VERMONT EXCHANGE PLANNING

TASK 6.0 ANALYSIS OF EXCHANGE FINANCIAL FUNCTIONS
DELIVERABLE 1: EXAMINATION OF THE FINANCIAL SYSTEMS AND FUNCTIONAL CAPACITIES OF STATE HEALTH INSURANCE PROGRAMS

INTRODUCTION

The federal Affordable Care Act (ACA) requires the establishment of health insurance Exchanges in each state (whether by the State or by the federal government). The ACA and subsequent guidance has begun to outline the business functions to be performed by the Exchanges. States, however, are given considerable latitude in determining how best to organize their Exchanges to meet their unique needs.

It is clear that the management of the Exchange will be complex. However, as Vermont plans for the development and implementation of its Exchange, there is no need to develop the necessary infrastructure from scratch. Many functions similar to those for which the Exchange will be responsible are already performed by other State agencies.

In some instances, the ability to leverage financial systems and processes is dependent on decisions that have yet to be made regarding the structure of the Exchange. For example, if an employer assessment is used to support the operation of the Exchange, then existing processes for the collection of other employer assessments could be adopted for the Exchange. If, however, other revenue strategies are identified (a tax on all health insurance premiums for example), the employer assessment collection process is not applicable. Other decisions on the systems and processes are foundational and independent of how the Exchange is organized, such as the need for an automated accounting system and audit procedures. These needs will exist regardless of the structure of the Exchange.

Though questions remain regarding the ultimate organization of the Exchange, this report is intended to begin inventorying potential opportunities to leverage existing processes in other state insurance programs as well as areas where such precedents do not exist and will have to be developed.

To develop this inventory, Burns & Associates, Inc. (B&A), under contract with Bailit Health Purchasing, met with representatives of the Department of Vermont Health Access (DVHA) to discuss the State's public health insurance programs and with the Employee Benefits unit within the Department of Human Resources to discuss the operations of the State Employees Health Plan. Among the programs administered by DVHA, it was determined that Catamount Health is most similar from an operational standpoint to the requirements that will or may be needed to operate an Exchange.

This report begins with an overview of these programs including a review of application and eligibility processes. The report then details the focus of our review—namely, the financial operations of these programs in the following areas: revenues and receipts, disbursements, and financial oversight.

OVERVIEW OF STATE-OPERATED HEALTH INSURANCE PROGRAMS

The State of Vermont offers a number of health insurance programs to its residents. Green Mountain Care is the family of low-cost and free health care programs offered to Vermonters by the State and its partners. Some provide insurance for children, others cover low-income residents, and others are available to all Vermonters. Specifically, these programs include:

- The State's Medicaid program and Children's Health Insurance Program (CHIP, named Dr. Dynasaur in Vermont).

- The Vermont Health Access Plan (VHAP), which offers coverage to individuals at least 18 years of age, with income less than 150 percent of the federal poverty level (FPL) for single adults and 185 percent of the FPL for adults with children, and who have not had health insurance for at least 12 months (though there are some exceptions to the coverage requirement). Premiums for VHAP are set on a sliding scale based on income and range from $0 to $49 per month.

- Catamount Health, a comprehensive health insurance plan currently offered by two commercial insurers and available to adults 18 years of age and older who have not had health insurance for at least 12 months (with exceptions similar to those in VHAP). The State provides premium assistance to individuals with incomes less than 300 percent of the FPL.

- Employer Sponsored Insurance (ESI) Premium Assistance, which offers State subsidies to individuals who meet the eligibility criteria for VHAP or Catamount Health and are eligible for cost-effective, comprehensive health insurance through their employer. Enrollees remain responsible for a portion of the premiums, with their share set according to their income and starting at a floor of $60 per month.

- A variety of prescription assistance programs.

Catamount Health

Catamount Health was established by Vermont's 2006 Health Care Affordability Act, which aimed to increase access to health care, control rising health care costs, and improve health care quality. Catamount Health provides comprehensive coverage including primary care, chronic care, and hospital services. Enrollment began in 2007 and approximately 12,500 Vermonters are currently enrolled.

Two commercial insurers offer insurance through Catamount Health: Blue Cross Blue Shield of Vermont (BCBS) and MVP Health Care (MVP). The plans' premium rates are actuarially determined and are subject to the State's usual rate-setting process through the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). Effective April 1, 2011, monthly premiums will be $447 for BCBS and $533 for MVP. Primary care providers are paid Medicare rates plus ten percent, and hospitals at cost plus ten percent.

Individuals with incomes greater than 300 percent of the FPL are responsible for the full monthly premium while those with incomes below that threshold are eligible for the Catamount Health Premium Assistance Program (CHAP), through which the State subsidizes the premiums. After the subsidy, which is set on a sliding scale according to income, enrollees' monthly premiums range from $60 to $208. MVP enrollees must also pay the difference in cost between the BCBS and MVP premiums, which increases their monthly cost of premium plus differential to $146 to $294. Both insurers have in-network deductibles of $500 per individual and $1000 per family and out-of-network deductibles of $1050 per individual and $2100 per family. Due to its higher premiums, MVP's share of enrollees has declined to approximately eight percent.

In addition to enrollees' share of premiums, funding for Catamount Health is derived from several sources. The State's cigarette tax was increased by $0.60 on July 1, 2006, and an additional $0.20 two years later, and other tobacco taxes were instituted, with the proceeds directed to the program. There is also an assessment levied against employers with employees who do not receive employer-sponsored insurance, regardless of whether coverage is offered. The assessment is annually indexed to the percentage change in Catamount Health premiums and is currently $113.03 per full-time equivalent (FTE) per quarter. Employers with four or fewer FTEs are exempt from the assessment. The program also receives matching federal Medicaid dollars. State General Fund dollars have been used to cover shortfalls in the program.

As part of his fiscal year 2012 budget proposal, Governor Shumlin has recommended that Catamount Health be folded into the state-operated Vermont Health Access Plan and become VHAP Expanded with the expectation that this move will save $6.2 million in the final three quarters of the fiscal year. The savings are due to lesser administrative overhead and reduced provider rates, estimated by provider groups to be nearly 33 percent rate cuts. The Governor's proposal would also increase deductibles from $500 to $1,200, though other costs, such as prescription drug copayments and co-insurance would be eliminated. Premiums would decrease, which would benefit full-pay enrollees. This proposal is being considered as part of the budget process.

Vermont State Employees Health Plan

The Vermont State Employees Health Plan provides health insurance coverage to state employees, retirees, their families, and a handful of other specially designated groups (e.g., elected officials, employees of the historical society).

The State is self-insured and contracts with Cigna to administer four plans:

- SelectCare, a managed care, HMO-like plan that is the most popular option.
- Two PPOs, TotalChoice and HealthGuard, with out-of-pocket limits of $1,050 and $2,300 per person, respectively.
- SafetyNet, a catastrophic plan with a $10,000 deductible and limited prescription drug benefits.

Employees, early retirees under 65 years of age, and special groups may choose from any of the four plans while retirees over 65 may only access the PPO plans. Each plan includes single, two-person, and family options.

As of January 15, a total of 22,369 individuals were enrolled in one of the four plans. Of approximately 8,108 state employees, 7,028 – nearly 87 percent – have elected to participate in the State's health insurance program. There are 3,889 participating retired employees and 86 individuals enrolled through a special group. The balance of enrollees is member dependents.

Premiums are set in-house by the Employee Benefits unit and its contracted actuarial firm, Milliman. Enrollees are responsible for 20 percent of premium costs regardless of the plan that they elect with the State covering the remaining 80 percent. In calendar year 2011, the employee share of bi-weekly premiums ranged from $41.60 for a single-person catastrophic plan to $195.09 for the TotalChoice PPO family plan.

Employee benefits, including health insurance, are subject to the State's collective bargaining agreement with the employee unions so any change to the terms of the program must be negotiated with the unions.

APPLICATION AND ENROLLMENT

The ACA includes an individual mandate, requiring everyone to acquire health insurance. Exchanges will play a key role in helping individuals to meet this requirement. To effectively fulfill this role, Exchanges must be easy for potential users to access. The ACA outlines a number of requirements regarding the processes that Exchanges must have in place in order to facilitate enrollment. Some of the processes used by the two programs in this review, and Catamount Health in particular, may prove to be applicable to an Exchange design in Vermont.

Catamount Health

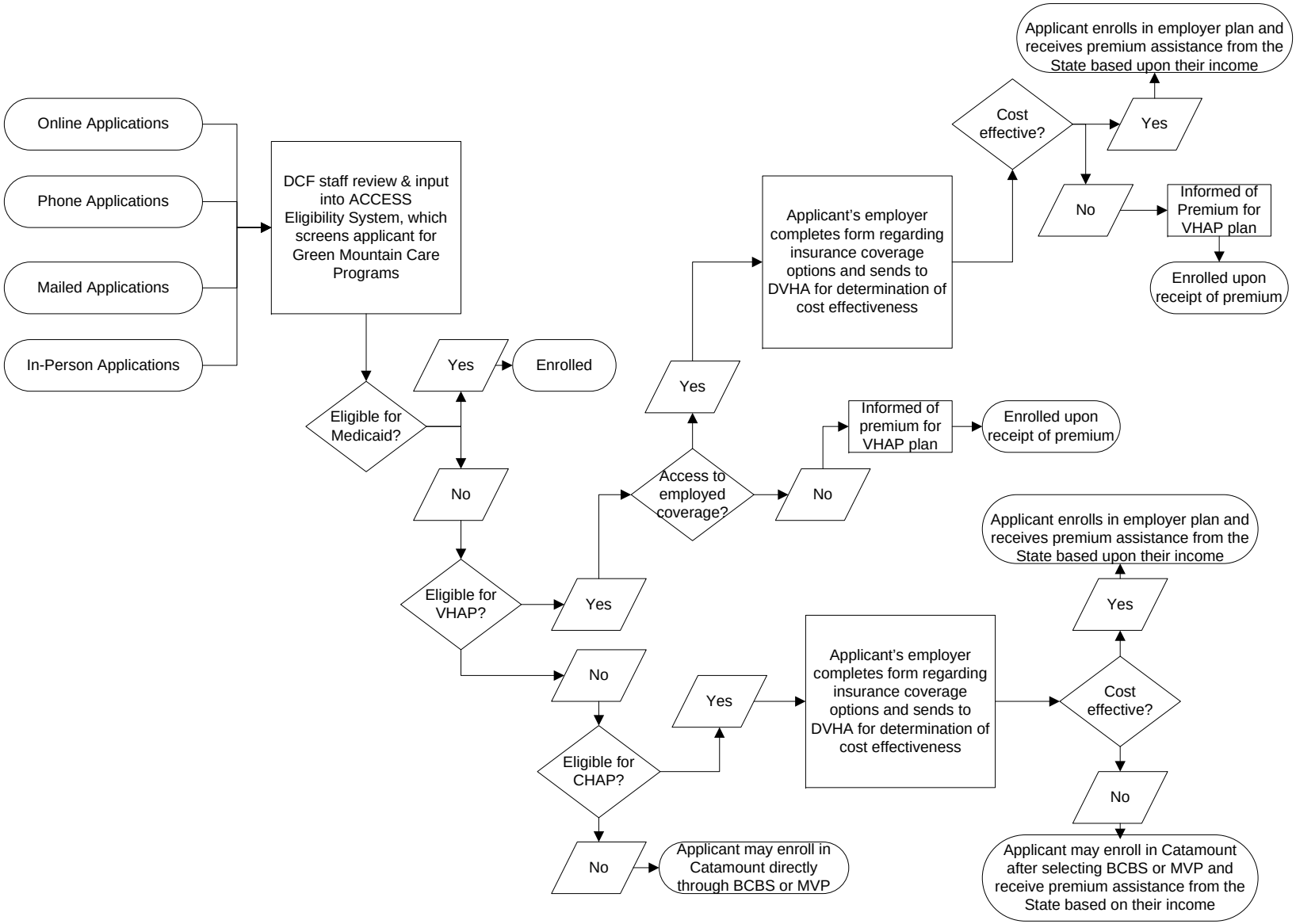
Figure 1 on the following page illustrates the enrollment process for Green Mountain Care.

There are a number of methods by which individuals can apply for coverage. They may apply online, by printing the form and mailing it to the Department of Children and Families' (DCF) Application and Document Processing Center, and in-person at a district office. There is a toll-free number staffed by a contractor that applicants may call if they need assistance. Insurance agents or brokers do not play any role in Catamount Health.

All applications are reviewed by the DCF health application unit for completeness. For an estimated one-third of applications, individuals are asked for additional information to document their income. Data matches with new hire reporting, wage reporting, and other sources are also employed to ensure accuracy.

Applications are manually input into the ACCESS eligibility system. Currently, this includes applications completed online, though DCF intends to add functionality that will allow the online applications to auto-populate the eligibility system. Once the application is input, the system

Figure 1:
Green Mountain Care Eligibility Process for Adults



determines the program for which the applicant qualifies and a notification with that information is mailed to the individual.

For those applicants eligible for VHAP, the notice includes the amount of their required premium. Coverage begins immediately upon payment of the premium.

Individuals employed more than twenty hours per week at incomes below 300 percent of the FPL receive a letter informing them that their employer must complete a form regarding the health insurance coverage options available to the applicant, if any. This information is sent to DVHA's Coordination of Benefits unit, which evaluates the cost-effectiveness of the plan compared to VHAP or Catamount Health, depending on the person's income level. If the plan is cost-effective, the applicant is sent a letter requiring him/her to enroll in the employer's coverage, and informing the applicant of the level of premium assistance to be received. If the employer's coverage is not cost-effective, the individual is informed that he/she may enroll in VHAP or one of the Catamount Health plans (depending on the income level). If the applicant is eligible for CHAP, he/she receives information about those plans and their required premium contribution. The CHAP-eligible individual must call a toll-free number (the same number through which individuals can make an application) to report which plan was selected. Enrollment occurs on the first of the month following that notification. Enrollees may change their chosen plan at any time. ACCESS provides a daily enrollment/ disenrollment file to BCBS and MVP. Renewals occur annually on the anniversary of enrollment.

If an individual is not eligible for VHAP or the Catamount Health Premium Assistance Program, but does meet the other Catamount Health eligibility requirements, they may participate in the full-pay program by enrolling directly with BCBS or MVP.

State Employees Health Plan

There is an open enrollment period that runs from November 1 through November 30 each year for the January 1 through December 31 period. Employees that do not wish to change their coverage do not have to take any action. For those who do wish to change their coverage, they may download and complete their election form electronically, but must submit their forms by mail to the Employee Benefits unit within the Department of Human Resources. The unit requires documentation for dependents, such as marriage licenses and attestations that adult dependents (through 26 years of age) do not have other offers of coverage.

Unit staff receive the enrollment forms and manually input them into the State's PeopleSoft Human Capital Management system. Prior to the first payroll in the new benefit year, a forms audit is conducted to ensure that elections have been properly input. The person reviewing the election is different than the individual who originally entered the information.

Questions regarding benefits are directed to the unit, which reports that approximately 8,000 calls are received each year, 60 to 65 percent of which are regarding health insurance. The highest volume is during the open enrollment period. Responding to these queries and manually processing enrollment forms requires extraordinary staff effort every November and December. At present, the State's personnel software cannot accommodate online enrollment, but the

current budget includes additional funding for software upgrades and the unit is currently considering which initiatives to address.

New employees have 60 days to elect coverage. Employees who had insurance coverage prior to hire (e.g., through a previous employer or their spouse) may enroll immediately. For everyone else, there is a 30-day waiting period.

Enrollees may not change their health insurance election during a plan year except for qualifying life events such as marriage, divorce, or birth of a child. Enrollees have 60 days to notify the State of such events. A forms audit is conducted prior to every pay period to verify the accuracy of all changes.

Potential Applicability to the Exchange

Catamount Health's application and enrollment processes include much of the functionality that will be required for the Exchange. For example, it already has a call center to respond to questions, though an expansion would probably be necessary in order to accommodate a larger program and to take applications over the phone. The most important piece of the application and enrollment process, though, is the automated systems that are used.

The State's ACCESS eligibility system determines eligibility for Medicaid and other programs in addition to Catamount Health. This linkage of program eligibility to Medicaid is an ACA requirement. The system also calculates premium assistance amounts and an individual's required payment, another ability that the Exchange will need. There are other areas where ACCESS is currently lacking in terms of its ability to meet ACA requirements. Most significantly, it does not currently provide online enrollment. DVHA is currently planning to add this functionality.

There are several remaining uncertainties as it relates to the eligibility system. First a technical analysis would be necessary in order to determine whether it could be modified to be ACA-compliant. Second, the State is considering replacing the system with the Vermont Integrated Workflow Eligibility System (VIEWS). The original plan was that VIEWS would be operational by December 2012, but that assumed that an RFP would be released in 2010. This did not occur. At the same time, Vermont is part of a consortium of New England states that are jointly building a flexible Exchange information technology framework in Massachusetts that would be shared with the other states. The intersection of these various initiatives has not yet been resolved.

REVENUES AND RECEIPTS

Exchanges must be financially self-sustaining by January 1, 2015. States have considerable latitude in determining how the Exchanges will be funded. As such, the State will have to determine how to fund the Exchange and how to collect the revenues. Additionally, procedures will have to be established to manage premiums and decisions made regarding the extent of Exchange involvement in this process.

Catamount Health

All revenues received for the Catamount Health program are deposited into the Catamount Fund. There is, however, a different process for each revenue stream.

Individual premium payments are the largest source of state revenue for the Catamount Health Program. ACCESS determines the level of premium assistance for which each enrollee is eligible and the balance of the premium that the enrollee must pay. This information is transmitted to TD Banknorth, with which the Agency of Human Services (AHS) contracts to handle billing and depositing. Bills are mailed to enrollees around the first of the month prior to the month of coverage. For example, bills for coverage for April are mailed to enrollees on March 1 and are due on March 15. Individuals are terminated from the program if payment is not received by approximately March 20, but in actuality they maintain coverage as long as they pay by the first business day in April.

Individuals may make these payments via electronic fund transfer, by credit card, and by mailing a check or money order (which is offered free by TD Banknorth for these payments). Mailed payments are sent to a TD Banknorth "lockbox". AHS Staff are responsible for reconciling issues such as payments being mailed without the bill, partial payments, etc. The bank deposits the payments and reports them to ACCESS, which communicates to another contractor, Hewlett-Packard (HP), the amounts due to each insurer. HP makes payment to the insurers. Remittance advice noting for whom payments are being made and for how much is included with the payment.

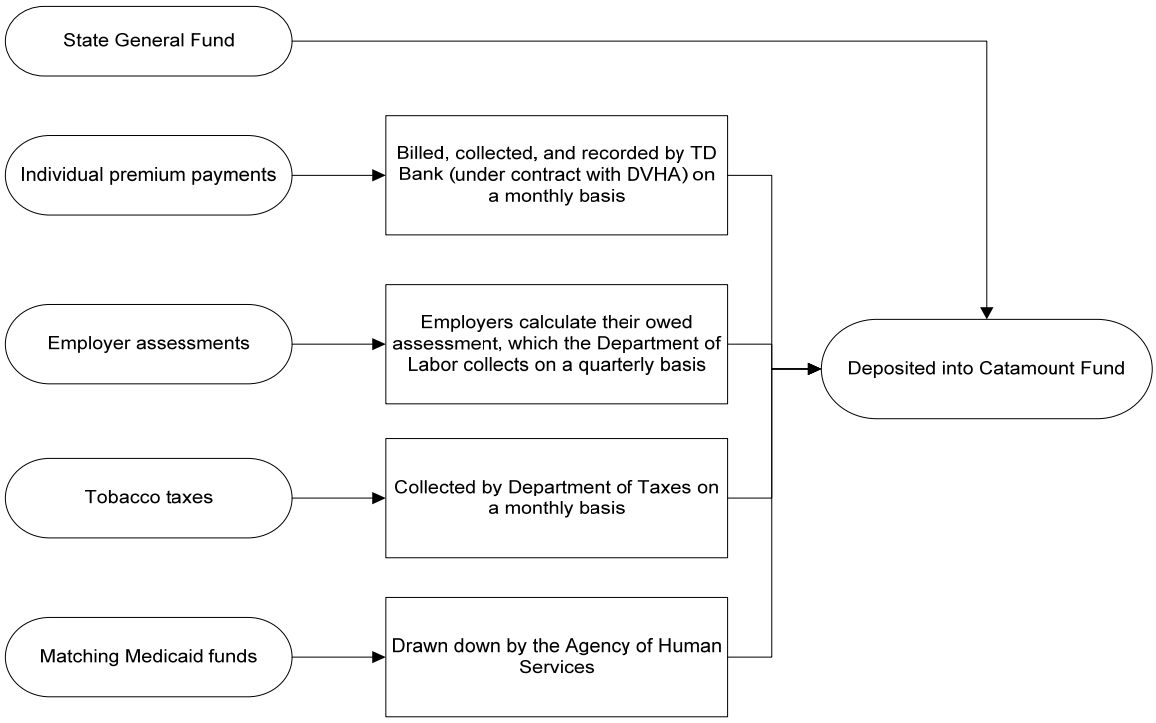
The Vermont Department of Labor (VDOL) is responsible for collecting the employer assessments. VDOL has created a form that employers use to calculate the amount owed. Employers pay the assessment quarterly, using the same schedule as for state unemployment insurance taxes, which are also collected by VDOL. The VDOL mainframe calculates the amount due based on the number of employees reported by employers and compares actual payments against this calculation. VDOL makes daily deposits into its account. It transfers the moneys to the Catamount Fund every Friday except during the two weeks prior and two weeks after the quarter end, when transfers are made daily. Any audits conducted by VDOL field representatives include a review of this assessment.

Tobacco taxes are collected by the Vermont Department of Taxes (VDOT), which transfers the Catamount Health program's share to the Catamount Fund.

Federal matching Medicaid funds are drawn down by the State's single state Medicaid agency, the Agency of Human Services, using the same process as for other Medicaid-funding programs.

Figure 2 illustrates the program's various revenue sources and responsibility for collecting each.

Figure 2:
Catamount Health Premium Assistance Program Revenues



State Employees Health Plan

Since the premiums for the State Employees Health Plan are paid through automatic payroll deductions and the employer contribution, the process is comparatively simple. The total premium amount is electronically transferred from the State agencies to the Employee Benefit unit's internal services fund. The ASO contractor, currently Cigna, is responsible for billing and collecting from the special groups that participate in the State Employee Health Plan program.

Potential Applicability to the Exchange

One necessary, and perhaps obvious, feature shared by Catamount Health and the State Employees Health Plan and important to the successful operation of the Exchange is the establishment of a dedicated fund for the program. Catamount Health has its Catamount Fund while the State Employees Health Plan has an internal services fund. Such dedicated funds prevent the comingling of dollars to ensure that program resources are used for their intended purposes and allow for effective management and oversight of revenues (and disbursements).

Decisions on how to fund the Exchange will in many ways dictate the processes that must be established to collect the revenues, but these decisions have not yet been made. Some informed assumptions can be made, however. In particular, decisions that the State made in terms of funding Catamount Health may provide insight into likely sources of funding for the Exchange,

including employer assessments and tobacco taxes. If either (or both) of these strategies are utilized for the Exchange, current processes would be capable of managing receipts.

Any assessment on employers should be collected by the Department of Labor. As VDOL already collects unemployment insurance taxes, which all employers must pay, and the Catamount Health assessment, it has relationships with the State's employers. Further, since VDOL already collects a universal tax, there is every reason to believe that it could effectively collect any new Exchange assessment additionally. As with the other taxes, the Department of Labor would collect the amounts due from employers and deposit the revenue into the Exchange fund. Ideally, an Exchange assessment would be collected quarterly using the same schedule as for unemployment insurance and the Catamount Health assessment as both employers and VDOL staff are familiar with this timing.

If a new tobacco tax or similar tax is imposed, it should be collected by the Department of Taxes. An increase in the tobacco tax would presumably be easy for VDOT to administer, with the amount of the increase simply being deposited into the Exchange fund. A new tax would likely require the establishment of new processes and could impact different payers, but VDOT would be best positioned to administer it.

Apart from revenues for the operation of the Exchange, the State will have to determine the role that the Exchange will play in the collection of premium revenues. Premiums for health insurance obtained by individuals through the Exchange will be paid by the individuals themselves, who may receive federal premium assistance tax credits. Currently, Catamount Health through its contract with TD Banknorth collects premiums from individuals who receive premium assistance and disburses these payments (as well as the State assistance amount) to the insurers, but individuals who do not qualify pay their premium directly to the insurer. Thus, the fundamental decision related to premium payments is whether the Exchange collects the moneys and pays them to insurers or individuals make payment directly to the insurers.

Insurers have the capacity to manage their own accounts receivable, so if the State decides that individuals will make payments directly to insurers, the Exchange would have little or no role in the process. If the State opts to collect premiums through the Exchange and disburse the funds to the appropriate insurers, it will need to consider whether to contract for this service as it currently does for Catamount Health or to build internal capacity. On one hand, banks and similar companies have the experience to effectively and efficiently manage high volumes of payments, and the State could rely on this expertise rather attempting to build the capability in-house. On the other hand, the Exchange will be more complicated than Catamount Health with additional sources of payments and (likely) more insurers, so existing accounting and reconciliation procedures for Catamount Health premiums may have to be enhanced to accommodate Exchange requirements.

One advantage that several commentators have noted in regards to the Exchange managing premium collections is the ability to aggregate premium costs for employers. If a small business's employees receive health insurance through the Exchange, it is possible that they will enroll with different insurers. Managing payments to multiple insurers could be burdensome for some small employers, so some observers have suggested that the Exchange could provide

assistance by allowing employers to make a single payment to the Exchange, which, in turn, would make disbursements to the appropriate insurers. This is a service that is not currently performed internally by any state program, so the capacity would have to be developed.

DISBURSEMENTS

The Exchange will need to establish policies and procedures for disbursing funds and other purchasing functions. As with revenues and receipts, the appropriate mechanisms for disbursements will, in some regards, be dependent upon decisions regarding the operation of the Exchange that have yet to be determined. For example, its role in collecting premiums will influence decisions related to disbursing funds to insurers. Other needs, such as purchasing controls, are more fundamental and will be necessary irrespective of the final design of the Exchange.

Catamount Health

As a function of a state department, Catamount Health's general operating expenses (e.g., paying salaries, purchasing office supplies, etc.), must comport with the State's financial policies. For instance, purchases must abide by DVHA's internal control policies, are recorded in the State's VISION accounting system, etc.

In terms of medical services, Catamount Health benefits are provided through BCBS and MVP. The program makes payments to these insurers on a prospective basis based on enrollment and premium payments as tracked through ACCESS. HP is responsible for making these payments once per month. There are additional 'clean-up' payments that are made weekly to reflect any new enrollees and any necessary reconciliations. Since Catamount Health is administered through commercial insurers, the program does not make payments to health care providers.

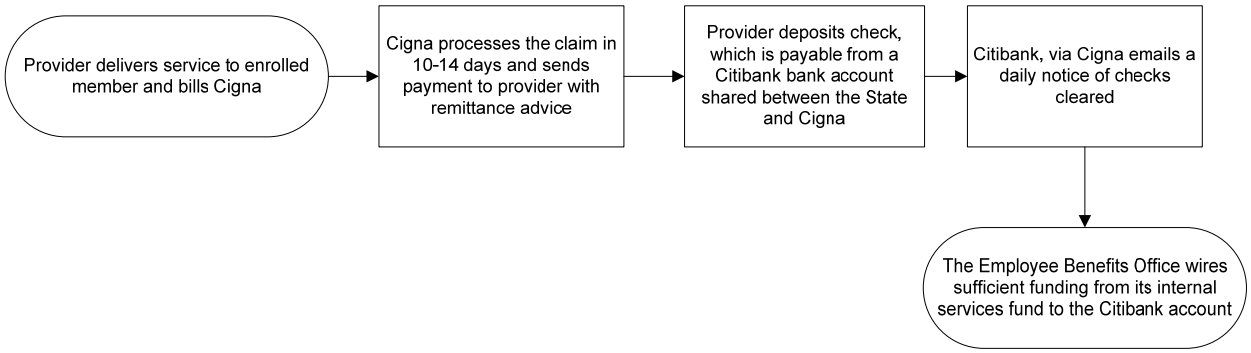
HP also is responsible for disbursements in the Employer Sponsored Insurance Premium Assistance Program. Rather than making payments to insurers, however, HP sends the funds directly to the beneficiaries to offset the premium costs that they contribute to their employers' plans. The premium assistance, after accounting for beneficiaries' required contributions, is generally paid via direct deposit into the recipients' bank accounts.

State Employees Health Plan

The State Employees Health Plan is similar to Catamount Health in regards to disbursements. Like Catamount Health, it is a unit of state government and, therefore, is subject to the State's purchasing procedures. The program also provides for the actual delivery of medical services through a commercial insurer and does not pay medical providers directly.

Medical providers delivering services to individuals enrolled in the State Employees Health Plan send claims for payment to Cigna which, in turn, reports these claims to Citibank. Each business day, Citibank sends to the Employee Benefits unit a detailed report regarding total claims to be paid to each provider. The unit then wires moneys from its internal services fund to Citibank for electronic disbursement to providers. Figure 3 illustrates this process.

Figure 3:
State Employees Health Plan Process for Provider Payments



Potential Applicability to the Exchange

As it relates to disbursements, the Exchange is likely to be quite similar to Catamount Health and the State Employees Health Plan. Current proposals for the Exchange would place it within state government (as a unit in DVHA). Its purchasing would, therefore, be subject to the same requirements as all other state programs. These processes should be sufficient to accommodate the Exchange's purchases.

Though the precise role of the Exchange in terms of collecting and disbursing premiums has yet to be fully determined, any responsibility in this regard could be managed using the same (or similar) processes as utilized by Catamount Health and the State Employees Health Plan. Both programs contract with insurers and are responsible for collecting, reconciling, and transmitting premium payments to these organizations. Catamount Health, in particular, is likely to be especially instructive once detailed plans for the operation of the Exchange emerge because it is essentially a "mini-Exchange."

In addition to learning from Catamount Health's current operations, there are lessons that can be drawn from its creation. Given the speed with which this program had to be implemented and the lack of experience operating this type of program, both Catamount Health's and participating insurers' processes and procedures relating to payments to insurers were insufficient. Consequently, the program experienced significant difficulties in its disbursements in the first year of operation. Specifically, BCBS' records were not properly reconciled with ACCESS eligibility files, mostly related to disenrollments. As a result, BCBS paid claims on behalf of individuals who should have been disenrolled from the program. To address the issue going forward, Catamount Health now sends an enrollment file to BCBS and MVP each week to allow the insurers to compare to their records.

Although the Catamount Health and State Employees Health Plan provide a platform on which to build the Exchange's purchasing and disbursement policies, Catamount Health's experience illustrates the importance of allowing sufficient time to design and test these policies.

FINANCIAL OVERSIGHT AND REPORTING

Strong, effective oversight of Exchange finances and a transparent accounting of its funds are hallmarks of the Affordable Care Act. Catamount Health and the State Employees Health Plan have a variety of mechanisms in place to monitor expenditures, prevent fraud, waste and abuse, and produce management reports. This existing infrastructure may serve as a foundation for Exchange requirements, but will in many instances need to be enhanced.

Catamount Health

As discussed in the previous section, as a unit of state government Catamount Health's fiscal operations are subject to all applicable State laws, regulations, and procedures governing public dollars. Program revenues and expenditures are maintained in the State's VISION accounting system. Additionally, since the program receives federal funds it is also subject to applicable federal requirements, including the provisions of Office of Management and Budget Circular A-133 relating to the "single audit." These various requirements speak to the general rules and internal controls that apply to custodians of public moneys.

The preceding sections touched on various program-specific measures that Catamount Health has in place, such as some of the checks and data matches that are performed when determining program eligibility, the responsibility for resolving discrepancies in consumers' premium payments, and the weekly enrollment reconciliation that now occurs between the program and its contracted insurers.

Catamount Health reports that it does not conduct any reviews of provider claims, but expects that BCBS and MVP do so. These insurers must also report all Catamount Health claim data to BISHCA's VHCURES all claims database.

The program maintains a monthly financial report that includes, at a high-level, sources and uses of funds. On the revenue side, the report notes receipts by fund source (i.e., enrollee premiums, employer assessments, tobacco taxes, State General Fund dollars, and federal funds). Expenditures are provided at a summary level, lacking detail (e.g., administrative costs are reported on a single line, but does not note the total spent on salary, fringe benefits, operating expenses, etc.). This information is available, however, so the report could be modified to incorporate additional detail. These reports are sent to legislative committees and are posted on DVHA's website.

State Employees Health Plan

Like Catamount Health, as a publicly funded program the State Employees Health Program must comply with all applicable state and federal requirements relating to oversight of public moneys. The program also employs a number of formal and informal strategies to ensure the integrity of program finances. Additionally, program contractors have their own quality assurance initiatives.

On an informal basis, the Employee Benefits unit reviews select claims. These efforts are generally targeted at larger claims. On days with an overall high volume and amount of claims, the unit will frequently review large dollar value claims. This review can include comparing a provider's historic claims pattern with the current claim or confirming that the services claimed are consistent with the provider's operations. The unit also reviews certain high-cost individuals to determine whether these expenses could have been lessened through more effective case management by Cigna.

There are also more formal processes that occur at the State level. The unit conducts audits of its medical, behavioral, and prescription plans every two years. These audits are contracted to Milliman, which subcontracts with Claims Technology to review claims data. To ensure timely identification and remediation of issues, the unit is considering utilizing smaller targeted audits at six-month intervals in lieu of the two year audits. In addition, Milliman audits prescription drug manufacturers' rebates programs to ensure that the program is receiving the full benefits of these agreements.

The State Employees Health Insurance Plan, like all State programs, is also subject to audits by the State Auditor. These audits could include testing individual expenditures or reviewing whether adult dependents are appropriately enrolled.

Additionally, program contractors have their own quality assurance strategies. For example, ExpressScripts readjudicates 100 percent of all pharmacy claims. When this vendor identifies trends (e.g., possible "doctor-shopping"), it proactively reaches out to physicians and pharmacists alerting them to the potential issue. ExpressScripts has also proposed tighter restrictions on the use of costly specialty drugs, but any change would require negotiation with the employee unions.

Program expenses are tracked through the State's VISION accounting system. The Employee Benefits unit produces financial management reports, but these reports are not widely distributed (e.g., they are not posted on the program's website).

Potential Applicability to the Exchange

Catamount Health and the State Employees Health Plan have a number of mechanisms in place to prevent fraud, waste, and abuse. These strategies occur at various stages: during enrollment, in payments to plan administrators, and at the provider claim level.

Some of these financial oversight policies and procedures may serve as a starting point for the Exchange, though some are dependent on the ultimate structure of the Exchanges. Like these programs, the Exchange will be a State unit and can utilize the VISION accounting system to manage its finances. If the Exchange will be handling premium collections, it would be advisable to study Catamount Health's processes for managing these funds as well as reviewing errors that were made in the initial implementation of the program. In terms of payments to providers, the programs have left the majority of the responsibility for quality control to the insurance companies managing the program. This would likely be true of plans in the Exchange, as well.

Reporting is an area that will need to be enhanced to comply with ACA requirements. The capacity to produce financial reports exists and both programs already generate some management reports. However, these reports lack the level of detail that may be necessary. Remedying these issues will, hopefully, be straightforward.

CONCLUSION

This report was intended to review existing capabilities within state programs that policymakers may be able to leverage in the Exchange. After this information has been reviewed by the Advisory Group, B&A will develop a matrix of all mandatory and optional functions that will be included in the Exchange with recommendations of options and the responsibility party for fulfilling each function.

Appendix A includes a preliminary list of these functions taken from federal guidance, whether the function is applicable in the Catamount Health or the State Employees Health Plan, and, if so, the responsible party.

Regardless of the direction taken by the Exchange related to financial capabilities, it is recommended that the Advisory Group ensure that a thorough readiness review of these functions is conducted with all parties participating in the process and that sufficient lead time be granted not only for the readiness review but for potential re-review where corrective action needs to be taken.

Appendix A: Summary of Mandatory and Optional Exchange Functions and Their Applicability in Current State Programs

Exchange Function Area	Catamount Health	State Employee Health
Certification, recertification, and decertification of qualified health plans	The two participating insurers are not 'certified'; BISHCA reviews proposed rate increases	The State is self-insured and the available plans are not 'certified'; premiums are determined internally
Call center	A call center is staffed by a contractor answers questions, but residents cannot apply by phone	Employees may call the Employee Benefits unit with questions, office staff are responsible for answering the calls
Website	Online application is available, but manual intervention is still required	Online enrollment currently unavailable
Premium tax credit and cost-sharing reduction calculator	The ACCESS eligibility system determines premium assistance levels, but this is not a function that is provided online for applicants.	Not applicable
Quality rating system	Plans are not rated for quality.	Plans are not rated for quality.
Navigator program	Not applicable	Not applicable
Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost sharing reductions, and Medicaid	ACCESS eligibility system determines eligibility for Medicaid and all other Green Mountain Care programs, as well as the level of premium assistance, as applicable	Not applicable
Seamless eligibility and enrollment process with Medicaid and other state programs	ACCESS eligibility system determines eligibility for Medicaid and all other Green Mountain Care programs	No link to Medicaid and other state programs
Enrollment process	Described in this report, see pg. 4	Described in this report, see pg. 6
Applications and notices	Described in this report, see pg. 4	Described in this report, see pg. 6
Individual responsibility determinations	Participation is not required so there is no mechanism provided for individuals to request an exemption	Participation is not required so there is no mechanism provided for individuals to request an exemption
Administration of premium tax credits and cost sharing reductions	ACCESS eligibility system determines level of premium assistance and this amount is reduced from enrollee bills	Not applicable
Adjudication of appeals of eligibility determinations	Through the normal procedure for all public program eligibility appeals	Not applicable
Notification and appeals of employer liability	Employers determine their Catamount Health assessments, which are collected by the State Department of Labor	Employer liability (share of premiums) is established by the Employee Benefits unit; there are no employer appeals
Information reporting to IRS and enrollees	Not applicable	Not applicable
Outreach and education	Catamount had a marketing consultant at the outset of the program to advertise and conduct outreach for the program	Not applicable
Free Choice Vouchers	Not applicable	Not applicable
Risk adjustment and transitional reinsurance	Not applicable	Not applicable
SHOP Exchange	Not applicable	Not applicable