VERMONT HEALTH INSURANCE EXCHANGE PLANNING

TASK 6.0: ANALYSIS OF EXCHANGE FINANCIAL FUNCTIONS FINAL REPORT, INCLUDING MATRIX OF FINANCIAL AND BUSINESS FUNCTIONS WITH COST ESTIMATES

AUGUST 30, 2011

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Bailit Health Purchasing (Bailit) is assisting the State of Vermont with the design of its health insurance Exchange to meet the requirements of the federal Affordable Care Act (ACA). Burns & Associates, Inc. (B&A), under contract with Bailit, is responsible for Task 6.0 of the Exchange work plan: An Analysis of Exchange Financial Functions. This report is the final deliverable within this contract Task. **It is important to note that the estimates provided herein are intended to provide a sense of the magnitude of costs, but will need to be further refined as the State continues its efforts to develop its vision for the Exchange and additional federal guidance becomes available as the implementation date for the Exchange draws nearer.**

In its first deliverable, B&A provided an overview of the financial infrastructure and practices in place in other state insurance programs, with a particular focus on the Catamount Health program and, to a lesser extent, the State Employees Health Insurance Plan.

The second deliverable outlined the various finance and business functions necessary for the operation of the Exchange and identified potential options and responsible parties to perform each function. A matrix was organized using the instructions for the Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges ("Establishment Grant"). These instructions delineate the responsibilities of state Exchanges and provide guidance on the requirements for applying for federal Establishment Grant funds. Bailit and B&A determined that the following Core Areas from the grant instructions would be included in the deliverable:

- Core Area 7: Financial Management
- Core Area 10: Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints
- Core Area 11: Business Operations of the Exchange. The Establishment Grant instructions list 19 discrete functions within this Core Area and B&A separately analyzed each.

The third deliverable included a one-page summary matrix listing B&A's estimated costs for each function and a report that provided background and analysis for each function. The matrix and report used the same organization and numbering convention as the second deliverable, but combined functions in instances in which they are different components of the same broader task and developing separate cost estimates for each would be impractical (e.g., the various features of the eligibility system are listed as separate sub-functions within Core Area 11, but, since these requirements do not exist in isolation, they were combined into a single task).

This final report is an update of the matrix and discussion included in the previous deliverable based upon feedback from State representatives and additional information that has become available in the interim, including the federal Department of Health and Human Services' (DHHS) proposed rule, *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans* (Federal Register 76:136 (July 15, 2011), p. 41866).

Cost estimates are provided for three time periods:

- Start-Up Activities (present through December 31, 2013) – the period prior to the date by which Exchanges must be operational. Establishment Grant awards may (for the most part) be used to fund these costs.
- First Year of Operation (January 1, 2014 – December 31, 2014) – Establishment Grant funds may also be used to support operational costs in the first year.

- Second Year of Operation (January 1, 2015 – December 31, 2015) – Beginning in this second year of operation, Exchanges must be self-sustaining.[1]

The report provides a brief description of the Core Areas included within this contract Task based upon a reading of the ACA, related federal guidance (notably the Establishment Grant instructions and DHHS's proposed regulations referenced previously), and Vermont H. 202(signed into law as Act 48 of 2011), which establishes the statutory framework for implementation of the Exchange, places the Exchange within the Department of Vermont Health Access (DVHA), and articulates a strategic plan for creating a single-payer and unified health system.

The report also details the methodology and assumptions employed to develop the estimated costs for each financial and business function. A fundamental factor in the ultimate cost of administering the Exchange is the number of individuals that will receive health insurance through the Exchange. As detailed in a separate report, B&A estimates that between 26,100 and 31,200 Vermonters will enroll in an individual plan through the Exchange. This assumes that the State does not create a 'basic health plan', an option that allows states to offer insurance plans outside of the Exchange to individuals with incomes below 200 percent of the federal poverty level. If the State does establish a basic health plan, enrollment in the Exchange would be lower. B&A further estimates that approximately 24,400 employers will offer coverage to between 81,000 and 88,900 residents through the Small Business Health Options Program (SHOP) Exchange.

Additionally, in developing cost assumptions, B&A sought information from DVHA; the Department for Children and Families (DCF); the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA); and the Vermont Department of Labor (DOL).

In some cases, the costs associated with operating the Exchange may replace existing costs. For example, if Medicaid eligibility is reduced since many individuals in the State's Medicaid expansion groups may become eligible for assistance through the Exchange, eligibility determination costs will shift from Medicaid to the Exchange. This analysis only provides estimates for Exchange costs; it does not attempt to consider such cost shifts, though this will be necessary when devising a sustainable funding strategy.

The estimates provided in this report have been rounded to the nearest $100,000 and, as stated above, will continue to evolve as information becomes available and plans are finalized. Individuals will be able to access health insurance through the Exchange on January 1, 2014, though the federal Department of Health and Human Services will assess the readiness of each Exchange by January 1, 2013.

[1] Sec. 1311(d)(5)(A)

DRAFT MATRIX OF FINANCIAL AND BUSINESS FUNCTIONS WITH COST ESTIMATES[2]

Function[3]	**Start-Up Activities (Through Dec. 31, 2013)**	**First Year of Operation (January 1, 2014 – December 31, 2014)**	**Second Year of Operation (January 1, 2015 – December 31, 2015)**
7: Financial Management	$600,000 - $900,000	$500,000 - $800,000	$500,000 - $800,000
Premium Collections	$100,000	$1,100,000	$900,000
10: Providing Assistance to Individuals/ Businesses	$500,000	$500,000	$500,000
11a: Certification of Qualified Health Plans	$1,200,000	$800,000	$800,000
11b: Call Center	*$2,500,000 - $3,000,000*	*$4,600,000 - $5,200,000*	*$3,100,000 - $3,500,000*
11c: Exchange Website	$200,000 - $300,000	$100,000	$100,000
(Various) Eligibility System Tasks[4]	*$3,400,000 - $10,100,000*	*$1,100,000 - $3,400,000*	*$200,000 - $700,000*
11m: Adjudicating Employer Appeals	$100,000	$200,000	$200,000
11d: Quality Rating System	$100,000	part of 11a	part of 11a
11e: Navigator Program	$500,000	$500,000	$500,000
(Various) Eligibility Determination Tasks[5]	*$500,000 - $700,000*	*$700,000 - $900,000*	*$700,000 - $900,000*
11l: Adjudicating Consumer Appeals	$100,000	$200,000	$200,000
11o: Outreach and Education	$1,800,000 - $3,400,000	$1,000,000 - $2,000,000	$500,000 - $1,000,000
11q: Risk Adjustment/ Transitional Reinsurance	$300,000 - $500,000	$200,000 - $300,000	$200,000 - $300,000
11r: SHOP-Specific Functions[6]	$1,000,000	$500,000	$500,000
Total	**$12,900,000 - $22,500,000**	**$12,000,000 - $16,500,000**	**$8,900,000 - $10,900,000**

[2] **All of the costs included in this report are estimates based upon available information. All estimates are subject to change as additional information becomes available. Figures in italics above are most likely to change due as assumptions are refined.**

[3] Free Choice Vouchers, identified as Core Area 11p in B&A's second deliverable were repealed by Sec. 1858 of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (signed into law by the President on April 15, 2011 as P.L. 112-10) and has therefore been removed from the matrix

[4] This task includes: 11h (Enrollment Process), 11i (Applications and Notices), 11k (Administration of Advance Premium Tax Credits and Cost-Sharing Reductions), 11m (Notifications and Appeals of Employer Liability for the Employer Responsibility Payment), 11n (Information and Reporting to IRS and Enrollee), and 11r (SHOP-Specific Functions).

[5] This task includes: 11f (Eligibility Determinations for Exchange Participation, Advance Payment of Premium Tax Credits, Cost-Sharing Reductions, and Medicaid), 11g (Seamless Eligibility and Enrollment Process with Medicaid and Applicable State Health Subsidy Programs), 11j (Individual Responsibility Determinations).

[6] Given the integration of the individual and Small Business Health Options Program (SHOP) Exchange, many SHOP costs are incorporated as part of the analyses for all financial and business functions.

CORE AREA 7: FINANCIAL MANAGEMENT		
	Est. Start-Up (through 2013)	**$600,000 - $900,000**
	Est. First Year of Operation (2014)	**$500,000 - $800,000**
	Est. Second Year of Operation (2015)	**$500,000 - $800,000**

Background

The Exchange must establish a financial management structure and accounting system to ensure sound management of Exchange funds. B&A previously identified various broad responsibilities, including:

- Core Area 7a: Develop Infrastructure and Internal Controls
- Core Area 7b: Managing Exchange Funding – receivables and disbursements
- Core Area 7c: Premium Payments
- Core Area 7d: Premiums for Coverage Purchased through the SHOP Exchange
- Core Area 7e: Transparency and Reporting

Discussion of premiums (Core Areas 7c and 7d) is included in the following section. The remaining responsibilities do not differ much from the requirements of other public programs in terms of developing effective internal controls, managing program moneys, and providing reports.

Analysis

As part of DVHA, the Exchange will be able to build on existing accounting systems, internal controls, and processes, although adaptations will likely be necessary to conform to the unique requirements of the Exchange.

DVHA's Fiscal and Administrative Operations unit has 13 employees and a total annual cost of approximately $1,000,000.[7] These staff are responsible for the multiple programs overseen by DVHA. Since the Exchange is expected to be somewhat lesser in scope than DVHA's array of programs, the financial staffing requirements are anticipated to be less. However, neither the degree to which a portion of existing staff costs will be shifted to the Exchange nor the number of new staff that will be needed to support the financial operations of the Exchange has yet been determined.

This report includes $150,000 to complete an analysis of the Exchange's financial infrastructure needs over the next year. Until this more detailed analysis is completed, this report assumes that the Exchange's ongoing costs will be between 50 and 75 percent of DVHA's financial management costs.

In addition to the funding to complete the financial needs analysis, this report assumes that start-up staffing costs will be equal to annual ongoing operating costs as staff duties are shifted to the Exchange and other staff are hired in the run-up to the implementation of the Exchange.

[7] Forrest, Betsy. "FW: 05 11 11 Betsy Special.xls." Email to Stephen Pawlowski. May 10, 2011.

CORE AREA 7c: PREMIUM PAYMENTS – AND – 7d: PREMIUMS FOR COVERAGE PURCHASED THROUGH THE SHOP EXCHANGE		**Est. Start-Up (through 2013)**	**$100,000**
		Est. First Year of Operation (2014)	**$1,100,000**
		Est. Second Year of Operation (2015)	**$900,000**

Background

The ACA generally requires that individuals receiving federal subsidies (premium tax credits) pay between 2.0 and 9.5 percent of their modified adjusted gross income on a sliding scale towards the cost of their health insurance premiums.[8] Although the State could provide assistance to Vermonters, such a decision has not been made and this report assumes that all residents receiving individual coverage through the Exchange will be responsible for paying at least some portion of the premium.

Exchanges are not required to bill, collect, or process individual's premiums. Individuals could make payments directly to insurers as is currently true for Catamount Health enrollees who do not receive premium assistance from the State or, more generally, when someone purchases insurance through the existing individual market. A number of states, though, are considering assigning this responsibility to Exchanges. Act 48 does this by adding 33 V.S.A. § 1805, which states that Exchanges shall be responsible for "collecting premium payments made for qualified health benefit plans from employers and individuals on a pretax basis, including collecting premium payments from multiple employers of one individual for a single plan covering that individual". It is noted, however, that DHHS has stated that the ACA requires that individuals always have the option to make payment directly to their qualified health plan issuer.

Analysis

Several of Vermont's existing health insurance programs require that beneficiaries pay some portion of the monthly premium. These programs include Dr. Dynasaur (the State's children's health insurance program), the Vermont Health Access Plan (VHAP), and certain pharmacy plans. As outlined in Deliverable 1, the State relies on a contractor to mail invoices to clients and process payments.

According to data provided by DCF, the contractor mailed an average of 41,000 invoices per month and processed an average of about 31,200 payments per month between June 2010 and February 2011.[9] The costs per mailing and per processed payments were $0.46 and $0.72, respectively, for a total of $1.18 per payment. The contractor also processes credit card payments, which were equal to about 4.6 percent of total transactions. Credit card costs averaged about $1.37 per transaction.

As noted, B&A estimates that between 26,100 and 31,200 Vermonters will purchase individual health insurance through the Exchange. Additionally, 24,400 businesses will offer coverage through the SHOP Exchange, providing insurance for another 81,000 to 88,900 individuals. DHHS has proposed that SHOP Exchanges allow employers to receive a single monthly bill for all qualified health plan in which their employees are enrolled and to pay a single monthly amount to the SHOP Exchange. This analysis therefore assumes that employees receiving health insurance through the SHOP Exchange will not receive invoices, but that each employer will receive a single consolidated invoice for all of its employees. In total, then, B&A estimates that the Exchange will mail and process an estimated 50,500 to 55,600

[8] Sec. 1401
[9] Cohen, David. "FW: Lockbox Costs." Email to Stephen Pawlowski. May 4, 2011.

invoices per month (the number of residents enrolled in the individual Exchange plus the number of small businesses participating in the SHOP Exchange).

The table below outlines the estimated cost to bill, collect, and process premium payments.

Figure 1: Premium Billing, Collection, and Processing Cost Estimate

	Enrollees	Mailing Costs		Processing Costs		Credit Card Transaction Costs			**Total Costs**
		Unit Cost	Annual Cost	Unit Cost	Annual Cost	Monthly Trans.	Unit Cost	Annual Cost	
High Est.	55,600	$0.46	$306,912	$0.72	$480,384	2,558	$1.37	$42,054	**$829,350**
Low Est.	50,500	$0.46	$278,760	$0.72	$436,320	2,323	$1.37	$38,190	**$753,270**

In addition to these costs, there is one staff in the business office that is responsible for resolving issues such as researching payments that include incomplete information and resolving partial payments. The cost of this staff and a portion of that individual's supervisor is approximately $100,000 annually.

This analysis includes an additional 25 percent of costs in the first year of the operation of the Exchange as a contingency for any unexpected issues that arise as the program is implemented.

Since the Exchange will likely build on the existing processes that are similar to this task, start-up costs are expected to be modest.

CORE AREA 10: PROVIDING ASSISTANCE TO INDIVIDUALS AND SMALL BUSINESSES, COVERAGE APPEALS, AND COMPLAINTS

Est. Start-Up (through 2013)	**$500,000**
Est. First Year of Operation (2014)	**$500,000**
Est. Second Year of Operation (2015)	**$500,000**

Background

The Exchanges represents significant changes to the health insurance market and it will be critical that there are resources to assist users (both individuals and small business). The Establishment Grant instructions recite many of the processes that must be put in place to provide this assistance, including a telephone hotline, a process to hear eligibility appeals, and Navigators.

Analysis

Many of the assistance processes that Exchanges may put into place are incorporated in other Core Areas (i.e., 11b covers the hotline/ call center requirement, 11e provides for Navigators, etc.) so these functions are not repeated here. However, it will also be important to provide other avenues for residents to receive assistance, including accessing information about eligibility and enrollment, resolving problems, answering questions, filing complaints and appeals, etc. The State intends to further clarify these services by analyzing data collected by consumer assistance programs and 'testing' the Exchange model with individuals and small business stakeholders through interviews and focus groups.

Preliminarily, these duties are similar to the functions of the State's existing health care ombudsman program and enrollment activities conducted by several non-profit organizations. For example, DVHA currently provides approximately $300,000 to the ombudsman program to assist individuals who have problems or questions related to Medicaid and other health programs (BISHCA separately provides $150,000 to the ombudsman program). Although the number of individuals receiving health insurance through the Exchange is projected to be somewhat smaller than those receiving Medicaid, it is anticipated that inquiries will be more prevalent from these individuals and more involved due to the characteristics of the Exchange (e.g., likely a greater choice of insurance plans, federal premium tax credits, etc.). This analysis therefore assumes an annual cost of $500,000 to support programs providing assistance to individuals and small businesses in addition to existing funding for the ombudsman program.

CORE AREA 11a: CERTIFICATION OF QUALIFIED HEALTH PLANS	**Est. Start-Up (through 2013)**	**$1,200,000**
	Est. First Year of Operation (2014)	**$800,000**
	Est. Second Year of Operation (2015)	**$800,000**

Background

The ACA requires that Exchanges certify, recertify, and decertify qualified health plans "consistent with guidelines developed by the [DHHS] Secretary".[10] Exchanges have discretion in determining the methodology for certifying products as qualified health plans. Exchanges may opt to include any plan that meets the minimum requirements for a qualified health plan, undertake a competitive bidding process and limit qualified health plans to those ranked highest, or negotiate with issuers on a case-by-case basis.

The ACA does provide some minimum requirements for qualified health plans. For example, plans seeking certification must submit a justification for any premium increase prior to implementation of the increase, and the Exchange must consider such increases when deciding whether to certify plans. Applicant plans must also publicly report various information, including claims payment policies and practices, data on the number of claims that are denied, data on enrollment and disenrollment, data on rating practices, and information on cost-sharing and payments with respect to any out-of-network coverage. DHHS also notes that Exchanges may consider other factors, including the reasonable of cost estimates, past performance, quality improvement activities, enhancements of provider networks, service areas, and premium rate increases prior to formation of the Exchange.

DHHS proposes that certain information be annually collected from qualified health plans, including rates, covered benefits, and cost-sharing information. DHHS will create a form for the collection of this information. Exchanges are not, however, required to recertify plans on an annual basis.

Act 48 adds 33 V.S.A. § 1806 outlining the State's requirements for certification as a qualified health plan, including offering essential benefits as defined by the ACA and any additional State-mandated benefits (or offering a limited dental benefits plan); providing at least 'silver' level coverage; not exceeding deductible limitations; meeting various prevention, quality, and wellness requirements; and charging the same premium for the plan whether or not it is obtained through the Exchange. When certifying plans, the Exchange is instructed to consider affordability; promotion of high-quality care,

[10] Sec. 1311(d)(4)(A)

prevention, and wellness; promotion of access to health care; participation in the State's health care reform efforts; and any other criteria it deems appropriate.

Analysis

BISHCA already reviews rate and form filings from health insurers wishing to offer coverage in the State. BISHCA requires that insurers use the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing (SERFF). It is anticipated that much of the information that the DHHS Secretary will require insurers to submit to be certified as qualified health plans in order to participate in the Exchange will be similar to that which is already mandated in Vermont.

BISHCA reports that it annually receives approximately 550 rate filings and a similar number of form filings.[11] These filings are rarely approved after the first review and each is resubmitted an average of twice more. BISHCA therefore reviews each year an estimated 1,500 – 1,600 rate filings and a like number of form filings.

To do this work, BISHCA currently has one analyst that reviews rates, another that reviews forms, a computer analyst, and a unit director. The estimated annual cost of this unit is approximately $400,000. Additionally, BISHCA utilizes an actuarial consultant to review rates under a two-year, $800,000 contract. The total annual cost of BISHCA's existing review of health insurer filings is $800,000 ($400,000 in staffing and $400,000 in consulting costs).

Act 48 assigns responsibility for qualified health plan certification, recertification, and decertification to the Exchange. It has yet to be determined whether the Exchange will hire staff to perform this function or enter into an intergovernmental agreement with BISHCA to rely on that agency's existing expertise.

Either way, the responsibilities associated with this task are anticipated to be similar to BISHCA's existing processes. It is unclear, however, how work volume will compare. Some existing plans may opt not to offer coverage through the Exchange, either because they cannot meet the criteria to be a qualified health plan or are content to operate outside of the Exchange. Given the intent to drive all health insurance coverage to the Exchange, this analysis assumes that the cost to the Exchange to certify qualified health plans will be comparable to BISHCA's current costs.

In order to prepare for open enrollment in mid-to-late 2013, the Establishment Grant instructions state that Exchanges should begin the process of selection and certification of qualified health plans in 2012. It is anticipated that costs will be higher in the first year of certifying qualified health plans in order to perform intensive reviews of proposed products, determine actuarial values, ensure parity between products in and out of the Exchange, etc. To accommodate the development of the necessary infrastructure and expertise, this analysis increases the estimated $800,000 annual ongoing cost by 50 percent in the start-up period.

CORE AREA 11b: CALL CENTER		
	Est. Start-Up (through 2013)	***$2,500,000 - $3,000,000***
	Est. First Year of Operation (2014)	***$4,600,000 - $5,200,000***
	Est. Second Year of Operation (2015)	***$3,100,000 - $3,500,000***

[11] Compton, Thomas. Telephone call with Stephen Pawlowski. May 4, 2011.

[**Note that the estimate range for this function relies on several assumptions that require further analysis and is, therefore, potentially subject to significant variation**.]

Background

The ACA requires that Exchanges "provide for the operation of a toll-free telephone hotline to respond to requests for assistance".[12] The call center should become operational prior to the initial open enrollment period, which DHHS proposes to begin October 31, 2013, likely requiring the call center to open in the second half of 2013. The State may opt to operate the call center with its own staff or contract for the service.

DVHA currently contracts with Maximus for the operation of a "toll-free hotline to assist enrollees and other interested individuals in understanding [medical] program benefits and policies and to respond to questions." DHHS notes that states have significant latitude in how call centers are structured, but states that they should have the ability to provide assistance to individuals and small businesses on a broad range of issues, including the types of qualified health plans offered, the details of each plan, available categories of assistance through the Exchange and other public health insurance programs, the application process, and availability of other resources such as Navigators. DHHS also suggests that Exchanges seeks to maximize accessibility of the call center by operating outside of normal business hours and increasing staffing levels during anticipated periods of high demand (such as enrollment periods).

Analysis

The call center operated by Maximus provides assistance for all of Vermont's public health programs, including Medicaid, Dr. Dynasaur, Vermont Health Access Plan, Catamount Health, and various prescription assistance programs. According to Maximus' monthly tracking report for January 2011, most calls are in regards to eligibility and client status, questions regarding premiums, updating case file information, and questions about benefits. The call center also places outbound calls to assist new enrollees in the selection of a health plan and physician, as appropriate.

According to a report summarizing statistics for January 2011 (which Maximus reported is a fairly typical month), the call center receives approximately 1,430 inbound calls per day and places about 370 outbound calls per day. Based on these figures, inbound calls represent about 80 percent of total call volume.

The cost of operating the call center in recent years has been about $2.6 million to $2.8 million annually. The call center is staffed by 17 member services representatives (MSR) and 11 temporary staff, 5 supervisors, and 8.5 administrative staff. Administrative costs such as rent and utilities, telephone, information systems, and office supplies comprise about $400,000 of the annual cost. The contract also includes 15 percent for general and administrative costs (in addition to the separately delineated administrative costs) and a 7.5 percent profit margin. Assuming that the average lengths of inbound and outbound calls are comparable, the overall per call cost is about $6.00, which includes all costs (salaries and fringe benefits for MSRs and supervisory and support staff, operating costs, general and administrative costs, and profit).

Maximus also tracks the program(s) in which callers are enrolled. A comparison of caller totals to the number of members included in DVHA's enrollment reports shows wide variation in the ratio of enrollees to inbound calls. Medicaid enrollees were least likely to place a phone call with only about 4 percent doing so in January 2011 while about 40 percent of enrollees in premium assistance programs such as the

[12] Sec. 1311(d)(4)(B)

Catamount Health Premium Assistance Program and employer-sponsored insurance premium assistance utilized the call center. Ratios for the other major programs ranged from 13 percent to 25 percent.

The enrollee to call ratios illustrate that programs with greater requirements, such as premium contributions, result in a greater need for assistance. This analysis assumes that demand for the hotline among Exchanges enrollees will be 50 percent higher than the highest utilization rates for existing programs in the first years of operation (i.e., 60 percent of Exchange enrollees will call the hotline each month) while in future years monthly utilization will be 40 percent, comparable to the current highest utilization rates. The table below outlines the estimated costs.

Figure 2: Call Center Volume and Cost Estimates

	Enrollees	Mo. Utilization	Call Volumes			Cost/ Call	Total Cost
			Per Month	Per Day	Per Year		
Year 1							
High Est.	107,100	60%	64,260	3,084	771,120	$6.00	$4,626,720
Low Est.	120,100	60%	72,060	3,459	864,720	$6.00	$5,188,320
Year 2							
High Est.	107,100	40%	42,840	2,056	514,080	$6.00	$3,084,480
Low Est.	120,100	40%	48,040	2,306	576,480	$6.00	$3,458,880

Vermont intends to provide separate phone numbers for the individual and SHOP Exchanges, but it is assumed that the calls will be handled by the same call center (though staff would likely be assigned to one number or the other). This analysis assumes that Vermonters receiving insurance through the Exchange will utilize the call center at the same rate regardless of whether they enroll in an individual plan or through the SHOP Exchange. Assuming between 107,100 and 120,100 Exchange enrollees, then, this analysis estimates that the call center will receive 64,300 to 72,100 calls per month, or 3,100 to 3,500 calls per day in the first year and 42,800 to 48,000 calls per month in the second year (2,100 to 2,300 calls per day).

A significant difference between the responsibilities of the existing call center and those of the call center to support the Exchange is that the current call center does not take applications, but this is a requirement of the Exchange call center. This requirement will increase the costs noted in the table above. Since estimates of the frequency with which individuals will apply for coverage through the Exchange across the various options (online, by phone, in person) have not yet been developed, costs to the call center could be greater in order to process applications. Total eligibility determination related costs are included in the estimate for Core Area 11f discussed later in this report. Once there are estimates regarding the application alternatives, costs may be shifted from that Core Area to the call center.

This analysis assumes that the Exchange will incur six months of operational costs as the call center is opened in advance of the initial open enrollment period. Start-up costs could also include the management of a procurement process as well as developing call scripts, acquiring space, and implementing call center technology. According to the Maximus budget, about $165,000 was expended on deployment of an interactive voice response system and information systems over the first three years of the contract. If the existing contract is expanded to include the Exchange population, some of these start-up costs would not be incurred. The analysis assumes a range of $200,000 to $400,000 for these costs.

CORE AREA 11c: EXCHANGE WEBSITE		
	Est. Start-Up (through 2013)	**$200,000 - $300,000**
	Est. First Year of Operation (2014)	**$100,000**
	Est. Second Year of Operation (2015)	**$100,000**

Background

Exchanges are required to maintain a website through which consumers can access a variety of information, including standardized comparative information on qualified health plans (premium and cost-sharing information, summary of benefits, level of coverage, results of enrollee satisfaction surveys, quality ratings, medical loss ratio, transparency of coverage measures, and the provider directory), financial data related to the Exchange, contact information for Navigators and other consumer assistance programs, and an electronic calculator that allows them to view the estimated cost of their coverage after accounting for premium tax credits and cost-sharing reductions. The website must also allow residents to apply for coverage and enroll online.[13] The Establishment Grant instructions note that HealthCare.gov can be used as a source of content for Exchange websites.

Analysis

By using HealthCare.gov as a guide, designing a website to which information such as qualified health plan details and transparency data will be posted is not anticipated to be complex. This analysis assumes that the design of the website will take between one-half and one full-time equivalent and would be performed by a contractor. The annual cost of maintaining and updating the website is anticipated to be modest.

Designing the eligibility system and ensuring the appropriate linkages to other applicable state health subsidy programs will be a much more complex undertaking and is discussed in the following section.

(VARIOUS): ELIGIBILITY SYSTEM TASKS		
	Est. Start-Up (through 2013)	***$3,400,000 - $10,100,000***
	Est. First Year of Operation (2014)	***$1,100,000 - $3,400,000***
	Est. Second Year of Operation (2015)	***$200,000 - $700,000***

[**Note that the estimate range for this function relies on several assumptions that require further analysis and is, therefore, potentially subject to significant variation.**]

Background

The Exchange will need to develop a system that will support eligibility determinations for premium tax credits and cost-sharing reductions. This task is comprised of several separate requirements delineated in the Establishment Grant instructions:

[13] Sec. 1311(d)(4)(C), Sec. 1311(d)(4)(G)

- Core Area 11h: Enrollment Process – facilitating qualified health plan selection for individuals determined eligible by providing information customized to the individual, receiving an individual's choice of plan, and providing enrollment transactions to qualified health plans
- Core Area 11i: Applications and Notices – including a single, streamlined application and other notices to facilitate enrollment
- Core Area 11k: Administration of Advance Premium Tax Credits and Cost-Sharing Reductions – acceptance of changes reported by individuals, consequent eligibility redeterminations, and communication of such to DHHS
- Core Area 11m: Notifications and Appeals of Employer Liability for the Employer Responsibility Payment – generation of notifications (the hearing of appeals is discussed in the next section)
- Core Area 11n: Information Reporting to IRS and Enrollee – annual transmittal of certain information regarding enrollees' coverage

Eligibility for Exchange participation must be seamlessly integrated with Medicaid, CHIP, and other applicable state health subsidy programs. A single streamlined application must be used to collect all necessary information for these programs. It is therefore assumed that a single system will be designed to manage eligibility. DHHS intends to create both a paper-based and web-based application that states may use to determine eligibility (and facilitate enrollment in a qualified health plan or other applicable state health subsidy programs). Similarly, for the SHOP Exchange DHHS intends to create a model single employer application and a model single employee application, which would require less detail than the application for the individual market. Even with the creation of templates by DHHS, it is anticipated that the State will experience significant costs in developing the necessary information technology infrastructure to manage the process.

The State has at least two options when charting its approach to the eligibility system for the Exchange. The State is currently in the procurement process for the Vermont Integrated Eligibility Workflow System (VIEWS) to replace DCF's ACCESS eligibility determination system. VIEWS would, presumably, accommodate Exchange eligibility determinations. The procurement process has not yet resulted in a contract and it is unknown whether work could be completed in time for initiation of the Exchange.

Additionally, Vermont is participating in the New England Innovator Grant being led by Massachusetts in order to develop an eligibility portal to serve individuals and employers and links to federal agencies to verify and share information. The preliminary design is scheduled to be available in September 2011, at which point the State will determine whether the design can serve as its platform.

This analysis relies upon previous cost estimates for VIEWS in order to project the cost of an eligibility system for the Exchange. It is noted, however, that in the absence of a contract award for VIEWS or the Innovator Grant's preliminary design of the system, the estimates are subject to significant variation.

In addition to determining eligibility, the Exchange must facilitate enrollment. It must be able to accept qualified health plan selection from an eligible individual, notify the issuer of such selection on a 'timely' basis, accept acknowledgement of that notification, and transmit any necessary information to the issuer.

Analysis

The Department of Building and General Services (BGS)' 2011 – 2015 capital bill five-year spreadsheet estimates that VIEWS will cost $45 million. This analysis assumes that VIEWS will provide eligibility determinations for the same programs as ACCESS, including the various health insurance programs, 3SquaresVT (supplemental nutrition assistance), ReachUp (cash assistance), and fuel assistance.

Since the system will benefit programs other than the Exchange, only a share of the total costs may be allocated to the Exchange.

There are a variety of ways to allocate costs for projects such as VIEWS. One methodology would be on a caseload basis with costs allocated to programs according to the number of individuals that benefit from each. For example, if there are 200,000 individuals enrolled in the programs (this would be a duplicated count because individuals may receive assistance from multiple programs), and 10,000 individuals were enrolled in ReachUp, 5 percent of the cost of VIEWS would be allocated to ReachUp. Based on B&A's estimated Exchange caseload and enrollment figures for the other programs, the number of Exchange cases could equal approximately 30 percent of total cases.

Costs may also be allocated more evenly across programs because the costs of programming the rules governing eligibility for a program are the same regardless of whether there are 10 enrollees or 10,000. The costs allocated to the Exchange using a methodology similar to this would depend on the number of programs involved in the system and this will depend on the definition of a program (e.g., are all Medicaid-funded programs a single program for this purpose or are they counted separately). Ultimately, the State will need approval of any cost allocation methodology from DHHS and any other federal agencies that would be participating in the cost (e.g., the United States Department of Agriculture if supplemental nutrition assistance is included).

Given that the BGS estimates assumed a five-year project, it is unclear whether work would be accelerated to meet the Exchange timeframe or if some non-mandatory functionality can be pushed back past the start-up period. Absent additional detail, this analysis assumes that 75 percent of the BGS budget estimate for VIEWS ($33.8 million) is allocable to the start-up period. It is further assumed that between 10 and 30 of the total cost of VIEWS would be allocated to the Exchange. The remaining design costs ($11.2 million) would be reflected in 2014, with the Exchange again allocated 10 to 30 percent of the total. Beginning in 2015, ongoing maintenance costs are estimated to be five percent of total development and implementation costs. It is, however, noted that a more precise analysis will be necessary as some requirements are unique to the Exchange (e.g., communications with the IRS) and should not be allocated to other programs.

CORE AREA 11m: APPEALS OF EMPLOYER LIABILITY	**Est. Start-Up (through 2013)**	**$100,000**
	Est. First Year of Operation (2014)	**$200,000**
	Est. Second Year of Operation (2015)	**$200,000**

Background

As noted in the preceding section, Exchanges must notify employers when an employee is determined to be eligible for advance payment of a premium tax credit because the employer does not offer minimum essential coverage or the coverage is not affordable or does not meet the minimum value requirement. The ACA mandates that employers be given the opportunity to appeal such determinations.[14] The systems components (e.g., generating the notices) are included as part of the Eligibility System Tasks discussed in the previous section. This section addresses the cost of hearing appeals.

[14] Sec. 1411(f)(2)

Analysis

Vermont currently levies an assessment on employers with employees who are not eligible for employer-sponsored insurance or opt not to accept the coverage. This assessment, however, is only appealable through the court process and so cannot be used as a basis for estimating volumes or costs of administrative appeals. A process to hear employer liability appeals will have to be designed, but these costs are expected to be modest.

Unemployment insurance determinations may be appealed by employers. Although this appeal process would differ significantly from employer liability appeals (because most unemployment insurance appeals include a dispute between the employer and employee regarding the latter's eligibility for benefits), information was requested regarding the structure and costs associated with the Department of Labor's Employment Security Board. This information was not immediately available so this analysis instead relies on the estimate for applicant's appeals of eligibility determination discussed in the discussion of Core Area 11l. Overall, this analysis assumes that the volume and employer appeals will be less than or equal to applicant appeals and, therefore, includes the same operational costs as for applicant appeals.

CORE AREA 11d: QUALITY RATING SYSTEM	**Est. Start-Up (through 2013)**	**$100,000**
	Est. First Year of Operation (2014)	**Included in 11a**
	Est. Second Year of Operation (2015)	**Included in 11a**

Background

Exchanges will be required to "assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the [DHHS] Secretary" and post this information on the Exchange website.[15] The rating system will "rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price."[16]

Analysis

Start-up costs for the Exchanges are anticipated to be limited to developing processes and procedures to apply the DHHS-designed rating system to health plans in Vermont and are therefore expected to be minimal. This analysis includes $100,000 in the start-up period in order for the Exchange to hire a consultant to assist in the development of a model and processes to apply the federal requirements as well as any other State-defined quality and wellness measures. After this initial development work, it is assumed that the ongoing costs associated with scoring health plans and assigning ratings are included in the certification process (Core Area 11a).

[15] Sec. 1311(d)(4)(D)
[16] Sec. 1311(c)(3)

CORE AREA 11e: NAVIGATOR PROGRAM	**Est. Start-Up (through 2013)**	**$500,000**
	Est. First Year of Operation (2014)	**$500,000**
	Est. Second Year of Operation (2015)	**$500,000**

Background

The ACA requires that Exchanges establish a Navigator program through which grants are made to entities to conduct public education activities, distribute fair and impartial information, facilitate enrollment in qualified health plans, and provide referrals to individuals with grievances, complaints, or questions.[17] Eligible entities include trade, industry, and professional associations; commercial fishing industry organizations; ranching and farming organizations; community and consumer-focused nonprofit groups; chambers of commerce; unions; resource partners of the Small Business Administration; other licensed insurance agents and brokers; and other entities capable of performing the function. DHHS has proposed that Exchange selects at least two of the types of eligible entities.

Health insurers may not serve as Navigators and Navigators may not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of individuals or employees in a qualified health plan. Further, Establishment Grant funds may not be used to make awards to Navigators.

33 V.S.A. § 1807 as added by Act 48 requires that "navigators are available to provide assistance in person or through interactive technology to individuals in all regions of the state". Act 48 does not specify what types of entities may be Navigators, other than affirming the list in the ACA, so it is possible that multiple entities will receive awards to provide Navigator services, with individual contracts limited to specific geographic areas or functions.

Analysis

As part of Vermont's ongoing health care reform efforts, DVHA currently has a contract with the Bi-State Primary Care Association that has similar goals as the Navigator program by working "with health care providers, community organizations, and state agencies to educate them about Vermont's Green Mountain Care programs, motivate them to actively promote the programs… and to enlist their participation in assisting individuals in completing the application process." In fiscal year 2009, the contract was approximately $91,100. Due to lower than anticipated demand for these services, however, the contract was reduced to about $77,400 for a 0.9 full-time equivalent in fiscal years 2010 and 2011.

States have wide discretion in terms of the size and scope of their Navigator programs. This analysis assumes that the State will establish a robust program in the initial year or two of the Exchange to ensure that Vermonters have access to assistance. Specifically, this analysis assumes that there will be an average of one half-time equivalent Navigator in each of DVHA's 12 districts (this is only an average, though, two or more smaller districts may be served by a single Navigator while a larger district may have more than one Navigator). Assuming a per-FTE cost of $85,000 (which includes salary, fringe benefits, operating expenses, and administrative overhead), the annual total cost would be $500,000. These Navigators do not include additional resources envisioned for small businesses, as discussed in Core Area 11r.

[17] Sec. 1311(i)

DHHS has proposed that Navigators be operational no later than the first day of the initial open enrollment period – October 1, 2013 – and this analysis assumes that the Navigators will be in place for one to two months in advance of this date. Coupled with the cost of developing and managing a request for proposal, it is expected that spending in the start-up period will total approximately $500,000.

CORE AREA 11f: ELIGIBILITY DETERMINATIONS, **11g: SEAMLESS PROCESS WITH OTHER PROGRAMS, – AND –** **11j: INDIVIDUAL RESPONSIBILITY DETERMINATIONS**	**Est. Start-Up (through 2013)**	***$500,000 - $700,000***
	Est. First Year of Operation (2014)	***$700,000 - $900,000***
	Est. Second Year of Operation (2015)	***$700,000 - $900,000***

[**Note that the estimate range for this function relies on several assumptions that require further analysis and is, therefore, potentially subject to significant variation.**]

Background

The Exchange will be responsible for administering a system of streamlined and coordinated eligibility and enrollment through which residents' may apply for enrollment in a qualified health plan, advance payment of premium tax credits, and cost-sharing reductions. The Exchange must also make determinations regarding exemptions from the ACA's individual responsibility requirement (i.e., to obtain health insurance coverage or pay a fine) due to lack of access to affordable coverage or due to an individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, or as an American Indian. Additionally, these Exchange-related determinations must be made in concert with eligibility determinations for Medicaid, CHIP, and other applicable state health subsidy programs.

Residents must be able to file an application online, by telephone, by mail, or in person. DHHS proposes to allow individuals to enroll in a qualified health plan only during open enrollment periods (October 1, 2013 through February 28, 2014 for the initial period and October 15 through December 7 each year thereafter), except in the case of special qualifying events. DHHS proposes that the SHOP Exchange permit rolling enrollment with annual open enrollment periods, allowing small businesses to purchase coverage at any point during the year (though employees could not change their qualified health plan selection except for special qualifying events).

Analysis

Currently, DCF is responsible for eligibility determinations for the State's various health insurance programs as well as other human service programs (e.g., 3SquaresVT, the State's supplemental nutrition assistance program, and ReachUp, the State's cash assistance program). Section 6 of Act 48 requires that the health care eligibility unit be transferred from DCF to DVHA after March 15, 2012 but not later than July 1, 2013.

DCF reports that this unit is staffed by 38 benefit program specialists and two health care program specialists who make eligibility determinations as well as supervisory and management staff. Taking into account salaries, fringe benefits, and other operating expenses, the annual cost of this unit is approximately $3.4 million. DCF and DVHA are collaboratively working to refine these estimates in order to transfer staff and funding as required by Act 48. Additionally, the call center contract with

Maximus (discussed in Core Area 11b) includes about $200,000 annually for material and postage costs to provide information to enrollees.

An estimate of the number of Medicaid determinations was not immediately available. According to information on the DCF website, there were about 176,000 Vermonters eligible for Medicaid in December 2010. B&A's estimated Exchange enrollment range for individual coverage is 26,100 to 31,200 or about 15 to 20 percent of the Medicaid total. Assuming that the time and resources to complete a determination for Exchange eligibility is comparable to that required for a Medicaid determination, the estimated cost would be between $500,000 and $700,000. The analysis assumes that determinations will begin in mid-2013.

CORE AREA 11l: ADJUDICATION OF APPEALS OF ELIGIBILITY DETERMINATIONS	**Est. Start-Up (through 2013)**	**$100,000**
	Est. First Year of Operation (2014)	**$200,000**
	Est. Second Year of Operation (2015)	**$200,000**

Background

Individuals have the right to appeal eligibility determinations made by the Exchange for premium subsidies and Exchange participation. Exchanges must establish a process for hearing these appeals. This process does not apply to the SHOP Exchange.

Analysis

The Human Services Board within the Agency of Human Services (AHS) is responsible for hearing appeals involving eligibility, benefits, coverage, and financial assistance made by AHS departments, including DVHA. It is therefore assumed that the Board will also hear Exchange-related appeals or, at the least, the costs of hearing appeals will be comparable to the Board's costs.

According to information provided by DVHA, the Board heard an average of about appeals 675 appeals in 2009 and 2010.[18] About 45 percent of these cases involved health care programs. The Board receives its own appropriation, which is about $350,000 for fiscal year 2012. This budget covers all of the appeals for which it has jurisdiction. Using these figures the cost per appeal is about $500. In addition to the Board's costs, staff attorneys from the relevant agency (e.g., DVHA or DCF) must prepare for and attend the hearings.

Assuming that an appeal involving a health care program requires an equal amount of resources as appeals in other programs, about $160,000 of the Board's budget is related to health care programs. B&A's estimates a range of 26,100 to 31,200 residents receiving individual coverage through the Exchange, equal to about 20 percent of the aggregate of current health care program caseloads.

Assuming that the likelihood of appeals for these enrollees will be similar to the appeal rate of existing health care program beneficiaries, it is assumed that one attorney will be required. Coupled with the costs for the Human Services Board or similar entity, expenses for adjudicating individuals' appeals are estimated to total about $200,000 annually.

[18] Forrest, Betsy. Facsimile to Stephen Pawlowski. August 30, 2011.

Building on existing appeal processes to develop policies for Exchange appeals is anticipated to require only minimal start-up resources.

CORE AREA 11o: OUTREACH AND EDUCATION	**Est. Start-Up (through 2013)**	**$1,800,000 - $3,400,000**
	Est. First Year of Operation (2014)	**$1,000,000 - $2,000,000**
	Est. Second Year of Operation (2015)	**$500,000 - $1,000,000**

Background

Exchanges must implement an outreach and education program to inform residents about the Exchange and the new coverage options available to them. States are given wide latitude in the design of their outreach and education programs.

Analysis

Vermont has experience with the development of an outreach and education campaign to inform residents of their health care options. After passage in 2006 of Acts 190 and 191, which established Catamount Health and instituted other policies to improve the affordability of and access to health care, DVHA awarded a contract to GMMB to "implement a comprehensive outreach and enrollment strategy…using a unified marketing campaign". As with the Exchange, the goal of Acts 190 and 191 was to achieve (near) universal health care coverage; the contract included the 2011 strategic goal that 96 percent of Vermonters will have health insurance coverage.

The GMMB contract included a number of services with a total budget of $1.6 million in the first year, as summarized in the table below.

Figure 3: Health Care Reform Outreach and Education Contract Budget May 1, 2007 – April 30, 2008

Service	**Amount**
Public Opinion Research	$138,420
Strategic Council	$207,790
Advertising, Branding, and Materials Development	$203,253
Web Consultation	$59,192
Ad Production	$463,335
Media Buy	$399,970
Earned Media Outreach/ Press Launch	$67,770
Stakeholder Outreach and Message Training	76,750
Total	**$1,616,480**

Spending declined significantly after the first year. Budgets were set at $500,000, but spending totaled $420,000 in fiscal year 2009 and $70,000 in fiscal year 2010.

Vermont will have great flexibility in the design of an outreach and education campaign. Though the scope of this contract was very similar to the aim of the ACA (that is, near-universal coverage), Exchanges represents a much more significant change to the health insurance landscape. This analysis therefore assumes that spending in the period leading up to implementation of the Exchange and the first

months of the Exchange may be as much as twice as much as the spending during the first year of the GMMB contract. Additionally, another $200,000 is included for employer-focused outreach including mailers and 12 seminars across the State.

On an ongoing basis, it is assumed that a higher level of investment in outreach and education will be necessary in the initial years of the Exchange. The model currently assumes a range of spending between $1 million and $2 million in 2014 and, in the following year, between $500,000 and $1 million.

CORE AREA 11q: RISK ADJUSTMENT AND TRANSITIONAL REINSURANCE	**Est. Start-Up (through 2013)**	**$300,000 - $500,000**
	Est. First Year of Operation (2014)	**$200,000 - $300,000**
	Est. Second Year of Operation (2015)	**$200,000 - $300,000**

Background

The ACA requires each state to implement a transitional reinsurance program and a risk adjustment program in order to mitigate adverse selection and minimize price disruptions. DHHS is tasked with developing the requirements for these programs, and released a proposed rule on July 15 titled *Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridor and Risk Adjustment* (Federal Register 76:136 (July 15, 2011), p. 41930).

Section 1341 of the ACA establishes the transitional reinsurance program. The program in each state will be administered by one or more non-profit "applicable reinsurance entities", the purpose of which is "to help stabilize premiums for coverage in the individual market in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest". In 2014, 2015, and 2016, all health insurance issuers and third party administrators on behalf of self-insured group health plans will be required to make payments to the applicable reinsurance entity(ies), which will use the funds to provide reinsurance for high-risk individuals for up to five years. Funds may also be collected for the administration of the applicable reinsurance entity (and additional levies are required for deposit into the federal treasury in order to offset certain other costs created by the ACA).

The July 15 publication proposes that DHHS will establish a national uniform contribution rate, which would be a percent of premiums. The percentage would be announced in a subsequent notice. Funds would not be pooled nationally, however; all contributions collected by a state would remain within that state. States would have the flexibility to exceed the national rate if needed to cover projected payments and/ or administrative costs. The proposed rule envisions insurers receiving reinsurance payments for individuals with medical costs that exceed a to-be-defined "attachment point", the threshold dollar amount incurred for essential health benefits for an enrolled individual. DHHS continues to seek comments on the timing of these cash flows. Lastly, states would have some flexibility to modify the formula and input values (e.g., the attachment point) that will be defined by DHHS.

Section 1343 of the ACA establishes a risk adjustment program. This program will assess a charge on "low actuarial risk plans" in which the actuarial risk of the enrollees of such plans is less than the average actuarial risk of all plans in the State. These revenues will be used to make payments to "high actuarial risk plans". The July 15 publication does not include the specific process for determining these payments, noting that the "federally certified risk adjustment methodology" will be released in a forthcoming federal

notice. Upon reviewing this methodology, states may propose an alternative risk management methodology, which must be approved by DHHS.

Analysis

Much of the responsibility for designing these programs resides with DHHS, but the Exchange will have both data collection and administrative responsibilities.

Exchanges are not permitted to operate the transitional reinsurance program; it must be administered by a separate non-profit entity. This applicable reinsurance entity will be responsible for receiving payments and making disbursements as well as collecting the necessary information from insurers in order to calculate payments. It is presumed that the applicable reinsurance entity will be funded through an assessment on premiums.

Exchanges may administer the risk adjustment program. A primary responsibility of the program will be the collection of data to support charges and payments. The proposed rule outlines minimum standards for data, including the use of '837' forms for all claims and encounter data and '834' forms for demographic and enrollment data. States with all payer claims databases in place prior to January 1, 2013 may receive an exception from these standards by submitting specified information to DHHS.

This analysis assumes that start-up costs will include the review of the forthcoming federal proposals for methodologies and values and then determine whether and to what degree to modify them, development of data collection procedures including the continued expansion of the VHCURES all payer claims database, establishment of administrative infrastructure, and procurement of an applicable reinsurance entity. The estimated cost of these tasks is between $300,000 and $500,000. On an ongoing basis, an estimated two or three employees will be required to oversee the program.

Core Area 11r: SHOP EXCHANGE-SPECIFIC FUNCTIONS	**Est. Start-Up (through 2013)**	**$1,000,000**
	Est. First Year of Operation (2014)	**$500,000**
	Est. Second Year of Operation (2015)	**$500,000**

Background

States must operate a Small Business Health Options Program (SHOP) Exchange. States may merge the operation of the SHOP Exchange with the individual market Exchange and are encouraged by DHHS to do so. The functions of the two Exchanges are similar, though there are a number of differences. For example, there are several requirements of the individual market Exchanges that do not apply to SHOP Exchanges, such as conducting individual eligibility determinations and hearing appeals of such, making available a calculator of advance payments of the premium tax credit (although DHHS encourages Exchanges to consider options to calculate and display net premiums to employees), etc. There are some requirements that are unique to the SHOP Exchange such as determining employer eligibility (e.g., size, offering coverage to all full-time employees, etc.) generally through self-reporting and attestations, allowing employers to limit employees' choice of qualified health plans to a certain level (e.g., gold or silver) or even to a single plan, providing employers with a monthly bill that identifies the total premiums owed, and enforcing certain certification criteria for qualified health plans that are not required in the individual market Exchange.

Analysis

Vermont intends to combine its individual and SHOP Exchanges. The costs of operating the latter are, therefore, largely incorporated in the design of the overall State Exchange discussed in the other Core Areas and business functions. For example, the estimated cost of the financial management of the Exchange including the aggregation of employer premiums (Core Area 7) is inclusive of both the individual and small business markets that will be included in a single Exchange in Vermont. Similarly, outreach to small business is included in the outreach and education discussion (Core Area 11o).

There are, however, the SHOP Exchange-specific requirements that must be considered. Additionally, the State envisions that there will be approximately six staff dedicated to providing support to small businesses (much as the Navigators will assist individuals).

Start-up costs to develop the SHOP Exchange-specific functions and assist small businesses in accessing the Exchange are estimated to equal approximately $1,000,000 while ongoing costs are projected to total about $500,000.