# Vermont Health Connect Operating Budget Analysis

Presentation to Vermont Legislative Committees
May 1, 2013

HEALTH MANAGEMENT ASSOCIATES

# Project Background

The Legislative Joint Fiscal Office asked HMA to provide an independent review of the proposed operating budget of the state's health insurance exchange, Vermont Health Connect (VHC).

**The Situation**

- The Patient Protection and Affordable Care Act (ACA) requires state Exchanges to be financially sustainability beginning January 1, 2015.
- Federal regulators expect a demonstration this year that Vermont has a budget for 2015 and explicit authority to raise revenue to meet projected costs.
- Vermont Health Connect has submitted a 2015 budget of $18.4 million, six months of which must be covered by the state FY 2015 budget. The first year of full state funding for Vermont Health Connect is FY 2016

**Challenges**

- Vermont's relatively small population creates unique challenges in financing a state-based Exchange.
- DVHA and Vermont Health Connect are swiftly moving toward a planned implementation of the Exchange for the beginning of open enrollment on October 1, 2013.

**Key Question**

- Given Vermont's strategic objectives for Vermont Health Connect, and evidence from other state-based Exchanges, is the proposed operating budget reasonable?

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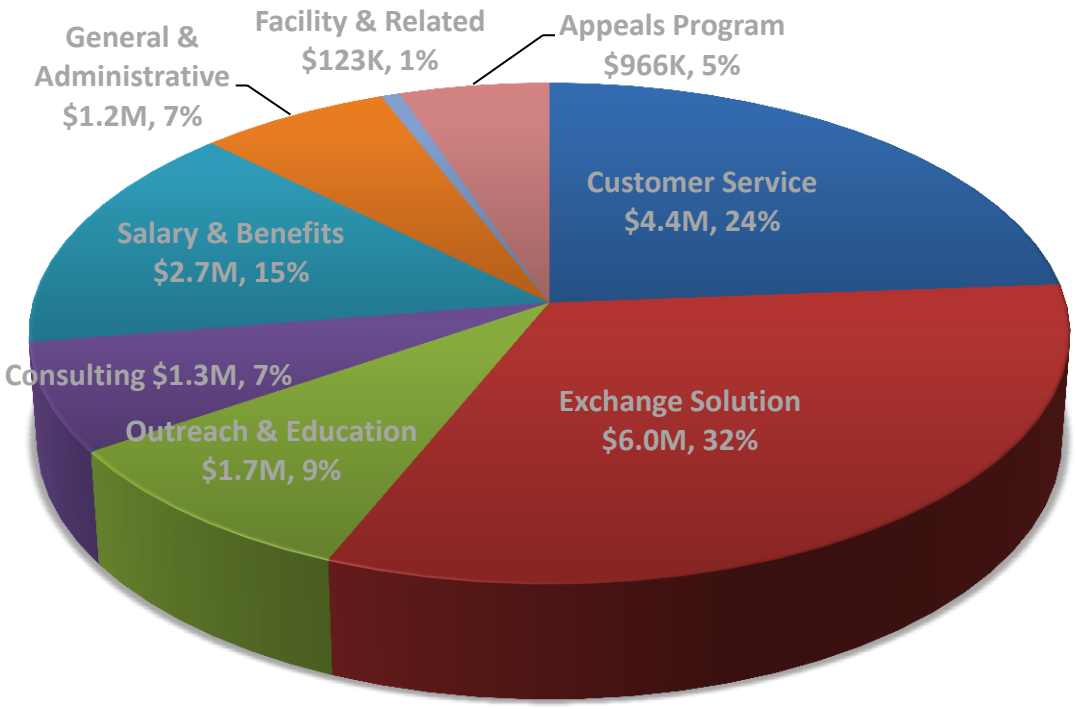
# Vermont Health Connect
# CY 2015 Operating Budget

| Operating Expenses | Low Enrollment | High Enrollment | Estimated Budget | Contracts/ Services |
|---|---|---|---|---|
| | 73,800 | 118,000 | | |
| Customer Service | $ 3,106,633 | $ 4,711,334 | $ 4,376,980 | Maximus |
| Exchange Solution | $ 5,645,404 | $ 7,565,013 | $ 5,955,950 | CGI<br>Benaissance |
| Subtotal - Systems Development and Support | $ 8,752,037 | $ 12,276,347 | $ 10,332,930 | |
| Outreach & Education | $ 1,817,775 | $ 1,835,480 | $ 1,705,220 | Navigators |
| Consulting & Professional | $ 1,287,934 | $ 1,390,088 | $ 1,291,436 | Actuary |
| Salary & Benefits | $ 3,109,703 | $ 3,109,703 | $ 2,735,187 | State staff |
| General & Administrative | $ 1,288,456 | $ 1,288,456 | $ 1,231,696 | |
| Facility & Related | $ 117,350 | $ 117,350 | $ 122,632 | |
| Appeals Program | $ 584,858 | $ 930,224 | $ 966,112 | |
| Subtotal - Program Operations | $ 8,206,076 | $ 8,671,301 | $ 8,052,282 | |
| Total Operating | $ 16,958,113 | $ 20,947,648 | $ 18,385,212 | |

# CY 2015 Operating Budget




- Two system-related and vendor-developed cost items (Customer Service & Exchange Solution) represent $10.3M or 56% of total operating expenses.
- Other program operations cost items (outreach, education, appeals, general admin) represent $8.1M or 44% of total operating expenses.

# The Bottom Line

- State-Based Exchanges are very expensive
- Vermont Health Connect is higher-cost on a per-member basis compared to larger states, but is not entirely out of line with state-based Exchanges
- Vermont's strategic decisions have led to increased costs
  - State premium and cost-sharing wrap
  - Decision to perform premium billing function for individuals
  - Ambitious IT infrastructure
  - Decision to make the Exchange an exclusive market
- Vermont's planning effort is impressive, but more attention should be paid to long-term budget projections and long-range strategic uses for Vermont Health Connect

# Vermont Health Connect is on track to meet all state-based exchange requirements, and in some areas will exceed those requirements

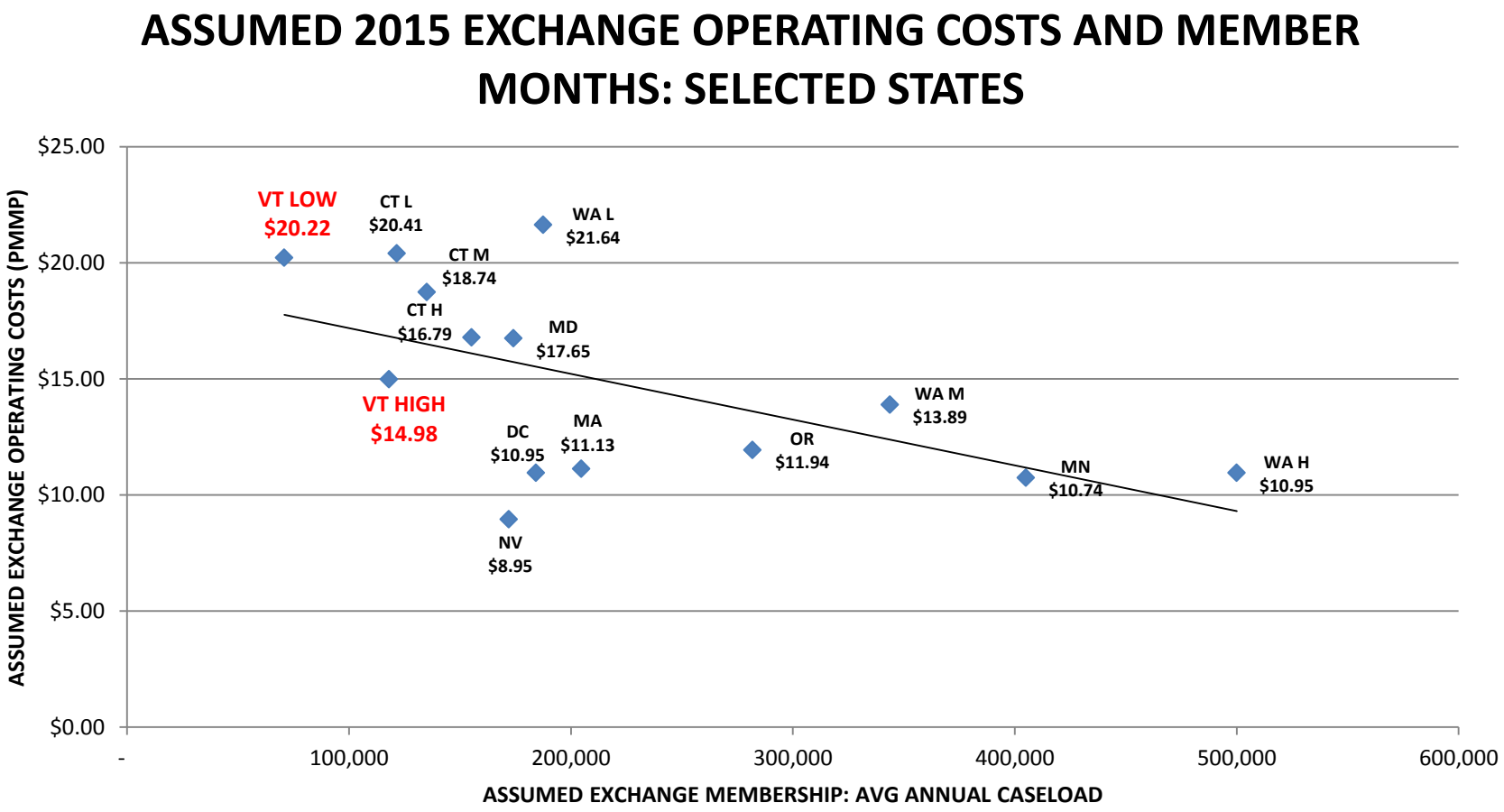
**The chart below is a summary of federal requirements for state-based Exchanges. It highlights areas where strategic decisions made in Vermont may have an influence on the design and cost of the Exchange.**

| Core Area | # of Requirements | Summary of Required Activities |
|---|---|---|
| 1. Legal Authority and Governance | 8 | - Legal authority to operate an ACA-compliant exchanges<br>- ACA-compliant governance structure |
| 2. Consumer and Stakeholder Engagement and Support | 23 | - Robust outreach, education and stakeholder engagement<br>- Consumer assistance through website – information on QHPs, Call Center and Navigators |
| 3. Eligibility and Enrollment | 34 | - Able to determine eligibility and conduct enrollment via web, phone, mail, in-person<br>- Able to conduct and manage appeals |
| 4. Plan Management | 20 | - Process for QHP issues certification and decertification<br>- Plan management system to ensure ongoing QHP compliance and performance |
| 5. Risk Adjustment and Reinsurance | 6 | - Legal authority and designated entity to operation risk adjustment and reinsurance |
| 6. SHOP | 10 | - SHOP meets all ACA requirements, including offering ACA-compliant Employee Choice products |
| 7. Organization and Human Resources | 3 | - Exchange has appropriate organizational structure and staffing to perform required activities |
| 8. Finance and Accounting | 3 | - Financial model / plan to monitor finances and track costs and revenues |
| 9. Technology | 3 | - Technology and system functionality complies with HHS IT guidance |
| 10. Privacy and Security | 5 | - Privacy and security procedures<br>- Safeguards for authenticating identity and protecting confidential information |
| 11. Oversight and Monitoring | 5 | - Tracking of performance and outcome metrics<br>- Compliance with ACA financial integrity provisions |
| 12. Contracting, Outsourcing and Agreements | 1 | - Execution of appropriate contractual, outsourcing, and partnership agreements with vendors and other public agencies |
| Total | 121 | |

# There are challenges with comparing operating budgets across states

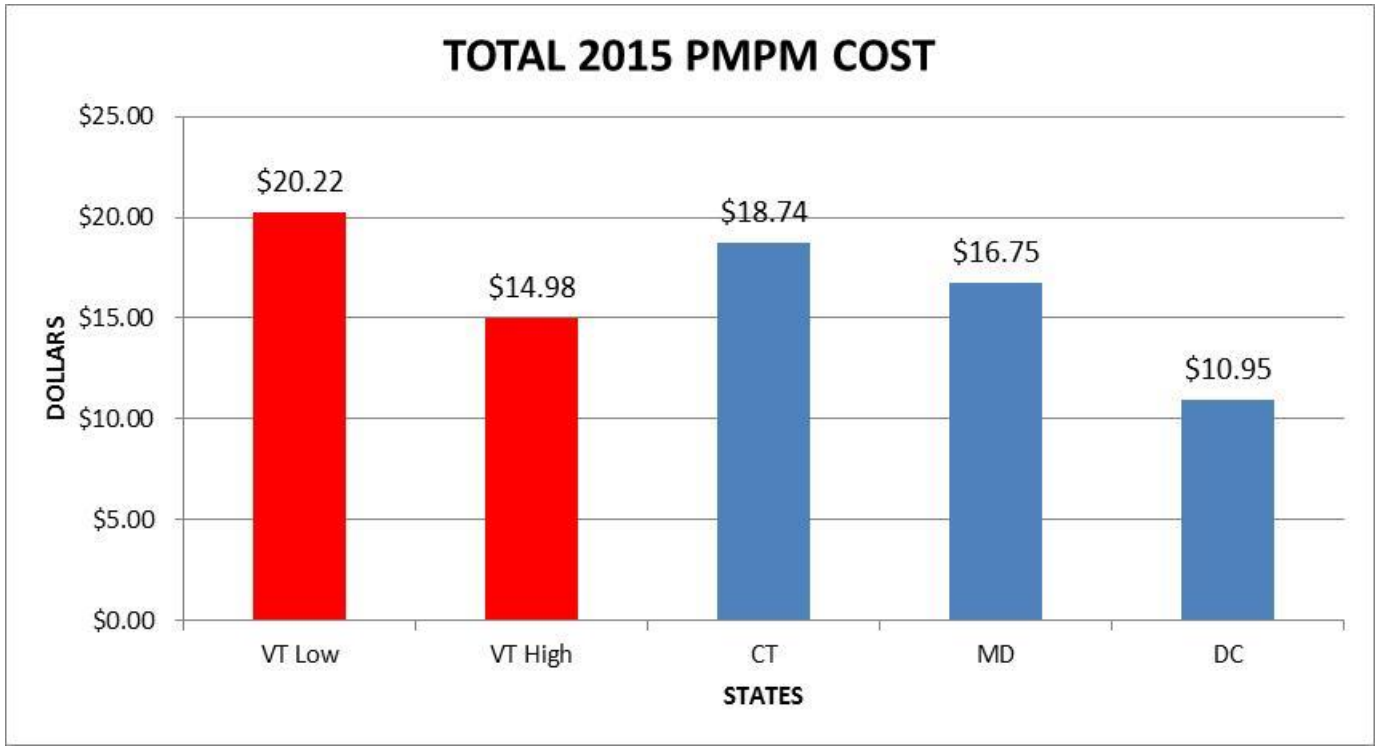
- HMA compared Vermont's 2015 Exchange cost estimates against other state-based Exchanges
  - Limited to states where public information available
  - Pure comparisons restrained by differences in definitions used in Exchange budget documents
- Best to normalize costs to per-member month (PMPM) basis
  - PMPM cost influenced by size of Exchange enrollment
  - Fixed vs. variable costs provide another dimension for comparison
- Other states are similarly situated
  - All state-based Exchanges are new, and unique
  - Very well-funded for start-up through federal establishment grants
  - Staff are focused on 2014 implementation matters

# Relationship Between PMPM Costs and Assumed Exchange Membership



# Total Cost Compared to Other Small States

- When compared to 2015 Cost Estimates for Exchanges with fewer than 200,000 members. Vermont's estimates are not far out of line.

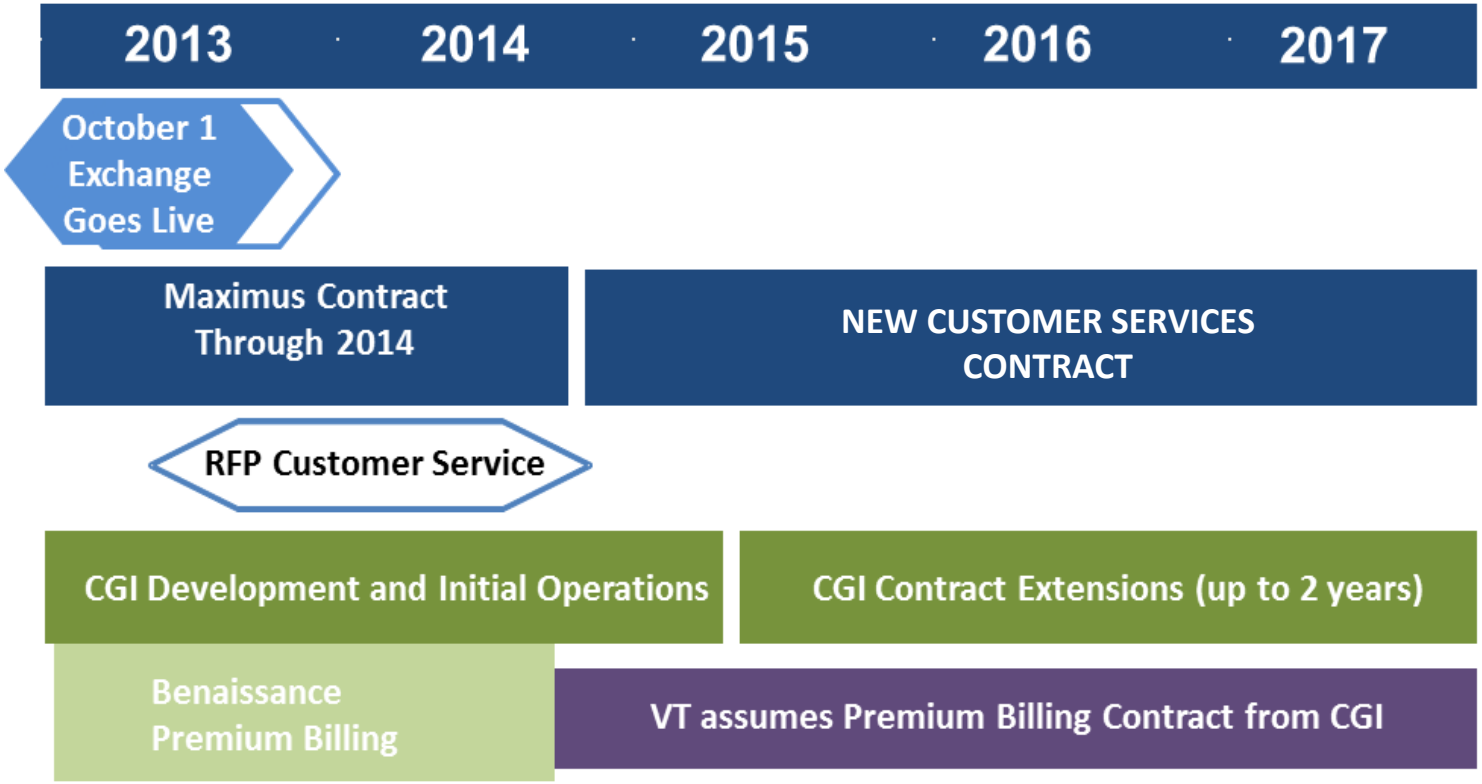


# Estimated Fixed and Variable Costs Against Comparison States

- Exchanges with lower levels of participation must spread fixed costs across smaller pool of consumers.
- Most of VT's variable cost appears linked to customer service function (est. $2.87 PMPM) and IT solution (est. $3.43 PMPM).

| STATE | FIXED COST PMPM | VARIABLE COST PMPM | FIXED COST % OF TOTAL |
|---|---|---|---|
| Vermont Low | $13.08 | $7.13 | 65% |
| Vermont High | $7.85 | $7.13 | 52% |
| Connecticut | $14.97 | $3.77 | 80% |
| Maryland | $10.22 | $6.53 | 61% |
| Washington | $9.22 | $4.67 | 66% |
| Minnesota | $10.74 | $6.34 | 63% |

# Focused Reviews:
# Major Vendor Relationships are in Place




Major contracts for Customer Services and IT are already negotiated. One vendor contract will be re-procured in 2014 (after initial open enrollment).

# Vermont Health Connect Customer Service *Contract Assessment*

***The Customer Service Call Center planned by Vermont Health Connect meets the ACA requirements for a state-based Exchange and is on par with other states pursuing the state-based Exchange model.***

Key Findings

- VHC has leveraged existing MAXIMUS – Medicaid relationship for Exchange customer service
  - Builds off existing fixed infrastructure and minimizes additional fixed costs
  - Synergy between call centers functions for Medicaid and Exchange populations makes this a fairly common approach across state-based Exchange states
- Variable PMPM costs (estimated at $2.87) are in line with assumptions made in other states
  - Generally these call center benchmarks are higher than commercial call centers
  - Content of calls is more complicated in public sector – eligibility issues are more involved and new SHOP rules will differ from typical commercial calls
- VHC Customer Service performance standards in line with industry standards – build on existing contract

# Vermont Health Connect Customer Service *Contract Assessment*

Key Findings, continued

- Payment terms of contract are largely based on a variable per-minute call rate
  - Demands close monitoring of call times
  - Allows for ramp-up for open enrollment (call center staffing maximum is 2.5X regular staffing levels)
- Cost-based nature of contract provides flexibility but also creates risks
  - Call avoidance is essential under this paradigm
- State has appropriately built start-up costs into contract payment terms – this is a way to maximize federal establishment grant money

| Customer Services Amendment Cost Category | Estimated Cost | Percent of Total |
|---|---|---|
| Start-up (Exchange only) | $3.7M | 29% |
| Fixed (Exchange and Medicaid) | $2.7M | 21% |
| Variable (Exchange and Medicaid) | $5.7M | 45% |

# Vermont Health Connect Premium Billing
# *Assessment of Approach*

***Providing premium billing services for individuals enrolling in QHPs is a business function that is not required by the ACA. VHC has chosen to perform the premium billing function using a premium billing vendor as a subcontractor to CGI.***

Key Findings

- Individual premium billing rate (draft) of $2.75 PMPM is higher than issuers' costs for same function, but roughly in line with other state-based Exchanges
  - Fixed start-up costs are covered through establishment grant funding
- PMPM costs ($2.75 for individual; $1.65 for small group) assume minimum thresholds of 25,000 members
  - This is in line with currently estimated enrollment
- Contracting structure is awkward and may create management issues
  - Typically premium billing is a component of customer service, not a larger IT development
  - Unclear whether and when premium billing vendor will take member calls
  - DVHA plans to take the contract "in-house" sometime in 2014

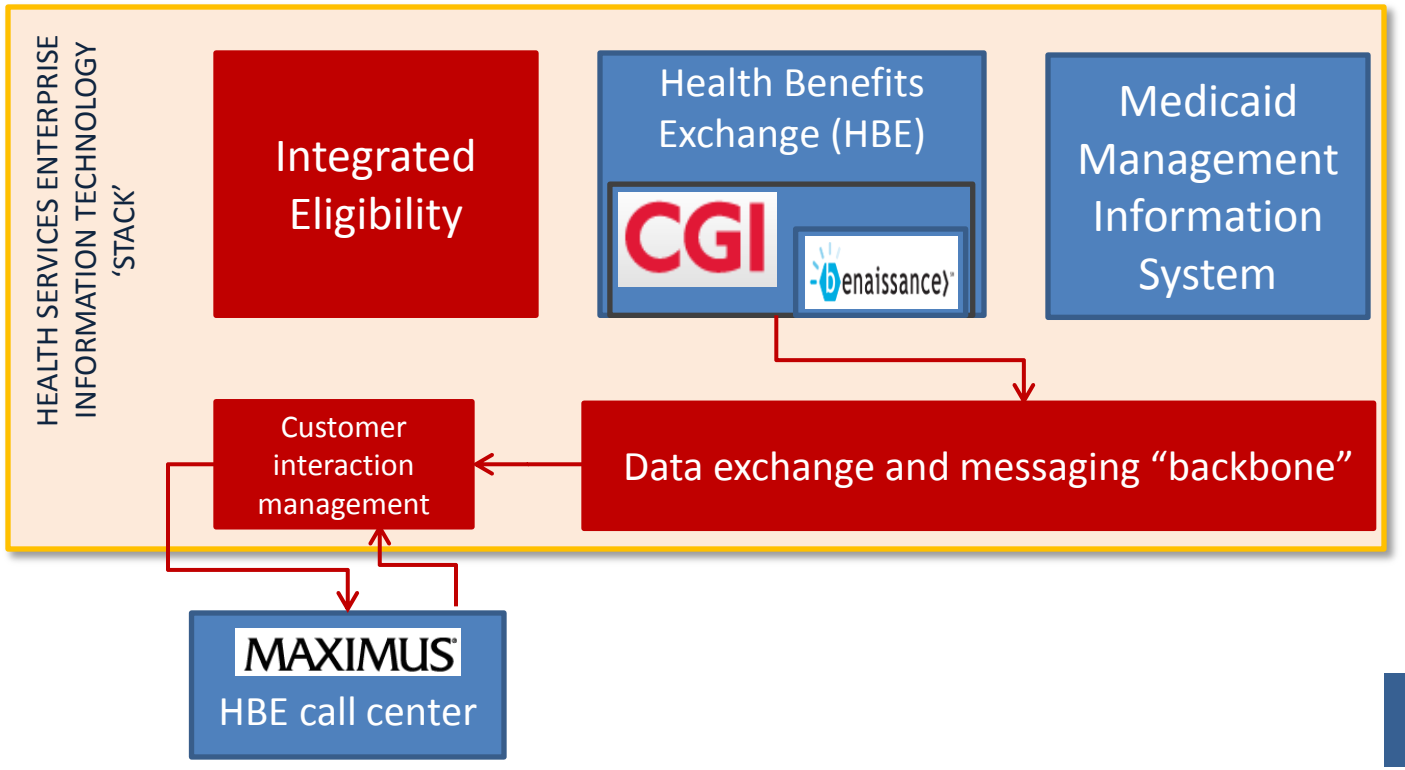
# Vermont Health Connect Premium Billing
# *Assessment of Approach*

Key Findings, continued

- Premium billing is a "post enrollment" service, when member is covered by a specific carrier
  - Areas of confusion for members can result in misdirected or repeat calls, consumer frustration and increased administrative costs
  - In Massachusetts, roughly 10% of post-enrollment calls are misdirected between the Exchange, a Health Plan and the State
- Performing this function may help set the stage for 2017
  - On the other hand, it's not even certain whether consumers will pay monthly premiums under a single payer scheme

# Vermont Health Connect IT Solution
## *High-Level Architecture*

- The State is building an IT solution for the Exchange that leverages the availability of federal funding and lays the foundation for future programs and program changes.



# Vermont Health Connect IT Solution
## *Cost Drivers*

- Solution as architected has the potential to be *high-performing*, *resilient*, *flexible*, *scalable*.
  - It should also be *compliant* with ACA-driven expectations for Exchange IT solutions.
  - It offers "value-adding" functionality – but all of this comes at a cost.
- The State has tried to defray some of these costs and has built very tough performance penalties into the IT solution contracts.

| What may drive costs UP | Notes/Comments |
|---|---|
| Performance | More horsepower = more expensive but "pays off" in customer satisfaction |
| Resiliency | Higher availability = more expensive **but** "pays off" in less disruption and reduced risk of catastrophic failure |
| Flexibility and scalability | Adds design complexity but "pays off" downstream in better response to policy or program design changes |
| Compliance | Every state **regardless of size** must comply with certain expectations |
| Functionality | - e.g. individual premium billing and aggregation<br>- "Baking in" functionality for later years using federal funds available **now** |

| What may drive costs DOWN | Notes/Comments |
|---|---|
| Use of the cloud | vs. dedicated capacity and communications infrastructure |
| Technology reuse | vs. "custom" development |
| Leverage experience and practices | Feds and other states working with CGI at the same time |
| Leverage state resources | e.g. *Customer Interaction Management* system for Maximus call center |
| Design excellence (can drive down maintenance and operations costs) | Design that makes it easier to both troubleshoot problems and implement changes post-development |

# Vermont Health Connect IT Solution
## *Maintenance and Operations Costs*

- Rule of thumb: annual recurring IT solution maintenance and operations (M&O) costs are ~ 15-25% of solution development costs
- When dealing with entirely new systems, M&O costs can be expected to be higher than the norm – especially in the first couple of years

| ***CGI costs only*** | | |
|---|---|---|
| | | |
| Solution development costs | $ 45,600,000 | |
| | | |
| Solution maintenance and operations costs (avg. first two full years) | $ 10,667,000 | |
| | | |
| **Maintenance and operations costs as a percentage of development costs:** | **23.4%** | |
| | | |

- VHC's contract with CGI builds in several thousand hours per year of activity which could be categorized as "over and above" M&O (typically this system enhancement is not included in the quoted heuristic)

# Vermont Health Connect IT Solution
## *Maintenance and Operations Costs (cont.)*

- Another way of looking at this issue: how does the cost of Vermont's solution compare to other state solutions?
  - A reasonable comparison, per Vermont's contract with CGI, is Hawaii.

| *CGI costs only* | | | |
|---|---|---|---|
| | Hawaii | Vermont | *Diff (%), VT to HI* |
| Solution development and implementation costs | $ 38,900,000 | $ 45,600,000 | *17%* |
| | | | |
| Solution maintenance and operations costs (total, through 12/31/15) | 24,005,000 | 23,988,000 | *0%* |
| | | | |
| **Maintenance and operations costs as a percentage of development costs:** | **62%** | **53%** | |

- VHC's M&O costs as a percentage of development and implementation costs are lower than Hawaii's - consistent with the argument that the Vermont solution is being built with "ease of maintenance" as a goal

# Vermont Health Connect IT Solution
## *Cost comparison across states*

- Comparing costs across states, particularly for a solution such as this one for which there is very little if any precedent, is difficult despite the fact that Exchange-specific requirements are fairly well prescribed.

| STATE | PRIMARY VENDOR | CONTRACT COST |
|---|---|---|
| California | Accenture | $359 million |
| New York | CSC | $184 million |
| Minnesota | Maximus | $41 million |
| Nevada | Xerox | $72 million |

- Variability across states may be due to:
  - Varying degrees of difficulty interfacing Exchange IT solution to existing systems (and the nature of those "legacy" systems)
  - Other functionality that these states may be building into their Exchange IT solutions, e.g. eligibility determination and enrollment for all "insurance affordability programs"
  - Extent to which Exchange IT solution costs have been "front-loaded" vs. "back-loaded" in contracts
  - Difficulty pinning down what a reasonable cost range should be for this type of solution

# Vermont Health Connect IT Solution
## *Conclusions*

- No evidence that Exchange IT solution costs are out of line with costs being incurred by other states
- Architecture, functionality and expectations associated with this solution may result in higher costs upfront, and higher associated maintenance costs, **but** they may:
  - Mitigate the risk of problems at go-live
  - Result in lower costs down the road (vis-à-vis what they *could* be) as inevitable programmatic changes are incorporated
  - Lay the foundation for future program changes and make it easier for the State to implement them
- The state has an impressively designed vision for Health IT systems (MMIS, HIE, Integrated Eligibility) and how they will complement each other
  - The vision may support functions needed in 2017
  - It also contemplates multiple complex development projects that have interdependencies

# Areas of Risk and Recommendations

Budget-specific Recommendations

- CY 2015 budget projections alone are inadequate for long-term planning. All fiscal analysis from this point forward should address fiscal years 2015-17 at a minimum. Vermont Health Connect should be projecting budget sustainability for 3-5 years.
- Assumptions of caseload are critical in every way and will need to be closely monitored
- The current budget model is not detailed enough and over time will not allow for easy analysis of cost drivers. For example, current budget lines for Systems Development and Support would be more informative if budgeted by function: Eligibility; Enrollment; Premium Billing; Customer Service Call Center.
- Clarity is needed regarding the role of Vermont Health Connect in the Article 48 single-payer vision for 2017

# Areas of Risk and Recommendations

Operations-related Recommendations

- The re-procurement of the customer services vendor contract should present new opportunities
  - A greater focus on call avoidance, using all tools available
  - Federal establishment grant funding will still be available for start up – that procurement should be designed to maximize federal funding to meet the needs of the customer service function
- Call center volume will be highly variable and is a cost driver. Close monitoring of call times and overall volume is essential.
- A central idea behind of the IT project is to maximize intuitive web technology, and therefore minimize call center volume. IT enhancements paid for with state funding should take account of this dynamic and the state should always assess when enhancements will decrease variable call center costs.
- The state should monitor administrative duplication with health plans and any associated consumer confusion. Unnecessary premium billing costs and misdirected calls will be areas to improve efficiency.

# Questions