermont is required to demonstrate to the United States Department of Health and Human Services (HHS) the State's ability and preparedness to conduct outreach and education to residents to inform them of the Exchange and how they can access coverage on the Exchange. To inform outreach and education planning, DVHA fielded a statewide survey to hear directly from Vermonters and identify their current understanding of and perceptions about health care coverage and the Exchange.

The survey finds that nearly one-third (29 percent) of Vermonters are either uninsured or worried about losing their health coverage in the next 12 months. At the same time, a large

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majority (73 percent) remain unaware that a new "online health insurance exchange" will be available beginning in 2014.

"The Health Benefit Exchange couldn't be more timely. We are learning that many Vermonters are worried about their health coverage situation but not familiar with the increased access to health coverage they will have in 2014," said DVHA Commissioner Mark Larson. "We see the Health Benefit Exchange as an opportunity to address the concerns of so many while creating a more accessible and secure marketplace for all Vermonters."

The Exchange will play a key role in connecting people to health coverage, and three in four Vermonters indicate comfort selecting a health plan through a website, which is the primary mechanism for enrollment. Vermonters want to be certain that health plans on the Exchange would cover basic services (e.g., doctor visits, hospital stays, preventive care and prescriptions), to have one place where they could find and compare plans, and to view side-by-side comparisons of plans' benefits and prices.

"We remain committed to educating Vermonters about the Exchange, and we continue to welcome input as we design the Exchange in a manner that works best for individuals, families and small businesses in Vermont," said Deputy Commissioner for the Health Benefit Exchange Lindsey Tucker. "Receiving feedback from residents guides our work and will help us create an Exchange that fulfills its potential as a trusted, useful resource for Vermonters." Tucker invites those interested in learning more about the Exchange and its progress to the next Exchange Advisory Board meeting in Montpelier on April 30, 2012.

The statewide telephone survey was conducted among 1,004 residents 18 and older March 17 through 25, 2012. The margin of sampling error is + 3.1 percentage points. Interviewing was conducted by landline and cell phone. The results of the survey will inform the development of the navigator program and outreach and education planning.

Contact Name: Mark Larson, DVHA, 312 Hurricane Lane, Williston, VT 05495

Contact Phone Number: 802-879-5901

Contact E-mail Address: [mark.larson@state.vt.us](mailto:mark.larson@state.vt.us)

###

*The Department of Vermont Health Access (DVHA)'s mission includes providing leadership for Vermont stakeholders to improve access, quality and cost effectiveness in health care reform; assisting Medicaid beneficiaries in accessing clinically appropriate health services; administering Vermont's public health insurance system efficiently and effectively; and collaborating with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.*

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**Attachments:**

**MOUs**

**Work plan**

**Data needs**

Interagency Agreement between  
Vermont Department for Children and Families (DCF)

AND

Department of Vermont Health Access (DVHA)

**I. Purpose**

The Department of Vermont Health Access (DVHA) was awarded funding under the U.S. Department of Health and Human Services (USDHHS) State Planning and Establishment Grants in September 2010 for the Affordable Care Act's Exchanges and is applying for funding for the State Implementation Grants in September 2011. The purpose of the funding is to help the State of Vermont to establish a State-Operated Health Insurance Exchange. The deliverables for this project will include a recommended implementation plan and budget for an operational exchange. This agreement formalizes the ongoing relationship between the Department for Children and Families (DCF) and DVHA regarding responsibilities for the establishment of the Health Insurance Exchange. The implementation plan will include the eleven exchange establishment core areas:

1. Background Research
2. Stakeholder Consultation
3. Legislative and Regulatory Action
4. Governance
5. Program Integration
6. Exchange IT Systems
7. Financial Management
8. Oversight and Program Integrity
9. Health Insurance Market Reforms
10. Providing Assistance to Individuals, and Small Businesses, Coverage, Appeals and Complaints
11. Business Operations of the Exchange

## **II. Collaboration**

The Department for Children and Families (DCF) and the Department of Vermont Health Access (DVHA) will work together to further all of the goals and requirements of establishing the state-operated health benefits exchange. The collaboration will continue during the first phase of the Level 1 implementation grant process, September 30, 2011-September 30, 2012, and on an ongoing basis. This agreement will outline what areas each department will be responsible for during the Level 1 grant process.

## **III. DCF Responsibility During Level 1 time period (September 30, 2011 – September 30, 2012)**

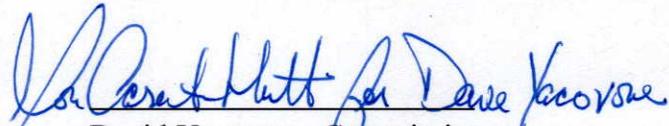
- Full participation with DVHA and its contractors on all tasks relating to the establishment of the Exchange to ensure integration with Medicaid and CHIP, including requirements for the call center and web portal
- Development of comparison tables and maps for Medicaid (current vs. 2014) and tax credits
- Development of eligibility and enrollment rules for tax credits and Medicaid
- In conjunction with the Information Technology (IT) vendor(s) and the Agency of Human Services (AHS), incorporation of tax credit and Medicaid eligibility and enrollment rules into the rules engine
- Development of streamlined, single application form and all necessary forms and notices for tax credit, Medicaid, and CHIP programs
- Assessment of current eligibility business processes and identification of changes needed to ensure that HHS requirements for an enhanced customer service experience are met, taking into consideration opportunities for vertical and horizontal integration opportunities with other publicly-funded programs
- Identification of resources needed to reduce waste, fraud, and abuse in the eligibility determination process

## **IV. DVHA Responsibility During Level 1 time period (September 30, 2011 – September 30, 2012)**

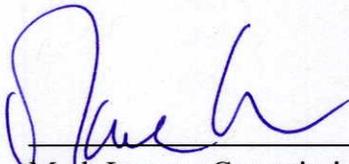
- Full participation with DCF and its contractors on all tasks relating to the establishment of the Exchange to ensure integration with Medicaid and CHIP, including requirements for the call center and web portal
- Maintenance of all documentation to comply with Federal grants.
- Administration of all Federal grants including budget, reports, and communications with the federal government
- Coordination with AHS and DCF on development of Exchange IT

- Review of current Medicaid customer service/call center functions and determination of what additional call center requirements and functions will be needed in the future
- Development of enrollment requirements for the exchange
- Development of exemption requirements from individual mandate
- Development of the requirements for a web portal.
- Review of current Medicaid Business operations for changes necessary in the future.
- Review of current financial management functions for changes necessary in the future
- Development of requirements for the navigator function for both individuals and small businesses
- Review of appeals processes for individuals and small businesses and determination of needed changes
- Review of current DVHA waste, fraud, and abuse prevention activities and determination of any needed changes
- Development of an outreach and education campaign
- Determination of necessary functions of a Small Business Health Options Program (SHOP exchange)
- Coordination of eligibility system assessment and changes with work of: MMIS, VIEWS, and ACCESS systems
- Identification of a recommended approach, preparation of a high-level budget estimate, and development of a timeline for implementation for all exchange activities
- Overall management of the exchange development process
- Coordination of activities with other division/units within DVHA including and not limited to:
  - Blueprint for Health
  - Clinical Services
  - Coordination of Benefits
  - Program Integrity
  - Information Technology
  - Business Office

- Coordination of activities with other division/units within the Agency of Human Services
  - AHS Information Technology
  - AHS Business Office
  - AHS Global Commitment/Health Care operations
- Coordination of activities with the Department of Banking, Insurance, Securities, and Health Care Administration and the Green Mountain Care Board
- Documentation of key steps and cost estimates with regard to the timeline for implementation
- ~~Management of Exchange advisory committee process, as well as other stakeholder involvement~~

  
David Yacovone, Commissioner  
Department for Children and Families

9/22/11  
Date

  
Mark Larson, Commissioner  
Department of Vermont Health Access (DVHA)

9.22.11  
Date

Interagency Agreement between

Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)

AND

Vermont Department of Vermont Health Access (DVHA)

**I. Purpose**

The Department of Vermont Health Access (DVHA) was awarded funding under the U.S. Department of Health and Human Services (USDHHS) State Planning and Establishment Grants in September 2010 for the Affordable Care Act's Exchanges and is applying for funding for the State Implementation Grants in September 2011. The purpose of the funding is to help the State of Vermont to establish a State-Operated Health Insurance Exchange. The deliverables for this project will include a recommended implementation plan and budget for an operational exchange. This agreement formalizes the ongoing relationship between BISHCA and DVHA regarding responsibilities for the Health Insurance Exchange. The implementation plan will include the eleven exchange establishment core areas:

1. Background Research
2. Stakeholder Consultation
3. Legislative and Regulatory Action
4. Governance
5. Program Integration
6. Exchange IT Systems
7. Financial Management
8. Oversight and Program Integrity
9. Health Insurance Market Reforms
10. Providing Assistance to Individuals, and Small Businesses, Coverage, Appeals and Complaints
11. Business Operations of the Exchange

## **II. Collaboration**

The Department of Banking, Insurance, Securities and Health Care Administration, BISHCA, and the Department of Vermont Health Access, DVHA, will work together to further all of the goals and requirements of establishing the state-operated health insurance exchange. The collaboration will continue during the first phase of the Level 1 implementation grant process, September 30, 2011-September 30, 2012, and on an ongoing basis. This agreement will outline what areas each department will be responsible for during the Level 1 grant process.

## **III. BISHCA Responsibility During Level 1 time period (September 30, 2011 – September 30, 2012)**

- Regulatory authority over Health Insurers
- Licensing authority over Health Insurers
- Insurance market law changes
- Review of current rate review process to determine any changes needed to comply with the Affordable Care Act
- Financial stability of insurance companies
- Insurance company solvency standards
- Market conduct investigations
- Development of criteria and process, including forms, notices, agreements, etc, to certify, recertify, and decertify qualified health plans
- Inside/Outside market study
- Small business/employers from 50 to 100 study
- Development of risk adjustment and reinsurance programs and collaborate with HHS on risk corridor program
- Standards for display of plan information on web portal
- Development of the consumer satisfaction survey design
- Development of standardized plan design options

- Implementation of final standardized plan design for platinum, gold, silver, and bronze plans
- Participation in the design of a quality rating system with the Vermont Department of Health and other involved entities
- Development of carrier reporting requirements
- Comparison of federally-defined essential health benefits with Vermont mandates, and estimated cost of continuing Vermont mandates not included in essential benefit package

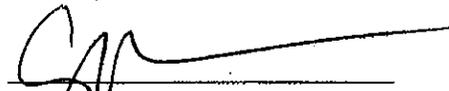
#### **IV. DVHA Responsibility During Level 1 time period (September 30, 2011 -- September 30, 2012)**

- Maintenance of all documentation to comply with Federal grants.
- Administration of all Federal grants including budget, reports, and communications with the federal government
- Development of Health Insurance Exchange Information Technology
- Review of current Medicaid customer service/call center functions and determination of what additional call center requirements and functions will be needed in the future
- Development of enrollment requirements for the exchange
- Development of exemption requirements from individual mandate
- Development of the requirements for a web portal.
- Review of current Medicaid Business operations for changes necessary in the future.
- Review of current financial management functions for changes necessary in the future
- Development of requirements for the navigator function for both individuals and small businesses
- Review of appeals processes for individuals and small businesses and determination of needed changes
- Review of current waste, fraud, and abuse prevention activities and determination of any needed changes
- Development of an outreach and education campaign

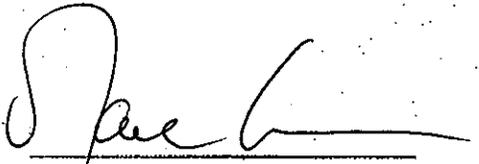
- Determination of necessary functions of a Small Business Health Options Program (SHOP exchange)
- Assessment of Vermont's current infrastructure, applications, interfaces, and business processes used to determine eligibility for publicly subsidized health coverage programs
- Documentation of weaknesses/gaps in the current system that will need to be addressed in order to create a streamlined eligibility system that can connect people to the appropriate health assistance program
- Identification of vertical and horizontal integration opportunities/challenges with regard to eligibility determination processes for other social service programs and potential to incorporate these programs into streamlined eligibility process
- Coordination of eligibility system assessment and changes with work of: MMIS, VIEWS, and ACCESS systems
- Development of options for establishing a streamlined, single application process that can be used to determine eligibility for premium subsidies that will be available through the HIX and other publicly subsidized health assistance programs
- Review of current Medicaid eligibility process and determine what changes are necessary for the process as well as the creation of a tax credit process
- Identification of a recommended approach, preparation of a high-level budget estimate, and development of a timeline for implementation for all exchange activities
- Overall management of the exchange development process
- Coordination of activities with other division/units within DVHA including and not limited to:
  - Blueprint for Health
  - Clinical Services
  - Coordination of Benefits
  - Program Integrity
  - Information Technology
  - Business Office
- Coordination of activities with other division/units within the Agency of Human Services
  - AHS Information Technology
  - AHS Business Office

o AHS Global Commitment/Health Care operations

- Coordination of activities with the Department for Children and Families
- Documentation of key steps and cost estimates with regard to the timeline for implementation
- Development of Exchange evaluation process
- Management of Exchange advisory committee process, as well as other stakeholder involvement

  
\_\_\_\_\_  
Georgia Maheras, Deputy Commissioner  
Division of Health Care Administration  
Department of Banking, Insurance, Securities  
& Health Care Administration

9/16/11  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Mark Larson, Commissioner  
Department of Vermont Health Access (DVHA)

9.21.11  
\_\_\_\_\_  
Date

## Exchange Evaluation Data Needs

1. Key questions
  - a. What are the effects on Vermonters?
    - i. New coverage
      1. Reduction in number of uninsured
    - ii. Better coverage
      1. Reduction in number of underinsured
    - iii. Change in source of coverage
      1. Type (private, public)
        - a. Details on public programs?
      2. Source (employer, individual)
      3. Through Exchange
    - iv. Change in cost of coverage
    - v. Change in out-of-pocket spending
    - vi. Changes in access to / use of care
    - vii. Change in health status
  - b. What are the effects on employers?
    - i. Change in offer / non-offer
      1. Drop coverage
      2. Newly offer coverage
    - ii. Change in benefits offered
    - iii. Change in cost to employer
      1. Aggregate premium
      2. Employer share
    - iv. Change in number of employees?
    - v. Coverage of employees in individual exchange
  - c. General operational
    - i. How has the process of obtaining coverage changed?
      1. Simplification
      2. Speed
      3. Service
2. Key data issues
  - a. Lack of information on:
    - i. Benefits
    - ii. Premiums
    - iii. Employer / employee contribution
  - b. Inability to track
    - i. People across sources of coverage
      1. E.g. someone who goes from group to individual coverage or Medicaid to private
3. Recommendations (in an ideal world)
  - a. Collect benefit information from payers at group level, including renewal date
    - i. Based on survey done for original exchange analysis
    - ii. VHCURES currently includes encrypted group name. Benefit info needs to link to this.
  - b. Develop mechanism to track individuals across changes in payer, group, and benefit

- i. While preserving anonymity
  - c. Conduct an annual employer survey, looking at offer, eligibility, benefits, and premium share
    - i. Piggyback on VT Dept. of Labor survey?
      - 1. <http://www.vtlmi.info/fringebene.pdf>
  - d. [Conduct periodic member surveys to assess customer satisfaction](#)
  - e. [Collect and analyze enrollment data](#)
  - f. Add exchange-specific questions to household survey, [provider survey](#), [BRFSS](#), and [national survey instruments](#)
- 4. Analytical Issues
  - a. Isolating changes attributable to Exchange from all other activities
    - i. Probably means that health status measures won't be usable, utilization measures may be challenging
  - b. Historical changes
    - i. How have benefits changed over time, prior to the implementation of the Exchange?
  - c. Underinsured
    - i. Distinguish potential from actual underinsurance?
      - 1. "I have a very high deductible, but I'm healthy" vs. "I'm sick and I can't afford care"

# Exchange Work Plan

## 1. Background Research

### Quality Programs and Initiatives

Activity	Timing	Outcome
State staff will inventory quality initiatives and conduct analysis to determine how to integrate or supplement existing quality programs and initiatives programs into the Exchange.	December 2011 – February 2012	Findings Report
Findings will be reported out to Exchange Advisory Board	March – May 2012	Board provides feedback
Policy recommendations will be made and quality initiatives adapted as appropriate.	June 2012	Policy recommendations on integrated quality initiatives are made

### Wellness and Health Promotion

Activity	Timing	Outcome
Develop and issue RFP for contracted services	October - December 2011	RFP and signed contract
Contractor will scan Vermont environment and conduct analysis on best practices and write report.	January – March 2012	Draft report
Findings will be reported out to Exchange Advisory Board	April 2012	Board provides feedback
Contractor incorporates feedback	May 2012	Final report
Recommendations are made for wellness initiatives in Exchange	May 2012	Wellness initiatives are determined

### Administrative Simplification

Activity	Timing	Outcome
Develop and issue RFP for contracted services and contract	October - December 2011	RFP and signed contract
Contractor will conduct research on administrative simplification and write a report with recommendations.	January – March 2012	Draft report
Present report findings to Exchange Advisory Board	April 2012	Board provides feedback
Contractor incorporates feedback	April 2012	Final Report
Make recommendations for administrative simplification	May 2012	Plan for administrative simplification is adopted

## 2. Stakeholder Consultation

### Exchange Advisory Board and Joint Advisory Committee Meetings

Activity	Timing	Outcome
Prepare agenda and topics for at least 10 Advisory Committee meetings	Monthly beginning January 2012	Calendar is set, people are invited, room is reserved, and agenda is prepared
Prepare meeting materials, post to website, conduct meetings.	Monthly beginning January 2012	Meetings occur.

### Meetings with Stakeholders in the State

Activity	Timing	Outcome
Continue meetings with stakeholders including:	Ongoing through	Understanding of various

<ul style="list-style-type: none"> <li>• Insurance carriers</li> <li>• Providers (medical professional and hospital groups)</li> <li>• Consumer advocates</li> <li>• Employers</li> <li>• Brokers</li> </ul>	April 2012	stakeholder options on Exchange
Secondary meetings with stakeholders to discuss passed legislation and further exchange development	May-June 2012	More in-depth opinions on Exchange issues

**Tribal Interaction - N/A (Vermont has no federally recognized tribes.)**

**Public Stakeholder Meetings**

Activity	Timing	Outcome
Engage communications contractor to assist with public stakeholder meetings for early education	January 2012	Contractor engaged
Hold public stakeholder input meetings on the Exchange at locations throughout the state.	February - August 2012	Run meetings throughout the state
Provide written summaries of meetings for website posting	May-September 2012	Meetings available to the public

**3. State Legislative/Regulatory**

**Assess Need for Additional Legislation and/or Regulation for Exchange**

Activity	Timing	Outcome
Develop and issue RFP and contract with ERISA attorney to assist with employer questions related to Exchange	February – March 2012	Contractor engaged
ERISA Contractor analyzes ERISA provisions along with goals of Vermont Exchange and provides guidance to state on employer issues	March – April 2012	Draft analysis
Discussion of findings at Advisory group	May 2012	
Draft state legislation and regulations for any necessary changes.	September 2012	Draft legislation and regulations

**4. Governance**

Activity	Timing	Outcome
Medicaid and Exchange Joint Advisory Committee is established	May 2012	Advisory Group members are appointed
Exchange hires an Deputy Commissioner to oversee operations of the exchange	October – November 2011	Deputy Commissioner hired
Job descriptions for other Exchange (and sister agency) positions are developed and posted with assistance from a contractor.	October – December 2011	Positions are posted
Exchange (and sister agency) positions are hired and begin work	January – June 2012	Hiring is completed

**5. Program Integration**

**Integration with Medicaid**

Activity	Timing	Outcome
Continue work of health Insurance Exchange operations subcommittee for Medicaid and the Exchange roles &	October - December 2011	Status report

responsibilities, identifying lead organization, and dealing with challenges, on issues including and not limited to: <ul style="list-style-type: none"> <li>• Eligibility determination, verification and enrollment</li> <li>• Strategies for compliance with “no wrong door” policy</li> <li>• Benefits &amp; IT systems</li> </ul>		
Use subcommittee to create options and recommendations on issues between Medicaid and the exchange (and potentially basic health plan), operating procedures between exchange and other state health programs, and cost allocations between exchange grant, Medicaid and other funding streams. Coordinate work group options with insurers and other private entities who will be involved in integration.	January - February 2012	Memo on options/recommendations for areas of overlap
Present options/recommendations to agency leadership and Exchange Advisory Board	March 2012	Revised memo

### **Integration with Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)**

Activity	Timing	Outcome
The Insurance Market Planning group will convene regular meetings to coordinate work, including: <ul style="list-style-type: none"> <li>• Roles and responsibilities of exchange and BISHCA for QHPs inside and outside exchange</li> <li>• Limiting adverse selection between exchange and outside market</li> </ul>	Ongoing	Work group for insurance market integration
Develop options for roles and responsibilities and market reforms that affect the exchange and the outside market and updates to the churning report and basic health plan reports.	October - December 2011	Memo on options for market reforms based on additional actuarial and market analyses, if needed
Present options to Legislature	January 2012	Understand preferred directions
Further develop preferred options	February 2012	Revised memo
Update and pass additional state legislation as needed	February – May 2012	Prepare for 2012 session

### **Sharing Information between BISHCA and Exchange**

Activity	Timing	Outcome
Work with BISHCA to ensure BISHCA collected information will be shared with the exchange to ensure Qualified Health Plans (QHPs) meet state insurance regulations, including: <ul style="list-style-type: none"> <li>• Rate review</li> <li>• State licensure</li> <li>• Solvency</li> <li>• Market conduct</li> <li>• Financial stability of insurance companies</li> <li>• New insurance market reforms in 2014</li> </ul>	October 2011 – September 2012	Staff communication and IT systems have process for exchanging information
Ensure way to share exchange-collected data on QHPs with BISHCA, including: <ul style="list-style-type: none"> <li>• Certification processes</li> <li>• Quality information</li> <li>• Performance requirements</li> </ul>	October 2011- September 2012 and ongoing	Staff communication and IT systems have process for exchanging information
Test information sharing through IT systems	October 2012 and ongoing	Functioning system

## 6. Exchange IT Systems

Activity	Timing	Outcome
Architecture Review, Implement and configure Oracle Suite for AHS use, Draft and issue RFP for System Integrator to assist with technical design of Exchange, Draft and issue RFP for VIEWS E & E system	November – December 2011	Detailed architecture review, ORACLE Suite reconfigured, System Integrator and contractor engaged
Collaborate with NESCIES for HIX components and complete final requirements documentation (including System design, Interface control, Data Management, and Database design))	November – December 2011	Attend meetings, determine whether NESCIES components can be leveraged
Review release by CMS of MITA 3.0	November – December 2011	Release reviewed
Draft and issue additional RFPs for HIX components as needed, Draft AHS roadmap summary, Establish eligibility and enrollment framework	January – March 2012	Roadmap drafted, eligibility and enrollment framework developed
Complete AHS roadmap, Complete eligibility and enrollment,	July – September 2012	
Implementation of provider directory	October – December 2012	
Kickoff for HIX Testing, Establish reporting and analytics readiness	April – June 2013	
HIX final testing and VIEWS implementation	July – September 2013	

## 7. Financial Management

### Align State Financial Monitoring Protocols with HHS Requirements

Activity	Timing	Outcome
Develop and issue RFP and engage contractor to assess federal requirements and determine necessary changes to VT's financial monitoring system	January – February 2012	Contractor engaged and report completed
Develop agency policies to bridge between state financial policies and federal policies	March 2012	Policies applying to federal funds
Integrate exchange financial functions into existing state financial management system	September 2012	Exchange financial management system

### Develop Sustainability Model for Exchange

Activity	Timing	Outcome
Develop and issue RFP and contract with contractor to finalize options for Exchange sustainability	December 2011	Contractor engaged
Contractor finalizes financial model to project exchange revenue and expenses over 5 years, recommended levels of funding required to make the exchange self-sustaining by January 2015, and the estimated resources required for the first 5 years of operation	January – February 2012	Final financial model
Finalize options for sustainability once federal guidance is provided	February 2012	Full set of options developed
Present options to Legislature and Exchange Advisory Group	February 2012 and ongoing	Narrow options with recommendations from both Legislature and Advisory Board

Draft legislation on potential funding mechanisms for the Exchange (if necessary)	January 2012 or January 2013	Draft legislation
Passed legislation on funding mechanisms for the exchange (if necessary)	March 2012 or April 2013	Funding mechanism in place for Exchange

#### **Establish New Accounting and Financial Management System for Exchange**

Activity	Timing	Outcome
Develop and issue RFP and contract with contractor to assess current accounting and financial management system and assess gaps	December 2011	Contractor engaged
Contractor assesses resources, needs, and gaps to develop a financial management structure for the Exchange	February 2012	Gaps, needs, resources available for financial model
Demonstrate capability to manage the finances of the Exchange soundly, including the ability to publish all expenses, receivables, and expenditures consistent with federal requirements	January-December 2013	Sound management of finances
Post information related to exchange financial management on the exchange website and identify other means to make financial activities transparent	January-December 2014	Website postings on financial management
Submit annual accounting report to HHS	Annually beginning in 2014	Annual accounting reports to HHS

### **8. Program Integrity**

#### **Ensure the Prevention of Waste, Fraud and Abuse**

Activity	Timing	Outcome
Develop and issue RFP and contract with contractor to assess current state policies and system	January 2012	Contractor engaged
Develop agency policies to bridge between state financial policies and federal grant policies	Ongoing through September 2012	Policies for both state and federal policies
Follow appropriate HHS audit procedures	Ongoing	Audit procedures adhered to

#### **Implement Oversight and Program Integrity Functions**

Activity	Timing	Outcome
Develop and issue RFP and contract with contractor to assess current state policies and system	January 2012	Contractor engaged
As part of operational plan contractor will assess existing programs, develop plan processes, and create hiring plan as necessary for oversight and program integrity functions	February- March 2012	
Continue to develop processes and hire staff and/or allocate functions to existing staff for oversight and program integrity functions	November 2011 – April 2012	Staff for oversight and program integrity functions
Present proposed oversight and program integrity functions to advisory board and legislature	May 2012	Recommendation for Board
Establish procedures for external audit by a qualified auditing entity to perform an independent external financial audit of the exchange and	September 2012 and updated on an ongoing basis	External audit procedures

connect this to existing state and federal auditing procedures		
Establish fraud detection procedures	January-March 2013; then ongoing	Fraud detection procedures
Develop procedures for reporting to HHS on efforts to prevent fraud, waste and abuse	April 2013	Procedures for preventing fraud, waste and abuse
Comply with HHS reporting requirements related to auditing and prevention of fraud, waste and abuse	July 2014	Reports to HHS on auditing and preventing fraud, waste and abuse

## 9. Health Insurance Market Reforms

### Preventing Adverse Selection

Activity	Timing	Outcome
Review results of RWJ funded brief that discusses adverse selection for individual and small group plans inside and outside the exchange and risk selection within the exchange.	October 2011- December 2011	Issue brief written with BISHCA
Use report as basis for discussions with advisory group and legislature	January 2012	Options/recommendations
Draft RFP and hire contractor for any follow-up work required	January – March 2012	Report drafted
Present options to Exchange Advisory Group and legislature	March – April 2012	Options presented at meeting.
Draft legislation as needed on association health plans, merging of individual and small group market, employer size at 50 or 100 at the start of Exchange, and whether there will be an outside market	March 2012	Draft bill
Pass legislation	May 2012	

### Risk Leveling

Activity	Timing	Outcome
Draft and issue RFP and engage contractor	January 2012	Contractor engaged
Contractor to write brief on how each of the three risk leveling mechanisms could work in Vermont and how they would interact with each other.	February – April	Draft issue brief
Discuss with Advisory group and Legislature	April 2012	Understanding of risk leveling issues
Coordinate State model with federal requirements	April – June 2012	Discussion with HHS
Decision made on risk leveling mechanisms	October 2012	

### Evaluate State-Mandated Benefits that Exceed Essential Health Benefits

Activity	Timing	Outcome
Draft and issue RFP and engage actuarial contractor to provide costs of extra benefits	January 2012	Contractor engaged
Review current state mandated benefits against essential health benefits	January 2012	List of benefits
Perform actuarial comparison of state mandated benefits that exceed essential health benefits	January – March 2012	Estimate of state cost of providing state-mandated benefits that exceed the essential health benefits (will be done regardless of whether evaluation process moves forward)
Present findings at Exchange Advisory Group meeting and Green Mountain Board	March 2012	Discussion of benefits

Introduce legislation and pass legislation to revise the state-mandated benefits that exceed the federal essential health benefits (as needed)	March 2012 – May 2012	Legislation drafted and passed. Establishes the benefits that must be offered in individual and small group plans beginning January 2014
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## 10. Providing Assistance to Individuals and Small Businesses, Coverage Appeals & Complaints

### Leverage Consumer Assistance Programs

Activity	Timing	Outcome
Collect and analyze data and assess the current availability of consumer assistance services, including: <ul style="list-style-type: none"> <li>• Help individuals determine eligibility for private and public coverage &amp; enroll in such coverage</li> <li>• Help file grievances and appeals</li> <li>• Provide information about consumer protections'</li> <li>• Collect data on inquiries and problems and how they are resolved</li> </ul>	October – December 2011	Use information to strengthen accountability of QHPs and functioning of the Exchange
Establish protocols for appeals of coverage determinations, including review standards, timelines, and provisions for consumers during the appeals process	July 2012	Appeals of coverage determination protocols
Draft scope of work for building capacity to handle coverage appeal functions	August 2012	Scope of work on capacity to handle coverage appeal functions
Establish a process for reviewing consumer complaint information collected by state consumer assistance programs when certifying QHPs	February- May 2013	Reviewing consumer complaint processes
Establish a process for referrals to other consumer assistance programs	February-May 2013	Process for referring consumers to other consumer assistance programs
Ensure any consumer complaints or coverage appeal requests are referred directly to the state program that is designated to process these calls	January-December 2014; ongoing	Procedures for referring complaints or coverage appeal requests to the state program

## 11. Business Functions

### Certification of Qualified Health Plans

Activity	Timing	Outcome
Draft RFP and hire contractor to develop the criteria for certification, decertification and recertification of QHPs and the consumer satisfaction survey process	January 2012	Contractor hired
Contractor develops plan for clear certification process including a timeline for application submission, evaluation, and selection of QHPs	January-March 2012	Draft certification process
Engage stakeholders and gather input on draft certification criteria	January 2012 – March 2012	Stakeholder meetings
Present report to advisory group and legislature	April – May 2012	
Draft certification documents that will be used in connection with certification of QHPs	June-August 2012	Certification documents
Begin training health plan issuers to become QHPs	November 2012	Health plan issuers trained
Begin contract process with health plan issuers	January 2013	Preliminary discussions underway

Complete certification process of QHPs	April 2013	Finish negotiations, complete contracts, and announce QHPs
Complete plan readiness reviews	July 2013	Test enrollment interfaces with plans, review member materials, test financial reconciliation, cross-functional implementation sessions with plans
Issue announcement on the selection of QHPs to the public	July 2013	Public announcement on selection of QHPs
Monitor the QHPs for practices, conduct, pricing, and products inside and outside the Exchange	Beginning January 1, 2014 and ongoing	Performance reports in coordination with OIC

### **Call Center**

Activity	Timing	Outcome
Draft and issue RFP and engage contractor to develop the criteria for the call center	December 2011	Contractor engaged
Contractor will assess current call center activity in Vermont including resources at BISHCA, DVHA and DCF	January – March 2012	Understand: <ul style="list-style-type: none"> <li>• How many calls a month</li> <li>• Volunteers</li> <li>• Training</li> <li>• Online functionality</li> <li>• Funding/operational costs</li> </ul>
Contractor will review current Customer Service Contract for Medicaid to learn about existing call center system functions and identify gaps	January – March 2012	Understand: <ul style="list-style-type: none"> <li>• What currently exists</li> <li>• What systems need to talk to each other to run call center</li> <li>• Calls per month</li> <li>• Staffing ratios</li> <li>• Online capability</li> <li>• Operational costs</li> </ul>
Contractor will develop criteria for RFP to select a vendor (or amend current contract) to operate call center	January 2012 - June 2012	RFP or contract amendment
Develop call center customer service representative protocols and scripts to respond to likely requests	January 2013	Protocols and scripts
Develop protocols for accommodating the hearing impaired and those with other disabilities and foreign language and translation services	February 2013	Protocols
Train call center representatives on eligibility verification and enrollment processes	March 2013	Understanding of eligibility systems and how they function
Launch call center	July 2013	800 number
Publicize call center through outreach campaign, website, etc.	July 2013	Outreach
Ongoing customer services monitoring	Ongoing	Performance report on call center

### **Quality Rating System**

Activity	Timing	Outcome
Review federal guidance on the quality rating system	November 2011 or whenever released	Understanding of what is required
Draft and issue RFP and engage contractor to determine what additional requirements Vermont may want to include for reporting	December 2011 – February 2012	Contractor engaged

Discuss with Advisory group, legislature, and stakeholders, options for additional requirements	March 2012	Feedback
Incorporate rating system into system and website development	January -April 2013	Rating system established
Post quality ratings on Exchange website prior to open enrollment	June 2013	Quality ratings on website
Continually update quality rating system as information from plans becomes available	Ongoing	Updated quality information

### **All Payer Rate Setting**

Activity	Timing	Outcome
Draft and issue RFP for contractor to study feasibility of all-payer rate setting system	November 2011	Contractor hired
Contractor studies current payment mechanisms and levels across payers in Vermont and proposes mechanisms for leveling	December 2011 – February 2012	Enumeration of current payment mechanisms and levels across payers and providers
Discuss with Advisory group, legislature, and stakeholders, options for reform	March – April 2012	Feedback incorporated
Write final report with recommendations	May 2012	Final report

### **Navigator Program**

Activity	Timing	Outcome
Review federal guidance on Navigator program	October – December 2011	Understand federal guidance
Draft and issue RFP and engage contractor to develop criteria and training materials for Navigator program	January 2012	Contractor engaged
Present options for Navigator program to legislature and advisory group	March 2012	Feedback
Begin developing RFP for the Navigator program	July 2012	RFP
RFP released	September 2012	Bids received
Receive bids from potential Navigators	November 2012	Navigators for May 2013-December 2014 (20 month program)
Award contracts to Navigators for 2013-2014	January 2013	Navigators announced
Train Navigators	May 2013	Navigators ready to assist consumers
Begin Navigator program	May 2013	Program operational
Require quarterly reporting from Navigators on performance	June 2013; September 2013; December 2013; March 2014; June 2014; September 2014; December 2014	
Release RFP for 2015 Navigators	September 2014	Grants for calendar year 2015 (12 month program)
Grants awarded	November 2014	Announcement of 2015 Navigators
Training for Navigators	December 2014	Navigators ready to assist consumers
Release RFP for 2016 and beyond Navigator program	Annually in September 2015	Grants for calendar year 2016 and each year afterwards

### **Eligibility Determinations**

Activity	Timing	Outcome
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Coordinate with health insurance Exchange operations subcommittee on eligibility changes	Ongoing	Regular meetings
Coordinate with BISHCA on planning efforts	Ongoing	Regular meetings with BISHCA
Release of federal guidance on many aspects of eligibility determinations and requirements	July 2011	Clearer understanding of eligibility processes
As part of operational plan and IT systems plan, build business requirements for eligibility system	October 2011-September 2012	IT systems and business functions in place
Work with health insurance Exchange operations subcommittee on building of business rules for eligibility for Medicaid	October 2011-December 2011	Clear business rules across Exchange and Medicaid
Consider options for handling churn between Medicaid and the Exchange (and potentially basic health plan) with Medicaid eligibility and IT systems teams	October 2011-December 2011	Work group to catalogue options
Develop policy options on handling churn	October 2011-December 2011	Options report
Present policy options to advisory group and legislature	January 2011	Recommendations

### **Application and Notices**

Activity	Timing	Outcome
Review federal requirements for applications and notices	January –March 2012	
Develop requirements for exchange’s applications and notices	March – June 2012	
Customize federal applications and notices to meet state’s need	June – August 2012	Customized applications and notices
Receive input from consumers providers and advocates on draft applications and notices	September 2012	Stakeholder feedback
Test final applications and notices on stakeholder group and consumers	November 2012 – March 2013	Final applications and notices
Begin utilizing applications and notices to support eligibility and enrollment processes	April 2013	Use applications and notices for enrollment

### **Outreach and Education**

Activity	Timing	Outcome
Develop RFP for development of a formal communications plan through 2014 that includes: <ul style="list-style-type: none"> <li>● Phase I: Research and Planning - Research through focus groups and or surveys on people’s knowledge, concerns, information sources, etc.</li> <li>● Phase II: Outreach and Educational Materials Development - Plan for education and outreach to target audiences               <ul style="list-style-type: none"> <li>— Role of Navigators in outreach and education</li> <li>— Develop performance metrics and performance plan of education/outreach campaign</li> </ul> </li> <li>● Phase III: Launch activities</li> </ul>	January 2012	RFP for communications/advertising firm to create communications plan.
Issue RFP for implementation of outreach and education campaign to include but not limited to: <ul style="list-style-type: none"> <li>● Toolkit for outreach and educational activities,</li> </ul>	February 2012	Bids for communications plan

<ul style="list-style-type: none"> <li>• Media strategy with paid advertising, in-kind and free and/or co-op advertising opportunities</li> <li>• Launch strategy for public outreach and education campaign</li> </ul>		
Engage firm to develop and carry out communications plan	March 2012	Communications firm in place
Complete research phase of communications plan	April - June - 2012	Understanding of people's knowledge and understanding
Create stakeholder group to get input on communications plan, educational materials, and marketing strategy	June 2012	Stakeholder feedback process
Complete planning phase of communications plan	July 2013	Plan for reaching target audience
Develop toolkit and design marketing campaign	July 2012- August 2012	Marketing materials
Launch outreach/education campaign	October 2012- December 2014	Ramp up toward open enrollment period
Identify ongoing outreach and education needs	March 2014	Ongoing needs
Provide ongoing outreach and education services	Ongoing	Ongoing outreach and education for exchange

### **SHOP-Specific Functions**

Activity	Timing	Outcome
Review federal guidance on Exchange role in aggregating premiums and other admin functions for small businesses (such as managing enrollment and billing)	January 2012	Consideration of guidance on any federal or exchange roles
Draft RFP and engage contractor to explore SHOP options	January 2012	Contractor engaged
Present viable options at advisory group meeting and with other stakeholders	April 2012	Feedback
Hire staff to implement SHOP functions	June 2012	Build staff capacity

### **Exchange Website and Calculator**

Activity	Timing	Outcome
Review federal guidance and prototype website from federal government	November 2011- January 2012	Guidance on how information might have to be presented
Review website provisions of New England States Innovator grant to determine if it can be used in Vermont	January – June 2012	
Begin development of system requirements for Exchange website with calculator	January 2012	Business requirements for website
Draft and issue RFP and engage contractor to develop Exchange website	March – August 2012	
Get consumer input to test information to be posted on website	August – October 2012	Feedback
Submit content for information website to HHS for comment	October 2012	HHS feedback
Launch informational website	February 2013	Informational website online
Continually update website based on consumer testing	Ongoing	Updated website and calculator

### **Individual and Employer Responsibility Determinations**

Activity	Timing	Outcome
Develop an issue an RFP to engage a contractor to assist with both aspects of this work	January 2012- March 2012	RFP
Contractor will review options and create a draft options report	March 2012 – August 2012	Draft options report
Make recommendations on both individual and employer responsibility determinations	September 2012	Decisions made about individual and employer responsibility determinations

#### **Enrolling individuals and businesses in qualified health plans**

Activity	Timing	Outcome
Create an RFP for contractor to develop enrollment options	January 2012 – March 2012	RFP
Contractor will review options and create a draft options report	March 2012 – August 2012	Draft options report
Make recommendations on enrollment processes	September 2012	Decisions made about enrollment processes in coordination with IT

#### **Universal Exchange Planning and Design**

Activity	Timing	Outcome
Develop RFP for contracted services and contract	January -March 2012	RFP and signed contract
Contractor will conduct research including the nature and timing of law changes, the coverage characteristics of Vermont population with coverage not addressed by Exchange in ACA, testing perceptions of groups and consumers, modeling the impact of bringing everyone into the Exchange, exploring how the Exchange can improve quality, develop a plan of outreach to stakeholders, determining staffing and budget.	March – August 2012	Draft report
Present report findings to Exchange Advisory Board	September 2012	Board provides feedback
Contractor incorporates feedback	September 2012	Final report
Make recommendations for Universal Exchange	September 2012	Decisions about the processes required for Universal Exchange

#### **Evaluation plan**

Activity	Timing	Outcome
Develop RFP for contracted services and contract	January -March 2012	RFP and signed contract
Contractor will assist the state with development of a comprehensive evaluation plan.	March – August 2012	Draft plan
Present draft plan to Exchange Advisory Board	September 2012	Board provides feedback

# Exchange Grant Expenses

9-30-2010 to 03-30-2012

	2010 - Q4	2011 - Q1	2011 - Q2	2011 - Q3	2011 - Q4	2012 - Q1	90 day Liquidation Period 2012 - Q2	Total
	10/1/10- 12/31/10	1/1/11-3/31/11	4/1/11- 6/30/11	7/1/11-9/30/11	10/1/11-12/31/11	1/1/12-3/31/12	4/1/12- 6/30/12	
<b>PERSONNEL</b>								
Salaries and Benefits	\$5,082.91	\$7,254.36	\$12,194.62	\$13,675.68	\$43,599.58	\$57,839.44	\$0.00	\$139,646.59
<b>Total Personnel</b>	<b>\$5,082.91</b>	<b>\$7,254.36</b>	<b>\$12,194.62</b>	<b>\$13,675.68</b>	<b>\$43,599.58</b>	<b>\$57,839.44</b>	<b>\$0.00</b>	<b>\$139,646.59</b>
<b>OPERATING</b>								
Advertising/Marketing								\$0.00
Training								\$0.00
Travel	\$1,326.15	\$567.35	\$1,588.47	\$746.89	\$1,068.98	\$927.28	\$0.00	\$6,225.12
Postage								\$0.00
Supplies/Materials								\$0.00
Printing								\$0.00
Hardware/Software		\$276.25				\$876.90	\$0.00	\$1,153.15
Other					\$25.00	\$260.39	\$0.00	\$285.39
<b>Total Operating</b>	<b>\$1,326.15</b>	<b>\$843.60</b>	<b>\$1,588.47</b>	<b>\$746.89</b>	<b>\$1,093.98</b>	<b>\$2,064.57</b>	<b>\$0.00</b>	<b>\$7,663.66</b>
<b>SUBCONTRACT:</b>								
Bailit Health		\$150,375.72	\$75,354.71	\$125,468.60	\$185,883.36	\$98,786.36	\$16,982.95	\$652,851.70
DVHA Administration	\$3,795.30	\$6,620.96	\$10,111.20	\$11,911.62	\$37,744.86	\$75,448.71	\$0.00	\$145,632.65
<b>TOTAL DIRECT</b>	<b>\$10,204.36</b>	<b>\$165,094.64</b>	<b>\$99,249.00</b>	<b>\$151,802.79</b>	<b>\$268,321.78</b>	<b>\$234,139.08</b>	<b>\$16,982.95</b>	<b>\$945,794.60</b>
AHS Indirects	\$1,625.58	\$2,065.47	\$9,113.00	\$4,486.38	\$14,169.16	\$22,745.81	\$0.00	\$54,205.40
<b>TOTAL GRANT EXPENSES</b>								
	\$11,829.94	\$167,160.11	\$108,362.00	\$156,289.17	\$282,490.94	\$256,884.89	\$16,982.95	\$1,000,000.00
<b>CAP Earnings Report</b>	11,829.94	167,160.11	108,362.00	156,289.16	282,490.94	256,884.89		
								Total Grant Funding
								<b>Balance</b>
								\$1,000,000.00
								<b>(\$0.00)</b>