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A Case Study of Vermont's Health Exchange: Missteps and Progress

Ashlynn R. Doyon

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Abstract: The implementation of Vermont’s state health exchange has been at the forefront of political debate in the Green Mountain State since the passage of Act No. 48 in 2011. This paper addresses the ways in which federal legislation under the Affordable Care Act (ACA), spurred the development of Vermont’s own state-based exchange. It identifies the objectives that policymakers put forth during development and assesses whether or not these goals have been met. The paper offers insight into the future prospects of Vermont Health Connect (VHC) under both new gubernatorial and presidential administrations. In addition to secondary source research, this analysis draws on informational interviews conducted with leading health care reform policymakers in Vermont, as well as reports to the Vermont General Assembly.

Vermont Health Connect (VHC) is the online portal to Vermont's health insurance marketplace. The exchange was developed in 2011 in response to the passage of the federal Affordable Care Act (ACA), and its implementation has been wrought with controversy. VHC's website paints a positive picture of the exchange, declaring that VHC is "for Vermonters, by Vermonters," and that it constitutes "one more step toward access to comprehensive health coverage for all Vermonters."¹ Nationally, experts praised the development of the exchange, stating "although Vermont is a small state, its reform efforts provide valuable lessons for other states in implementing ACA reforms."² In contrast, during the 2016 gubernatorial race Vermont's newly elected Governor, Phil Scott, campaigned on the message that Vermont is unaffordable largely because of its health care system.³ Scott advocated that "what we have right now is fully dysfunctional. . . . it's not working, so we need to transition to something else."⁴ Additionally, information technology problems associated with the exchange's rollout led to a customer service backlog that peaked at over 10,000 cases and sparked a media firestorm.⁵ This controversy surrounding Vermont's health exchange has been playing out in the Green Mountain State over the past six years. This paper seeks to address the question of whether or not VHC has indeed been successful in meeting policy objectives and to contribute to the body of analytical literature on this subject.

¹ "About Vermont Health Connect," *Vermont Health Connect*, accessed May 1, 2017,

² Laura K. Grubb, "Lessons from Vermont's Health Care Reform," *New England Journal of Medicine*, no. 368 (April 4, 2013).

³ Peter Hirschfeld, "Scott Says It's Time To Abandon Vermont Health Connect," *Vermont Public Radio*, accessed May 1, 2017, <http://digital.vpr.net/post/scott-says-its-time-abandon-vermont-health-connect#stream/0>.

⁴ *Ibid.*

⁵ "2015 SMART Report: Executive Summary," *Vermont Health Connect*, (Vermont Agency of Human Services, Montpelier, VT, 2015).

The paper first describes the research approach, including a personal disclaimer regarding my preconceived view of VHC and the process by which I conducted interviews with leading health care reform policymakers in Vermont. It then gives a review of the literature relevant to an analysis of Vermont's health care exchange. The paper discusses the ACA's provisions for state exchanges broadly before focusing on what they mean for states themselves and the context of health care reform in Vermont, with particular regard to the passage of *Act No. 48. An act relating to a universal and unified health system*. It offers an answer to the question of why Vermont opted to build its own exchange by outlining three policy objectives, and then presents an analysis of how well VHC has fulfilled those policy goals. This thesis does not analyze whether these health care objectives are good or bad, but merely assesses whether or not they have been met. Finally, the paper considers the current climate regarding VHC and offers insight about the next steps for policymakers in Vermont. Please note that this paper also includes two appendices: Appendix 1 details the interview parameters utilized in my research; and Appendix 2 comments on Act 48's other initiatives and what those developments mean for health care reform in Vermont.

There is a void in academic literature when it comes to the evaluation of VHC as a specific case. Countless news articles and media stories express consumer frustration with VHC and reports issued by the Green Mountain Care Board (GMCB) or Governor's Office of Health Care Reform outline the exchange's technological developments, qualified health plans, and effects on the uninsured rate. Yet, an analysis of how the implications of VHC measure up to the policy's initial objectives is absent from the mix. This study addresses the intent and objectives of Vermont's state exchange and analyzes

whether or not those goals have been carried out; thus, it represents a new contribution to the body of work that currently exists on this topic. Furthermore, this paper's analysis of VHC is timely in that it takes place in the wake of the 2016 election, amidst a period of transition for both Vermont's gubernatorial administration and the presidential administration, when new political actors and agendas have the potential to create significant change in the health care arena.

Research Approach and Relevant Literature

This project was inspired by an undergraduate internship experience in the Vermont Governor's Office. In the summer of 2014, I worked as a Constituent Services Intern in the Office of Governor Peter Shumlin. One of my primary tasks during this time was to answer the Governor's publicly accessible hotline. Constituents can call this line in order to speak with a staff person in the office and express an opinion regarding an issue or seek and be directed to state resources and services for various needs. I estimate that more than half of the calls and correspondence that I handled during this period related to VHC and these instances fell under both of the aforementioned categories. My internship experience left me wanting to understand further the complexities of health care reform in Vermont and why so many people appeared to be dissatisfied with the exchange. I left the Governor's office with an impression similar to the one that I think that many Vermonters hold regarding VHC. I was frustrated that I received such a high volume of calls from constituents having difficulty with the exchange, when it was supposed to be something that improved their health care situation. Three years later I began a yearlong research project with a preconceived bias against the exchange, hoping

to better understand the policy; I ended the project with a drastically different perspective.

Methodology and Interviews

This paper is comprised of four principle research components. First, I assess the provisions and consequences of the ACA as they pertain to state exchanges using academic literature. Second, I identify the policy objectives of VHC through an examination of the actual legislation passed by the Vermont General Assembly. Next, I use reports commissioned by the Legislature and authored by stakeholders in Vermont health care policy to analyze VHC's fulfillment of the identified policy objectives. Finally, I maintain and augment the conclusions drawn from primary and secondary sources using evidence gathered in a series of informational interviews.

For this project, I interviewed three health care reform policy advisors who worked in the Shumlin administration: Michael Costa; Robin Lunge; and Lawrence Miller. Michael Costa served as the Deputy Director of Health Care Reform under Governor Shumlin and in the Scott administration serves as the Deputy Commissioner of Health Services and Managed Care at the Department of Vermont Health Access. Robin Lunge was the Director of Health Care Reform under Governor Shumlin and currently serves as a member of the Green Mountain Care Board (GMCB). Lawrence Miller worked as the Chief of Health Care Reform in the Shumlin administration. All of the interviewees were appointed by Peter Shumlin and held a favorable view of his administration's health care reform efforts. This is to be expected as one of the roles of the Governor is to appoint policymakers and Governor Shumlin was in office at the time of Act 48's passage and throughout the development of VHC until January 2017. Each

interviewee's specific policymaking role gives authority to the material collected during the interviews and so their responses are attributed in the text. Discussions varied in length from 30-90 minutes. For more information about the interview procedures, see Appendix 1.

Relevant Literature

A large body of academic literature exists on the topic of the ACA itself, and although a relatively significant amount has been written on the subject of state exchanges, there lacks literature pertaining to the specific and trying circumstances of VHC. For the purposes of this thesis, the academic literature falls into three categories. There is a body of literature that broadly addresses the development of the ACA and the arena of health care reform in the United States overall. A number of works assess the implications of the ACA for specific populations, and most pertinent to this study, there is a series of literature that discusses the ways in which the ACA interacts with state exchanges.

Paul Starr's book, entitled *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform*, takes an historical approach in its explanation of the complexities of health care reform.⁶ It addresses the question of why health care is such a complicated and intense issue in the United States. This is an especially conspicuous question when our country is compared to other world powers. Starr asserts that the answer to this question is rooted in historical approaches to the issue. He argues that America suffers from both economic and psychological barriers when it comes to health care. Also included in this broad first category are works such as John E. McDonough's

⁶ Paul Starr, *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform* (New Haven: Yale University Press, 2013).

book, *Inside National Health Reform*, that focus mostly on the ACA and the legislative history of the policy issue under President Barack Obama.⁷ McDonough describes how the development takes place over a two-year period, beginning with the 2008 presidential campaign and culminating with the signing of the bill in 2010. McDonough is a health care policy expert at Harvard and is able to explain in detail the inner workings of the legislation itself, alongside the political processes leading to its passage.

Additionally, there are a number of articles that project or assess the implications of the provisions of the ACA for specific populations. Winkelman, HwaJong, and Davis conducted a study from 2008 to 2015 in order to ascertain changes in coverage among previously incarcerated young men.⁸ The study concluded that the level of coverage improved among this specific population under the ACA but that previously incarcerated young men still comprise a significant percentage of the uninsured.⁹ Similar studies have been conducted that focus on other population categories such as race, ethnicity, and even the adult population of the state of Georgia.^{10,11} These studies are relevant to a project that examines in part, how the ACA and the VHC exchange that developed under it affect

⁷ John E. McDonough, *Inside National Health Reform* (Berkeley: University of California Press, 2011).

⁸ Tyler N. A. Winkelman, Choi HwaJong, and Matthew M. Davis, "The Affordable Care Act, Insurance Coverage, and Health Care Utilization of Previously Incarcerated Young Men: 2008-2015," *American Journal of Public Health* 107, no. 5 (March 2017): pp. 807-811.

⁹ *Ibid.*, 1.

¹⁰ Monica Gentili, Pravara Harati, and Nicoleta Serban, "Projecting the Impact of the Affordable Care Act Provisions on Accessibility and Availability of Primary Care Providers for the Adult Population in Georgia," *American Journal of Public Health* 106, no. 8 (August 1, 2016): pp. 1470-1476.

¹¹ Thomas C. Buchmueller, Zachary M. Levinson, Helen G. Levy, Barbara L. Wolfe, "Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage," *American Journal of Public Health* 106, no. 8 (August 1, 2016): pp. 1416-1421.

Vermonters as a specific population. The following section details how the third category of literature relevant to this thesis discusses the ways that the ACA interacts with state exchanges.

ACA and State Exchanges

The language of the ACA provides guidelines for how state exchanges should be developed and implemented. There is a body of literature that analyzes the implications of these novel provisions. Section 1311 of the ACA articulates in statute the requirement of states to establish an exchange and outlines the four criteria that these exchanges must meet.¹²

(Sec. 1311, as modified by Sec. 10104) Requires states to establish an American Health Benefit Exchange that: (1) facilitates the purchase of qualified health plans; and (2) provides for the establishment of a Small Business Health Options Program that is designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans in the small group market in the state.

Requires the Secretary to establish criteria for the certification of health plans as qualified health plans, including requirements for: (1) meeting market requirements; and (2) ensuring a sufficient choice of providers.

Sets forth the requirements for an Exchange, including that an Exchange: (1) must be a governmental agency or nonprofit entity that is established by a state; (2) may not make any health plan available that is not a qualified health plan; (3) must implement procedures for certification of health plans as qualified health plans; and (4) must require health plans seeking certification to submit a justification of any premium increase prior to implementation of such increase.

The guidelines put forth in the ACA allow for much discretion in the construction of state exchanges. In light of this flexibility, Ericson and Starc present a compelling argument about the importance of wise decisions by exchange designers. Their article,

¹² The Staff of The Washington Post, *Landmark: the inside story of America's new health-care law and what it means for us all* (New York: PublicAffairs, 2010), 200-201.

entitled “Designing and Regulating Health Insurance Exchanges: Lessons from Massachusetts,” asserts that “states have substantial latitude in shaping how exchanges operate and the way consumers make decisions . . . yet because exchanges are new, exchange designers have been forced to rely on intuition rather than evidence.”¹³ Paul Starr echoes this sentiment about the intricacies of state exchanges by putting them in context: “States have long varied sharply in the share of their population without insurance. The disparities reflect the states’ economic and demographic characteristics as well as their institutions and politics.”¹⁴

Fox and Blanchet relate the task of designing state exchanges under the ACA to health care reform efforts in Vermont. The authors discuss the political background of the passage of Act 48, through data compiled from 120 interviews with individuals involved in the policy’s development.¹⁵ They offer praise to Vermont’s handling of the ACA and the provisions of Act 48 by writing that “while other states are fighting with the federal government over the constitutionality of the ACA and refusing to implement exchanges, Vermont has been fighting over how quickly it can do more to go beyond national reform.”¹⁶ The idea of going beyond national reform is crucial to the development of the VHC exchange. The objectives that the policy seeks to carry out aim higher than the federally mandated criteria for state exchanges written in the ACA.

¹³ Keith M. Marzilli Ericson and Amanda Starc, "Designing and Regulating Health Insurance Exchanges: Lessons from Massachusetts," *Inquiry* 49, no. 4 (December 2012), 329-330.

¹⁴ Starr, *Remedy and Reaction*, 163.

¹⁵ Ashley M. Fox and Nathan J. Blanchet, "The Little State That Couldn't Could? The Politics Of ‘Single-Payer’ Health Coverage In Vermont," *Journal Of Health Politics, Policy & Law* 40, no. 3 (2015), 478.

¹⁶ *Ibid.*

Health Care Reform in Vermont

The State of Vermont is touted as having “a history of pioneering healthcare reform.”¹⁷ The Vermont Agency of Administration cites that the state began its legislative reform efforts in 2006, while some officials assert that Vermont’s history of pioneering health care reform actually extends back 25 or 30 years.^{18,19} In order to provide health coverage for children, teens, and pregnant people, Vermont created the Dr. Dynasaur program in 1989. In 2006 the state passed the Catamount Health initiative, the Vermont Health Access Program (VHAP), and six key health care reform principles under *Act No. 191. An act relating to health care affordability for Vermonters*: 1) universal access to coverage and essential health care services; 2) comprehensive and continuous health care coverage; 3) a health delivery system that models continuous improvement of health care quality and safety; 4) sufficient, equitable, fair, and sustainable financing; 5) accountability for quality, cost, access, and participation; and 6) the engagement of Vermonters to lead healthy lifestyles with a focus on preventative care.²⁰ This legacy of being at the forefront of health care reform helped to propel Vermont to take the lead with the development of VHC in 2011.

¹⁷ “Report on the Impact of Expanding Vermont Health Connect to Include Large Group Employers” (Green Mountain Care Board, Montpelier, VT, February 11, 2016), 3.

¹⁸ “Making Quality Health Care Available to All Vermonters | Health Care Reform,” Vermont Agency of Administration, accessed May 1, 2017, <http://hcr.vermont.gov/>.

¹⁹ Robin Lunge (Director of Health Care Reform, GMCB) in discussion with the author, March 1, 2017.

²⁰ 1 V.S.A. § 191.

Act 48

Perhaps the largest health care reform milestone in Vermont came when the legislature passed Act 48 in 2011, on the heels of the ACA.²¹ As an October 2011 piece in *VTDigger* exemplifies, Act 48 was met with substantial political controversy.²² Proponents of the new law argued that Act 48's tilt toward a universal health care system would streamline coverage, cut costs, and mimic other countries in order to provide better quality care.²³ Those opposed held concerns that it is unfair to spread the costs associated with poor health habits to all residents and that such a system would lead to unsustainable costs and budget deficits.²⁴ However, all sides in the debate surrounding Act 48 agreed that some reform was necessary due to the fact that the "costs of health care [were] rising faster than the economy."²⁵

At the time of Act 48's passage, health care costs in Vermont had been increasing at rates of up to 8.5% per year, coverage was failing to improve, and close to 200,000 (out of a population of approximately 626,000)²⁶ people lacked adequate health insurance.²⁷ In response to these circumstances, Act 48 took three primary actions. The first was the creation of a regulatory body, the GMCB, tasked with "changing the way we

²¹ "Making Quality Health Care Available to All Vermonters."

²² Alan Panebaker, "Health care gurus spar over Act 48," *VTDigger*, October 21, 2011, accessed May 01, 2017, <https://vtdigger.org/2011/10/21/health-care-gurus-spar-over-act-48/>.

²³ *Ibid.*

²⁴ *Ibid.*

²⁵ *Ibid.*

²⁶ "2011 Vermont Population Estimates" (Vermont Department of Health, Burlington, VT, January 2013), 1.

²⁷ "Brief Summary of Act 48 Vermont Health Reform Law of 2011," (Vermont Agency of Administration, Montpelier, VT, 2011).

pay for health care and controlling growth in health care costs.”²⁸ Second, the legislation charged the Secretary of Administration with the job of designing a prospective financing plan for a single-payer health care system.²⁹ Lastly, Act 48 established Vermont’s own health benefit exchange in accordance with the requirements of federal law as prescribed in the ACA. This provision led to the formation of VHC.³⁰ Also of significance, Act 48 created in statute, the position of the Director of Health Care Reform who is “responsible for coordinating health care reform initiatives across state government” and overseeing “collaborations for health care reform among executive branch agencies, departments, offices, and the Green Mountain Care Board.”³¹

Vermont’s Own Exchange

The provision of Act 48 in which the State of Vermont establishes its own exchange separate from the federal exchange represents a deliberate policy choice. When asked why Vermont chose to implement a state-based exchange, Robin Lunge, former Director of Health Care Reform in the Shumlin administration, called the decision a “no-brainer.”³² Lunge notes that because Vermont has typically been at the forefront of covering Vermonters through Medicaid expansion, prior to the passage of the ACA, the state already had coverage for Vermonters whose income was up to 300% of the Federal Poverty Level (FPL).³³ Thus, under the federal government’s exchange, Vermonters would receive less help paying for health care, coupled with higher out-of-pocket costs.³⁴

²⁸ Ibid., 1.

²⁹ Ibid., 1.

³⁰ Ibid., 1.

³¹ “Making Quality Health Care Available to All Vermonters.”

³² Robin Lunge, March 1, 2017.

³³ Ibid.

³⁴ Ibid.

The exchange created under Act 48 allowed the state to implement a state-based premium supplement and cost-sharing reduction in addition to assistance provided by the ACA, in order for financial assistance in Vermont to basically stay the same.³⁵ Under VHC Vermonters are able to benefit from several types of financial assistance including Advanced Premium Tax Credits, Vermont Premium Assistance, and other Cost-Sharing Reductions (CSR).³⁶

In 2014, then Governor of Vermont, Peter Shumlin, appointed a Chief of Health Care Reform to be his senior advisor on the topic.³⁷ Lawrence Miller, the person drafted for this job, also cites concrete reasons for Vermont's decision to establish a state-based exchange. Miller articulates that a state-based exchange would be able to help the state maximize the benefits of Medicaid expansion subsidies, maintain the affordability curve already in place in the state, and continue Vermont's generosity in terms of health care funding.³⁸ This was to be accomplished through Vermont's own arrangement of premium assistance and cost-sharing measures under the exchange.³⁹ As an additional incentive, Vermont received substantial financial support from the federal government to develop its own exchange.⁴⁰ The state was "awarded more than \$250 million in federal funding . . . the fifth-highest amount among the states, although Vermont has the country's second-

³⁵ Ibid.

³⁶ Lawrence Miller, "Vermont Health Connect Report" (Office of the Governor, Montpelier, VT, June 27, 2016), 26.

³⁷ John Flowers, "In Profile: Lawrence Miller takes on health care reform," VTDigger, April 20, 2014, accessed May 1, 2017, <https://vtdigger.org/2014/04/20/profile-lawrence-miller-goes-leading-states-economic-development-efforts-taking-health-care-reform/>.

³⁸ Lawrence Miller (Chief of Health Care Reform) in discussion with the author, March 6, 2017.

³⁹ Ibid.

⁴⁰ Grubb, "Lessons from Vermont's Health Care Reform," 1277.

smallest population,” which meant that “state exchange development [was] 100% federally funded.”⁴¹

Assessment of VHC and its Policy Objectives

Act 48 outlines 14 principles for health care reform that are meant to guide the implementation of its legislated reforms.⁴² While Act 48 takes three primary actions, this thesis focuses on the establishment of Vermont’s own health care exchange. The analysis identifies the principles of health care reform directly related to the exchange as the main policy objectives for VHC. The relevant principles sourced directly from the legislation are as follows and are listed with the corresponding numeral from the law itself:⁴³

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting.

(3) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.

(6) Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand.

(7) Individuals have a personal responsibility to maintain their own health and to use health resources wisely, and all individuals should have a financial stake in the health services they receive.

(11) The financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably.

⁴¹ Ibid.

⁴² 1a V.N.A. § 48.

⁴³ Ibid.

(13) Vermont's health care system must operate as a partnership between consumers, employers, health care professionals, hospitals, and the state and federal government.

The six applicable principles articulated by the legislation, coupled with the reasoning discussed above for the deliberate choice to create a state-based exchange in Vermont, lead to the formation of three policy objectives for VHC. These objectives can be summarized as follows, and are the basis of this assessment of the exchange: 1) VHC should function efficiently in order to increase the number of Vermonters covered by quality health insurance; 2) the financing structure of the exchange should maximize the use of state and federal dollars in order to provide cost-savings to Vermonters; and 3) VHC should serve as a tool through which Vermonters can learn about health care options and make educated purchasing choices.

Information Technology Missteps

VHC has been widely criticized for its information technology shortcomings and blunders. These faults are pertinent to the third principle for health care reform in Act 48 that requires the health care system to be “efficient in operation,” which corresponds to the policy objective that VHC must function efficiently.⁴⁴ The series of information technology problems associated with VHC are important to this analysis, because the glitches hampered tens of thousands of consumers from effectively accessing VHC's health care coverage. Since its rollout, VHC has been wrought with technical problems, many of which received significant media attention. This section defines the five most

⁴⁴ Ibid.

prominent information technology issues, and the ways in which VHC has addressed them.

Qualified Special Cases

Qualified special cases “are cases that are escalated to a dedicated customer service team due to their complexity, medical or financial urgency, or inability to be resolved through normal channels.”⁴⁵ Oftentimes this escalation is a consequence of one of the other three major errors (renewals processing, service level agreement, or change of circumstance), in conjunction with other factors unique to the individual’s situation. Subsequent monthly reports written for the General Assembly in order to detail the status of VHC indicate that these types of cases are decreasing in instance from previous periods.⁴⁶ For example, over a nine-week period in the spring of 2015, the number of pending cases was cut from 115 to 22 and in June 2015 the number of new cases each week was the lowest it had been in six months.⁴⁷

Renewals Processing

Most of the types of renewals that the VHC system has had difficulty processing include Eligibility/Plan Change Renewals, age-offs, and Program Change Renewals.⁴⁸ If a consumer’s eligibility for a cost-sharing reduction subsidy changed, if he or she aged off of the parameters established by his/her current plan, or if the individual needed to choose a new plan, making the necessary changes to health coverage in a timely manner

⁴⁵ Ibid., 9.

⁴⁶ Ibid.

⁴⁷ “Vermont Health Connect Update on June 2015 Project Development, Operations, and Enrollment Data,” (Department of Vermont Health Access, Williston, VT, July 22, 2015), 14.

⁴⁸ “Vermont Health Connect Monthly Report” (Department of Vermont Health Access, Williston, VT, May 14 2015), 7.

might prove difficult, because processing of these renewals required time-consuming manual workarounds. By April 2015, however, VHC claimed to have a handle on this particular problem and had completed 89.2% of the backlogged renewals.⁴⁹

Service Level Agreement errors - 834 transaction and premium processing errors (carrier integration)

VHC has also had information technology problems with coordinating and updating information between its system and the systems of the individual insurance carriers. In other words, if a consumer made a change through VHC, the actual insurance provider may not have received information regarding the change and it would not be reflected in the consumer's coverage. To remedy this problem, VHC put in place the following improved protocol: "within 24 hours of receiving an 834 file from VHC, insurance carriers will respond with either a confirmation that coverage has been effectuated, a rejection, or a request for more time. This allows VHC to confirm that the information in its system and the insurer's system is aligned."⁵⁰

Change of Circumstance

The change of circumstance glitch in the VHC system has perhaps received the most media and public attention. A monthly report provided to the Vermont General Assembly defines what situations generally produce this problem:

"Some changes, known as 'qualifying events,' allow customers to sign up for health insurance or change health plans outside of the annual Open Enrollment period. Examples of qualifying events include getting married or losing job-

⁴⁹ Ibid.

⁵⁰ "Vermont Health Connect Update on Project Development, Operations, and Enrollment Data" (Department of Vermont Health Access, Williston, VT, August 21, 2015), 15.

sponsored insurance. Other changes, such as income changes can impact the amount of financial help a customer receives. Finally, some changes are simply adjustments to personal information, such as a name change, an address change, or even a preference to be called on their cell phone instead of their home phone.”⁵¹

In August 2015, VHC improved the handling of these changes and others (such as requested terminations, citizenship status, and pregnancy), so that they could be processed immediately over the phone.⁵² This new functionality of being able to “process changes in real-time,” has enabled VHC staff to reduce the bottleneck of circumstance requests.⁵³

Technical Missteps

The complexities of these electronic problems demonstrate that the basis of the fault attributed to VHC is in the technology. These information technology issues lead to serious service complications, but they are system errors rather than issues with the health care reform policy that VHC represents. The Shumlin administration addressed this at the end of his term when it declared that the “technical bugs in the exchange are nearly resolved.”⁵⁴ Comparable health care reform efforts, such as the Massachusetts overhaul in 2006, experienced implementation snags as well.⁵⁵ In the case of Massachusetts, John Rother, executive vice president of policy and strategy at AARP noted that the passing of

⁵¹ “Vermont Health Connect Update on Project Development, Operations, and Enrollment Data” (Department of Vermont Health Access, Williston, VT, September 23, 2015), 11.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Hirschfeld, “Scott Says It’s Time to Abandon Vermont Health Connect.”

⁵⁵ Alex Wayne and Edward Epstein, “Obama Seals Legislative Legacy With Health Insurance Overhaul,” *CQ Weekly*, March 29, 2010, 748-53.

legislation was only “10 percent of the accomplishment, and implementing it well was 90 percent.”⁵⁶ Rother also purports that “you can have a good piece of legislation that can get completely screwed up by mistakes in implementation,” but that is not to say that the reform effort is not fundamentally positive.⁵⁷ It is through this lens that VHC’s information technology hurdles must be viewed. The glitches are problematic, but VHC has upgraded its system’s functionality in order to correct them and implementation obstacles are inevitable, no matter what the policy or reform effort.

How VHC Achieves Act 48’s Policy Objectives

Although the implementation of the VHC health insurance marketplace portal and website has faced serious information technology issues, the exchange has had success in regard to each of the policy objectives that this paper derives from Act 48’s principles of health care reform. The development and implementation of VHC has helped to increase the number of Vermonters covered by quality health insurance, the exchange utilizes a financing structure that maximizes the use of federal dollars, and VHC does considerable community outreach and education so that Vermonters can learn about health care options and make educated purchasing choices. In affirming that VHC has fulfilled these initial policy goals, it is helpful to examine each objective individually.

Levels of Health Insurance Coverage

The first of VHC’s policy objectives is that the exchange should facilitate growth in the number of Vermonters who are covered by health insurance. In this respect, the numbers clearly show that VHC is accomplishing this goal. In January 2015, an update submitted to the legislature by VHC reported, “Vermont’s uninsured rate was cut nearly

⁵⁶ Ibid.

⁵⁷ Ibid.

in half over the past two years.”⁵⁸ As of that time, Vermont ranked second in the nation in terms of health coverage with 3.7% of the population, or roughly 23,000 people, remaining uninsured.⁵⁹ Vermont also ranks number one in the nation for insuring children, “having cut the number of uninsured children in [the] state from nearly 2,800 in 2012 to fewer than 1,300 in 2014.”⁶⁰ VHC also reports that significant numbers of Vermonters obtain health insurance during the exchange’s annual open enrollment periods. For example, from December 2014 to April 2015 (the Open Enrollment period was from November 15, 2014 to February 15, 2015), the number of people entering into Qualified Health Plans (QHPs) or Medicaid plans for the first time under VHC was more than 20,000.⁶¹

The Vermont Household Health Insurance Survey (VHHIS) is the go-to tool for a comprehensive assessment of health insurance coverage in Vermont.⁶² The State of Vermont has used the VHHIS in order to measure and track the “health insurance coverage status, affordability of insurance and health care services of the Vermont population for over a decade,” conducting surveys in 2000, 2005, 2008, 2009, 2012, and 2014.⁶³ The VHHIS presents the results in terms of both percentages and a count of individuals. This is important to note because the number of respondents varies with each VHHIS. For example, in the 2009 survey, roughly 1,000 more Vermont households were

⁵⁸ “VHC Monthly Report,” May 14, 2015, 22.

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

⁶¹ *Ibid.*, 3.

⁶² *Ibid.*, 22.

⁶³ “Comprehensive Report: 2014 Vermont Household Health Insurance Survey” (Vermont Department of Regulation, Insurance Division, Montpelier, VT, March 2015), 1.

surveyed than for the 2014 survey.⁶⁴ VHC typically reports its enrollment in numbers rather than percentages, so the count data does offer a useful comparison. The VHHIS results are also an example of descriptive statistics, the findings reduce all of the variables that effect health care in Vermont to simple numbers. As such, there are limits to the conclusions that can be drawn from these numbers because it is plausible that factors other than VHC could be affecting the observed changes. VHC did begin operation in October 2013,⁶⁵ so the results of the most recent VHHIS survey, conducted in 2014, could be demonstrative the exchange’s effects. Changes in the survey results from 2012 to 2014 particularly, support VHC’s claim that it is continually helping to insure more Vermonters.

Figure 1 shows that Vermont’s uninsured rate of 3.7% in 2014 represents a “significant decrease from the percentage without coverage observed in 2012.”⁶⁶ The 2014 survey found that 22,231 Vermonters were uninsured, compared to 47,460 in 2009 and 42,760 in 2012, with a much smaller reduction in the 2009-2012 period.⁶⁷ Figure 2, comparing the rate of uninsured children with the child poverty rate over time, illustrates VHC’s effectiveness in insuring Vermont children. It shows a steady decline in the uninsured rate, independent of the child poverty rate. The VHHIS discovered that “only

⁶⁴ “2009 Vermont Household Health Insurance Survey” (Vermont Department of Banking, Insurance, Securities and Health Care Administration, Montpelier, VT, 2009), 1.

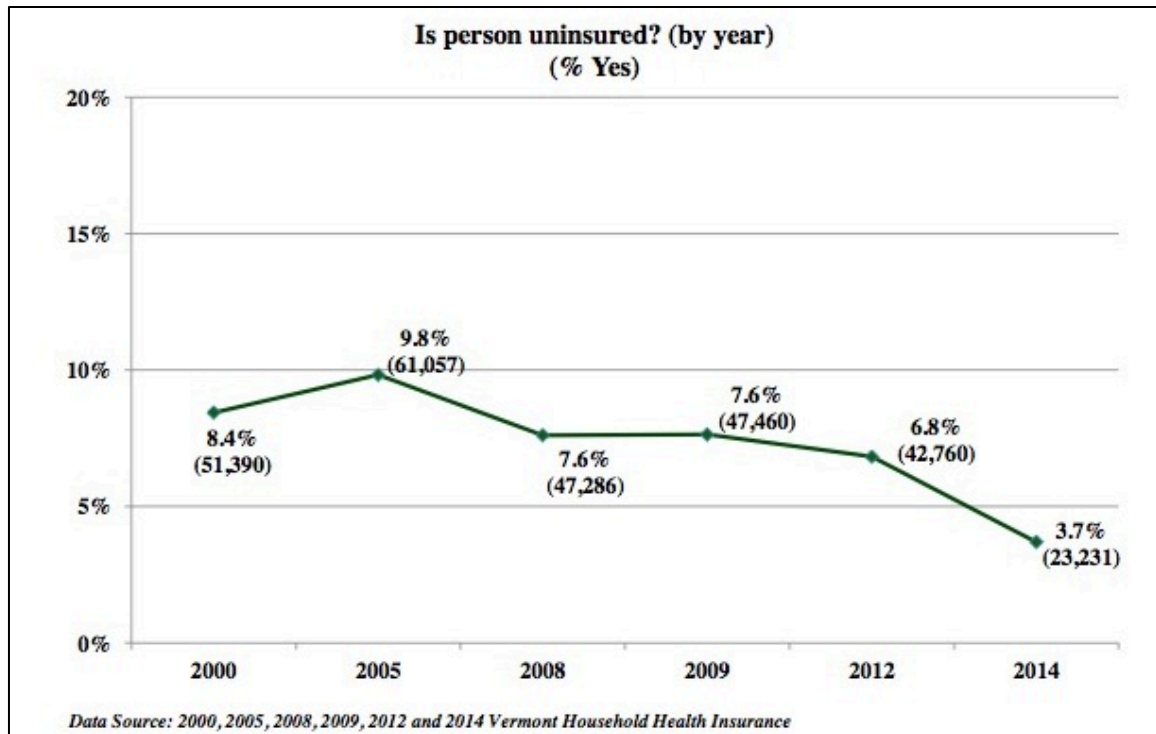
⁶⁵ “Vermont Health Connect Enrollment Update” (Department of Vermont Health Access, Williston, VT, April 30, 2014).

⁶⁶ “Comprehensive Report,” Vermont Department of Regulation, 1.

⁶⁷ Ibid.

1.0% (approximately 1,300) of children aged 0 to 17 lacked health insurance coverage in 2014 compared to 2.5% in 2012.”⁶⁸

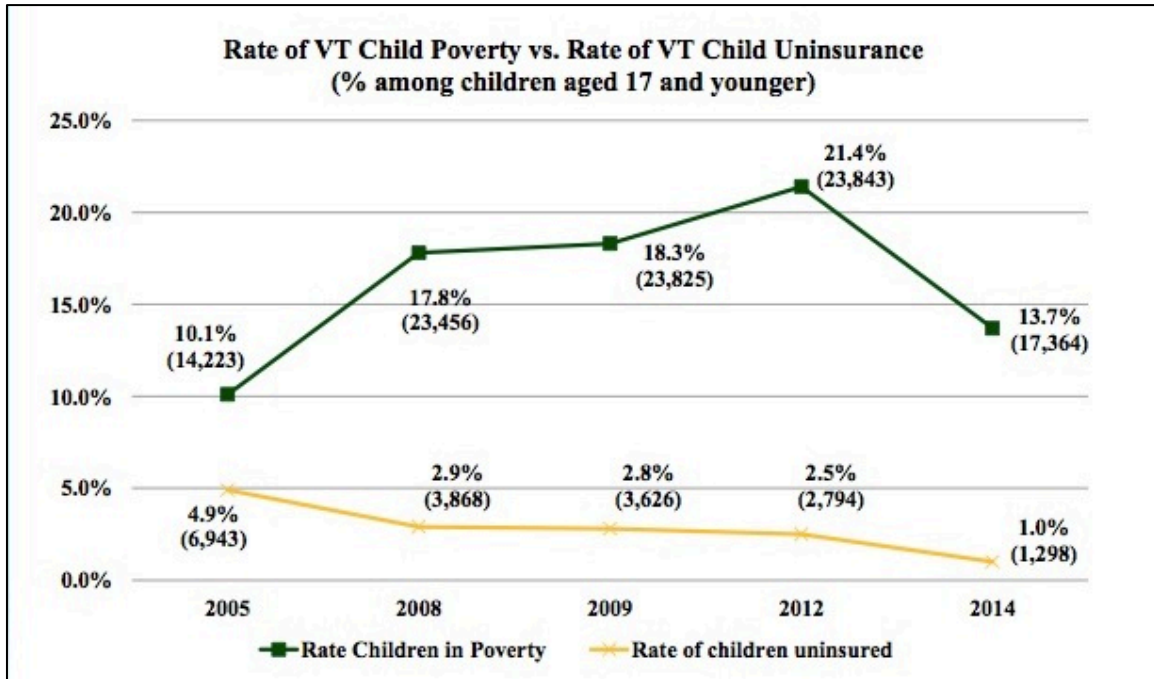
Figure 1 - The Uninsured Rate in Vermont⁶⁹



⁶⁸ Ibid.

⁶⁹ Brian Robertson and Mark Noyes, “2014 Vermont Household Health Insurance Survey Initial Findings” (Vermont Department of Financial Regulation Insurance Division, Montpelier, VT, 2014), 12, <http://hcr.vermont.gov/sites/hcr/files/pdfs/survey/2014-VHHIS-Initial-Findings-Presentation.pdf>.

Figure 2 - Rate of VT Child Poverty vs. Rate of VT Children Uninsured (Data Source: 2005, 2008, 2009, 2012, and 2014 VHHIS)⁷⁰



The 2014 VHHIS noted decreases in not only the uninsured rates among Vermont’s children, but for all other resident age categories as well. Table 1 presents the percentage of uninsured persons in the state of Vermont. Table 2 shows the number of uninsured persons counted in the survey. Although the 2014 survey shows that Vermonters aged 25 to 34 “had the highest uninsured rate at 11.0% (7,936),” this number declined significantly from the 2012 survey’s findings of 18.2% (12,848).⁷¹ Another particularly noteworthy decrease in the uninsured rate appears among those aged 18 to 24. The uninsured rate dropped from 11.5% (9,341) in 2012 to 4.6% (2,920) in 2014.⁷²

⁷⁰ Robertson and Noyes, “2014 VHHIS Research Findings,” 14.

⁷¹ “Comprehensive Report,” Vermont Department of Regulation, 1.

⁷² Ibid.

Table 1 - Uninsured Rates in Vermont by Age⁷³

Is person uninsured? (% by Age)							
Age Group	Rate					Change	
	2005	2008	2009	2012	2014	2005 to 2014	2012 to 2014
0-17	4.9%	2.9%	2.8%	2.5%	1.0%	-3.9%	-1.5%
18-24	25.0%	21.5%	17.4%	11.5%	4.6%	-20.4%	-6.9%
25-34	17.9%	13.4%	16.1%	18.2%	11.0%	-6.9%	-7.2%
35-44	12.7%	9.0%	9.9%	7.2%	5.1%	-7.6%	-2.1%
45-64	8.9%	7.2%	7.1%	6.2%	3.7%	-5.2%	-2.5%
65+	.5%	.1%	0.1%	0.3%	0.3%	-0.2%	0.0%
Total	9.8%	7.6%	7.6%	6.8%	3.7%	-6.1%	-3.1%

Data Source: 2005, 2008, 2009, 2012 and 2014 Vermont Household Health Insurance Surveys

⁷³ Robertson and Noyes, “2014 VHHIS Research Findings,” 17.

Table 2 - Number of Persons Uninsured by Age (Data Source: 2005, 2008, 2009, 2012, and 2014 VHHIS)⁷⁴

Is person uninsured? (Count by Age)							
Age Group	Count					Change	
	2005	2008	2009	2012	2014	2005 to 2014	2012 to 2014
0-17	6,943	3,869	3,626	2,770	1,298	-5,645	-1,472
18-24	11,923	12,096	10,839	9,341	2,920	-9,003	-6,421
25-34	14,044	9,712	11,133	12,848	7,936	-6,108	-4,912
35-44	11,312	7,851	8,364	5,408	3,693	-7,619	-1,715
45-64	16,417	13,636	13,438	12,121	7,076	-9,341	-5,045
65+	408	123	60	272	308	-100	+36
Total	61,047	47,287	47,460	42,760	23,231	-37,816	-19,529

As a result of the implementation of VHC and provisions spelled out in the ACA, a greater number of Vermonters are eligible for coverage and subsidies to help offset the costs of health insurance. Due to the ACA and Vermont’s acceptance of its Medicaid expansion provisions, Vermont residents with “an annual income of less than 139% of Federal Poverty Level (FPL) were eligible for coverage through Medicaid beginning in 2014.”⁷⁵ Prior to the ACA’s passage, Vermont provided coverage through its Dr. Dynasaur program for children whose annual household income was less than 317% of the FPL.⁷⁶ For Vermont residents not covered by Medicaid or Dr. Dynasaur, but with annual incomes of less than 400% of the FPL, subsidies are offered to help with the

⁷⁴ Ibid., 18.

⁷⁵ “Comprehensive Report,” Vermont Department of Regulation, 2.

⁷⁶ Ibid.

purchasing of insurance through VHC.⁷⁷ Table 3 illustrates how this expanded eligibility for coverage and subsidies has led to increased levels of coverage for those with incomes across all levels with respect to the FPL. Table 4 shows this change in terms of survey count.

⁷⁷ Ibid.

Table 3 - Uninsured Rate by Income Relative to FPL⁷⁸

Is person uninsured? (% by annual family income – FPL)							
Income (% FPL)	Rate					Change	
	2005	2008	2009	2012	2014	2005 to 2014	2012 to 2014
Less than 100%	18.0%	13.7%	11.9%	9.0%	4.8%	-13.2%	-4.2%
100% to 199%	16.1%	13.1%	13.3%	12.2%	5.3%	-10.8%	-6.9%
200% to 299%	11.5%	9.8%	10.0%	8.8%	4.9%	-6.6%	-3.9%
300%+	4.5%	3.5%	3.9%	3.8%	2.5%	-2.0%	-1.3%
Total	9.8%	7.6%	7.6%	6.8%	3.7%	-6.1%	-3.1%

Data Source: 2005, 2008, 2009, 2012 and 2014 Vermont Household Health Insurance Surveys

⁷⁸ Robertson and Noyes, “2014 VHHIS Research Findings,” 20.

Table 4 - Number of Persons Uninsured by Income Relative to FPL⁷⁹

Is person uninsured? (Count by annual family income – FPL)							
Income (% FPL)	Count					Change	
	2005	2008	2009	2012	2014	2005 to 2014	2012 to 2014
Less than 100%	16,396	12,342	10,601	9,383	4,582	-11,814	-4,801
100% to 199%	18,674	13,426	13,767	11,794	5,918	-12,756	-5,876
200% to 299%	12,676	10,284	10,575	9,627	4,719	-7,957	-4,908
300%+	13,311	11,234	12,516	11,955	8,012	-5,299	-3,943
Total	61,047	47,287	47,460	42,759	23,231	-37,816	-19,528

Data Source: 2005, 2008, 2009, 2012 and 2014 Vermont Household Health Insurance Surveys

Another key finding of the VHHIS relevant to levels of health insurance coverage in Vermont is that the cost of coverage remains a “primary barrier” for the uninsured to obtain coverage. The survey reports that nearly half of respondents specified that “the cost of health insurance was the only reason they currently lacked coverage.”⁸⁰ Table 5 indicates that this perception about the cost of health coverage is improving over time, with the number of such responses having decreased since 2009. With the implementation of VHC in October 2013, the percent of uninsured persons that designated cost as a major factor deterring them from obtaining coverage decreased from

⁷⁹ Ibid., 21.

⁸⁰ “Comprehensive Report,” Vermont Department of Regulation, 22.

72.3% to 65.6% from 2012 to 2014. VHC aims to make health insurance more affordable for Vermonters through various types of financial assistance.

Table 5 - Reasoning for Lack of Coverage (Data Source: 2009, 2012, and 2014 VHHIS) ⁸¹

Are any of the following reasons that person is not currently covered by any type of health insurance? (% among uninsured by year)						
	2009	2012	2014	2009	2012	2014
	Rate	Rate	Rate	Count	Count	Count
Cost is a major or only reason	79.5%	72.3%	65.6%	37,728	30,934	15,263
Could no longer afford the cost of premiums for ESI	28.1%	9.4%	25.2%	13,338	4,012	5,768
Lost coverage or no longer eligible for Medicaid	N/A	12.6%	21.2%	N/A	5,383	4,870
You or another member of the family lost their job	23.4%	10.3%	21.0%	11,089	4,420	4,821
Previously enrolled in a state program that was ended	N/A	N/A	19.9%	N/A	N/A	4,558
Employer stopped offering health insurance coverage	14.8%	3.9%	15.1%	7,027	1,653	3,454
No longer eligible for insurance through an employer because of a reduction in the number of hours	11.0%	4.9%	10.6%	5,206	2,097	2,435

The results of the 2014 VHHIS indicate that levels of health insurance coverage have increased among Vermonters in measurable and significant ways since the implementation of VHC. The overall uninsured rate was nearly cut in half from 2012 to 2014, substantial progress has been made in providing coverage to all of Vermont’s children, expanded subsidies and eligibility requirements have helped more people obtain coverage at all income levels, and fewer people view cost as an inhibiting factor to getting health insurance. In addition to these survey results, VHC reports significant increases in the number of individuals covered by QHPs and Medicaid after each Open

⁸¹ Robertson and Noyes, “2014 VHHIS Research Findings,” 23.

Enrollment period (an increase of 10,000 from December 2014 to April 2015).⁸² These facts support the assessment that VHC has met the policy objective that it must increase the number of Vermonters covered by health insurance.

Maximization of Federal and State Funds

VHC's second policy goal as derived from Act 48 and the decision to create a state-sponsored exchange is that its reforms should help to maximize the receipt of federal funds in order to be able to pass on cost-savings to Vermonters. In a 2013 article for the *New England Journal of Medicine*, Dr. Laura K. Grubb, MD, MPH, praises policymakers in Vermont for doing just that. Grubb maintains that other states can learn lessons from Vermont and the state's handling of reform under the ACA. In terms of VHC she writes: "The development of a health insurance exchange presents opportunities for state-specific health care innovation . . . states may capitalize on federal financing opportunities to build new state health programs and realize cost savings."⁸³ Vermont's Medicaid expansion project is another example of a savvy harnessing of federal funds to maximize benefits for Vermonters.⁸⁴ Grubb notes that Vermont received \$249 million in federal financing for the expansion of a Medicaid program that stretches far beyond the federal eligibility mark and will save the state 10.9% in expenditures; this is in contrast to states that did not expand their Medicaid programs.⁸⁵

The exchange also helps to pass cost-savings attributed to the use of federal funds on to non-Medicaid recipients. Of VHC customers covered by private QHPs in 2015, three out of five (63%) qualified for the federal Advanced Premium Tax Credit (APTC),

⁸² "VHC Monthly Report," May 14, 2015, 3.

⁸³ Grubb, "Lessons from Vermont's Health Care Reform."

⁸⁴ Ibid.

⁸⁵ Ibid.

which is in addition to the more than half of customers who received Vermont Premium Assistance (VPA) and other cost-sharing reductions (CSR).⁸⁶ Policyholders can choose to apply the APTC to their monthly premiums or to receive the credit annually upon the filing of federal income taxes. (Eligibility for the APTC usually extends to individuals with an annual income of less than \$47,520 and families with an income of less than \$97,200.^{87,88}) Moreover, many Vermonters receiving financial help to lower the cost of health insurance find that their monthly premium bills are not increasing because when health plan costs rise, the amount of financial help increases as well.⁸⁹

The federal tax credit operates in conjunction with the state financial help resulting in a real effect on the out of pocket costs for the various QHPs in the exchange. An example of this is offered in regular reports provided to the Vermont General Assembly on behalf of VHC:⁹⁰

The typical (median) individual receiving CSR is enrolled in a Standard Silver 87 plan with a \$600 medical deductible and \$1,250 maximum out-of-pocket. This individual also receives \$362 in premium assistance. If she purchased a Standard Silver plan with a full-cost of \$466, it would cost her \$104 per month.

Figure 3 shows a graphic representation of how financial help is distributed to Vermonters and the types of plans that those receiving aid are able to choose under VHC.

⁸⁶ “VHC Monthly Report,” May 14, 2015, 4.

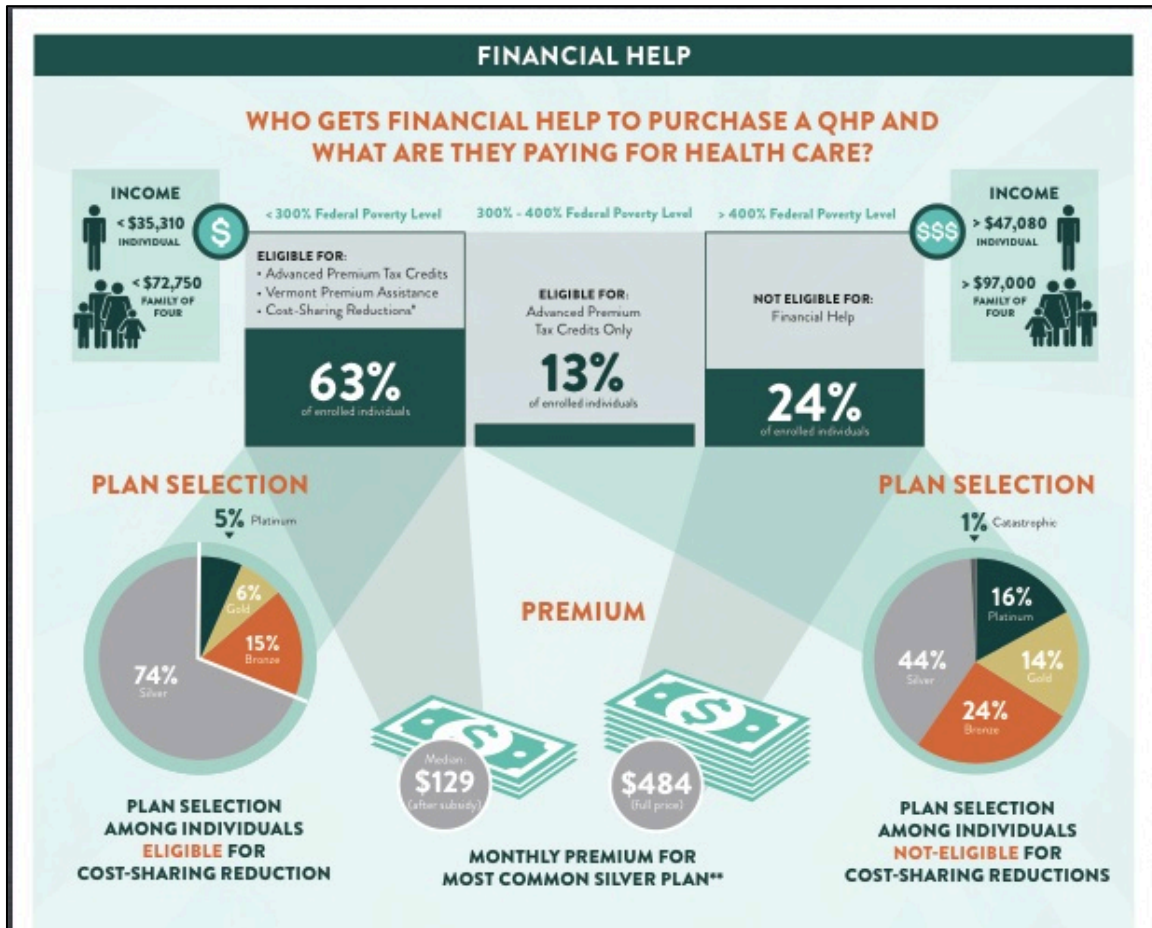
⁸⁷ “Tax Credits For Individuals and Families,” *Vermont Health Connect*, http://info.healthconnect.vermont.gov/sites/hcexchange/files/VHC%20Tax%20Credits%20Worksheet_updated%202%2026.pdf.

⁸⁸ “Glossary of Terms,” *Vermont Health Connect*, accessed May 1, 2017, <http://info.healthconnect.vermont.gov/glossary>.

⁸⁹ “Vermont Health Connect Update on Project Development, Operations, and Enrollment Data” (Department of Vermont Health Access, Williston, VT, December 1, 2015), 3.

⁹⁰ *Ibid.*, 20.

Figure 3 - Financial Help Information Graphic⁹¹



It is important to note that there are four levels of CSR that are determined by household income relative to the FPL and that “Vermonters with lower incomes qualify for CSR levels that offer steeper reductions in out-of-pocket costs.”⁹² VHC calculates that “Vermonters who qualify for the two less generous levels of CSR could conceivably have a lower total cost in a Gold or Platinum plan,” while those “who qualify for the two most generous levels of CSR can expect a lower total cost in a Silver plan.”⁹³ Many of the plan

⁹¹ Lawrence Miller, “Vermont Health Connect Report” (Office of the Governor, Montpelier, VT, June 27, 2016), 26.

⁹² “VHC Update,” December 1, 2015, 20.

⁹³ Ibid.

designs and rates for 2016 were similar to those that have been offered in the past, with only minor changes to “some deductibles, maximum out-of-pockets, and cost-sharing requirements,” so that a similar situation where lower-income Vermonters are able to purchase higher metal plans can be predicted for upcoming years.⁹⁴ It is evident that the financial help offered to Vermonters through VHC in the form of federal funds and other cost-sharing mechanisms helps to ease the health insurance financial burden for Vermonters and often allows them to purchase a higher metal plan, therefore increasing their benefits.

Consumer Outreach and Education

The exchange’s third policy objective is to serve as a tool through which Vermonters can learn about health care options and make educated purchasing choices. VHC orchestrates a number of efforts to ensure that those who need help with coverage the most have access to the resources that they need to maximize their benefits. In May 2015, VHC reported that it has “continued to engage CSR-eligible customers, especially those who qualify for the most generous CSR levels (Silver 87 and Silver 94), to make sure they understand how cost-sharing reductions work and what they mean for their total health care costs.”⁹⁵ In order to educate Vermonters about the exchange, VHC also offers “Health Insurance 101” information sessions across the state, ahead of each Open Enrollment period.⁹⁶ These are free, public, events, often held at local libraries and pharmacies with the goal of helping customers “better understand health insurance terms,

⁹⁴ “Vermont Health Connect Update on Project Development, Operations, and Enrollment Data” (Department of Vermont Health Access, Williston, VT, October 26, 2015), 4.

⁹⁵ “VHC Monthly Report,” May 14, 2015, 5.

⁹⁶ “VHC Update,” September 23, 2015, 19.

financial help, and the Vermont Health Connect system,” so that they are able to “choose the right health plan for their needs and budget.”⁹⁷

VHC undertakes additional outreach efforts ahead of each annual Open Enrollment period. The VHC Assister Program coordinates Navigators, Certified Application Counselors, and Brokers during this high-traffic period. This team of Assistors helps to “ensure that Vermonters in every corner of the state have access to in-person assistance if they need help understanding health insurance or signing up for a plan.”⁹⁸ For example, in September 2015, VHC conducted 993 consultations, or consumer interactions of at least 10 minutes duration.⁹⁹ In October of the same year, the exchange reported 535 consultations.¹⁰⁰ In order to prepare for the Open Enrollment period, VHC also distributes “promotional and educational materials” to its “customer-facing partners.”¹⁰¹ This distribution includes “mailings to restaurants and radios, print, and online ads to ensure that Vermonters know the implications of not signing up for insurance.”¹⁰² The content of these materials focuses not only on the “benefits of health coverage,” but also on the “fact that the federal Shared Responsibility Provision fee for not having coverage increases” each year.¹⁰³ In 2016, the cost of this provision was \$695.00 per adult, or 2.5% of household income, dependent upon whichever amount is

⁹⁷ Ibid.

⁹⁸ “VHC Update,” December 1, 2015, 17.

⁹⁹ Ibid.

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

¹⁰² “Vermont Health Connect Update on Project Development, Operations, and Enrollment Data” (Department of Vermont Health Access, Williston, VT, December 31, 2015), 12.

¹⁰³ Ibid.

greater.¹⁰⁴ This kind of community engagement and outreach on the topic of health insurance options was not available prior to the implementation of the exchange, and so the fact that there are educational efforts at all under VHC constitutes fulfillment of the third policy objective.

VHC's Current Prospects

A Question for Vermont

Six years after the passage of Act 48 and four since VHC's first Open Enrollment period, the exchange is still a controversial topic in Vermont. The question at hand in 2017 is whether or not Vermont should keep the VHC exchange or abandon it for a new system. The state's newly elected governor, Phil Scott, campaigned with the message that Vermonters pay high rates for a system that fails to function properly.¹⁰⁵ Scott advocated that Vermont should switch to either "the federal exchange or a state partnership model."¹⁰⁶ The Governor maintains that his "administration is set to examine a number of proposals that are designed to improve the reliability" of VHC, although as of March 29, 2017, he was not issuing any details about these alternatives.^{107,108} Scott's budget proposals indicate that he foresees a degree of cost-savings resulting from the encouragement of VHC's commercial customers to purchase insurance directly from

¹⁰⁴ Ibid.

¹⁰⁵ "Health Care Reform | Phil Scott for VT Governor 2016," Phil Scott For Governor, accessed May 1, 2017, <http://www.philscott.org/leadership-that-works/vermont-health-care-reform/>.

¹⁰⁶ Ibid.

¹⁰⁷ Bob Kinzel, "Scott Administration Considers Options for the Future of Vermont Health Connect," VPR, April 10, 2017, accessed May 1, 2017, digital.vpr.net/post/scott-administration-considers-options-future-vermont-health-connect#stream/0.

¹⁰⁸ Erin Mansfield, "Scott: Vermont Health Connect exit plan likely by year's end," *VT Digger*, March 31, 2017, accessed May 01, 2017, <https://vtdigger.org/2017/03/30/scott-vermont-health-connect-exit-plan-likely-by-years-end/>.

carriers as well as from transferring some of VHC’s contracted services to the Agency of Human Services.¹⁰⁹

In December 2016, Strategic Solutions Group, LLC, published a 121-page report commissioned by the Vermont General Assembly, “Recommendations for the Future of the Vermont Health Benefit Exchange.”¹¹⁰ This report evaluates VHC’s operational readiness, feasibility, and cost effectiveness.¹¹¹ It then assesses alternatives to the exchange.¹¹² In terms of operational readiness, the report finds that VHC’s current system works for those under both QHPs and Medicaid, although technical deficiencies exist in the system so that it does not meet all “service level expectations.”¹¹³ The report also notes “many other states have faced similar challenges with the system implementation and operational support,” and that “building on the current VHC system is the most feasibly and cost-effective technology option to achieve long-term sustainability.”^{114,115} Strategic Solutions examined six alternative solutions to the VHC system including the federal exchange and partnerships with other states, but found that they either “do not support the unique Vermont health benefits policy, or introduce excessive costs or risks.”¹¹⁶ The report’s finding that the state should retain VHC appears to undermine Governor Scott’s proposals; however, his Secretary of Human Services, Al Gobeille,

¹⁰⁹ Ibid.

¹¹⁰ “Recommendations for the Future of the Vermont Health Benefit Exchange” (Strategic Solutions, LLC, Indianapolis, IN, December 21, 2016).

¹¹¹ Ibid., 3.

¹¹² Ibid.

¹¹³ Ibid.

¹¹⁴ Ibid.

¹¹⁵ Ibid., 4.

¹¹⁶ Ibid.

points out that Strategic Solutions represents a potential conflict of interest because it is a company that is often hired to fix broken exchanges.¹¹⁷

An additional facet of VHC's current prospects is whether or not, if Vermont keeps the exchange, it should be expanded to include more groups of Vermonters. Under the current version of the exchange, "all individual and small group employees and their families are treated as a single risk pool across the state," in which they purchase coverage through VHC.¹¹⁸ Through the passage of Act No. 54 in 2015, the legislature tasked the GMCB with assessing the impact on insurance rates if groups such as employees of companies with over 100 employees, or government employees, were allowed to purchase coverage on the exchange.¹¹⁹ The GMCB hired Lewis and Ellis, Inc. to analyze this impact and their report finds that "allowing large employers to enter VHC will produce higher premiums on average in the large group market," and "that more Vermonters, including small group employers and individual policyholders, would be negatively impacted than positively impacted."¹²⁰

VHC and the Trump Administration

The central tenet of President Trump's health care reform initiative is a "three-pronged approach to repeal and replace," the ACA.¹²¹ In his first 100 days in office,

¹¹⁷ Emma Lamberton, "Scott's team begins process of redirecting Vermont health care," *Watchdog.org*, January 05, 2017, accessed May 01, 2017, <http://watchdog.org/285297/phil-scott-health-care-team/>.

¹¹⁸ "Report on the Impact of Expanding Vermont Health Connect to Include Large Group Employers," February 11, 2016, 4.

¹¹⁹ *Ibid.*, 3.

¹²⁰ *Ibid.*

¹²¹ "Three-Pronged Approach to Repeal and Replace Obamacare" (The White House, Washington, D.C.), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/20170308_HEA_obamacare_pdf_three-phases-3.pdf

Trump supported the American Health Care Act (AHCA), a piece of legislation that would eliminate the ACA and put in its place a system that expands Health Savings Accounts and high-risk pools, allows insurance to be purchased across state lines, encourages full-year enrollment and less restrictive insurance plans under the exchanges, and would reduce prescription drug costs by changing the Food and Drug Administration's approval process.¹²²

The AHCA had a 17% approval rating and did not even come up for a vote in the House of Representatives because it would have taken insurance away from millions of Americans.¹²³ Yet, in April 2017, Representative Tom MacArthur of New Jersey proposed a similar plan.¹²⁴ These plans are not only criticized across at the federal level, they also have tangible consequences for Vermont's exchange.

Under VHC, Vermonters are offered financial help in multiple ways as a result of ACA provisions. Individuals and families with annual incomes that fall between 100% and 400% of the FPL are eligible for refundable premium tax credits when they purchase health insurance coverage through the state marketplace.¹²⁵ The AHCA also proposes refundable tax credits, but eligibility would vary only with age and annual inflation, rather than in addition to income and regional cost of insurance.¹²⁶ For example, under the ACA's approach the tax credits are more generous for lower incomes and those with

¹²² Ibid.

¹²³ Editorial, "Trumpcare 2.0: It's Even Worse Than the Original," *The New York Times*, April 28, 2017, accessed May 1, 2017, https://www.nytimes.com/2017/04/28/opinion/trumpcare-2-0-its-even-worse-than-the-original.html?_r=4.

¹²⁴ Ibid.

¹²⁵ Cynthia Cox, Gary Claxton, and Larry Levitt, "How Affordable Care Act Repeal and Replace Plans Might Shift Health Insurance Tax Credits" (The Henry J. Kaiser Family Foundation, March 2017), 1.

¹²⁶ Ibid., 2.

an income over 400% of the FPL do not receive a credit, whereas under the AHCA the tax credit “is flat for incomes up to \$75,000 for an individual and \$150,000 for a married couple, and so would provide relatively more assistance to people with upper-middle incomes.”¹²⁷ These differing eligibility approaches have significant effects on the cost of insurance for those who rely on financial assistance to make health insurance more affordable.

Of particular importance to the VHC exchange, those who would receive less financial assistance under the AHCA, as a result of its tax credit approach, are the “people who are older, lower-income, or live in high-premium areas.”¹²⁸ Vermont checks off all of these boxes. In fact, an interactive map created by the Kaiser Family Foundation predicts that under the AHCA, Vermonters in each of the state’s 13 counties would see a large increase in premiums paid after tax credits and would also spend a greater percentage of their income on health insurance.¹²⁹ Figure 4 predicts the way in which the replacement proposals under the Trump administration might affect health insurance tax credits by income and geography in the year 2020 for a 40-year-old individual. Figure 5 shows the predicted effects on a family of four. Vermont is a high-cost premium area. The AHCA provides more generous tax credits to middle and higher income individuals and families, while the ACA provides dramatically higher tax credits for lower income individuals and families.

¹²⁷ Ibid.

¹²⁸ "Premiums and Tax Credits Under the Affordable Care Act vs. the American Health Care Act: Interactive Maps," The Henry J. Kaiser Family Foundation, April 27, 2017, , accessed May 01, 2017, <http://kff.org/interactive/tax-credits-under-the-affordable-care-act-vs-replacement-proposal-interactive-map/>.

¹²⁹ Ibid.

Figure 4 - Health Insurance Tax Credits, 40-year-old individual¹³⁰

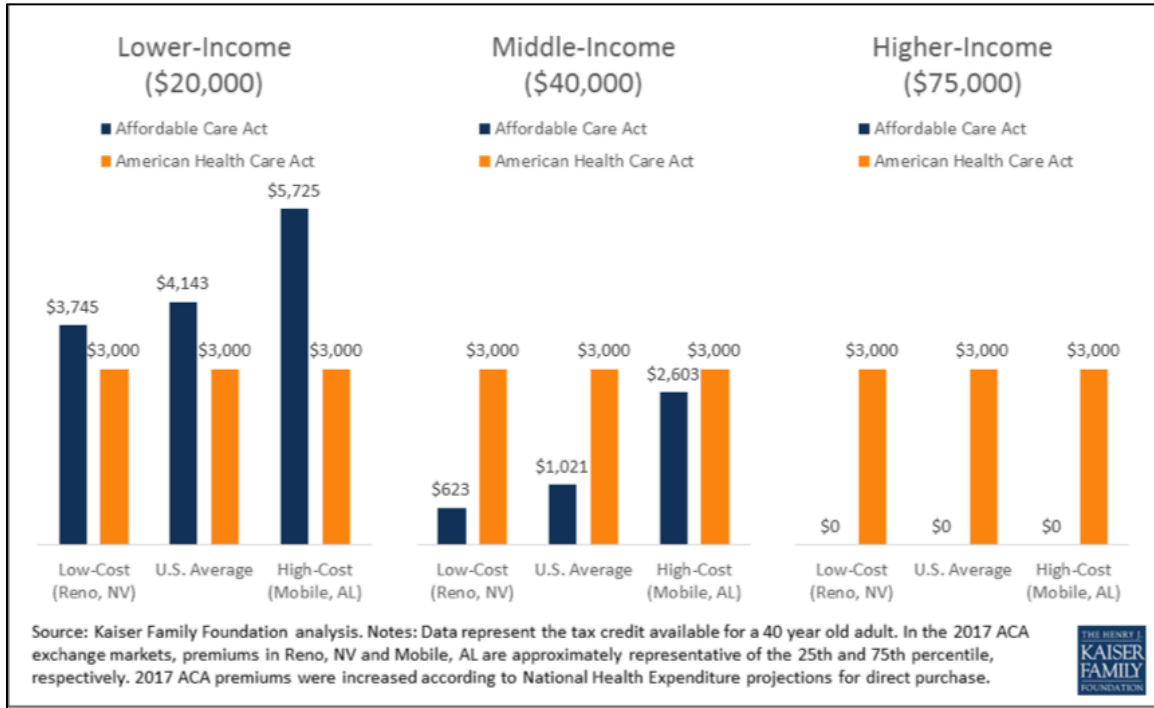
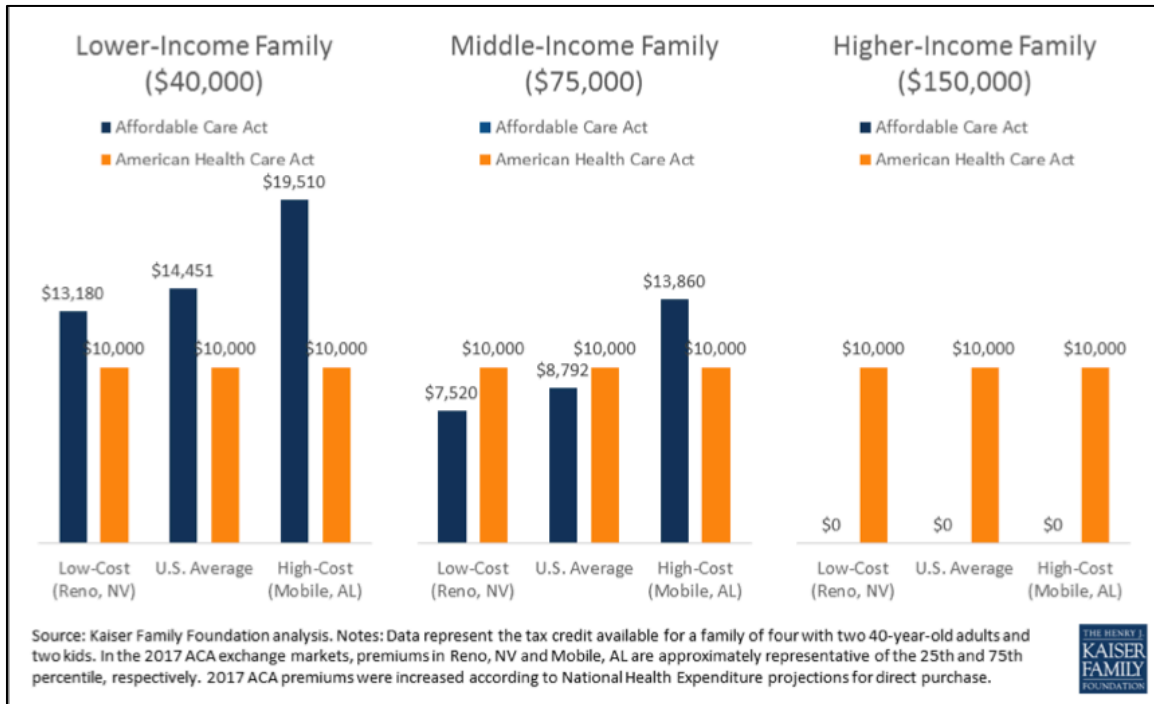


Figure 5 - Health Insurance Tax Credits, family of four¹³¹



¹³⁰ Cox et al., March 2017, 6.

¹³¹ Ibid., 7.

One of the primary policy objectives of VHC is to maximize the use of federal and state funds in order to pass along cost-savings benefits to Vermonters. The AHCA replacement proposal would make it more difficult for the VHC exchange to fulfill this objective because Vermonters, especially those with lower incomes, would see less financial assistance in the form of refundable tax credits. This in turn, would make Vermont health insurance premiums more expensive and less accessible for the most vulnerable populations.

Conclusion

On the heels of the ACA's passage in 2010, the State of Vermont decided to take the opportunity to develop and implement its own state-based insurance marketplace portal, VHC. This decision was established through actions taken in Act 48 of 2011, because Vermont had already extended coverage beyond federal requirements prior to the ACA. This paper articulated that VHC is associated with three distinct policy objectives:

- 1) VHC should function efficiently in order to increase the number of Vermonters covered by quality health insurance;
- 2) The financing structure of the exchange should maximize the use of state and federal dollars in order to provide cost-savings to Vermonters; and
- 3) VHC should serve as a tool through which Vermonters can learn about health care options and make educated purchasing choices.

Although a series of information technology problems has affected the system's functionality, VHC is continually working to improve and remedy these faults, a caveat that is nearly unavoidable in terms of policy implementation. In contrast to this component of VHC, the analysis in this paper shows that the exchange has met all of the

remaining policy objectives; Vermont has seen declines in its overall uninsured rate, in the uninsured rate among children, and in the uninsured rate across all categories of the FPL. The exchange also utilizes state and federal funds in order to provide various forms of financial assistance to Vermonters so that they can purchase a higher metal QHP, and carries out community outreach and education efforts in several forms.

VHC's presence in Vermont is still quite controversial. The new gubernatorial administration is seeking to abandon the exchange for a new system, despite the finding of the Strategic Solutions study that the most cost-effective way of handling VHC at this point in time is to build upon the current, fundamentally strong, technological platform and that each of the six proposed alternatives to the exchange posed both policy and financial risks. The results of this analysis support Strategic Solutions' ultimate finding. VHC, in its current state, is meeting the policy objectives laid out for it in Act 48 and the initial decision to establish a state-based exchange. This result, along with the finding that the exchange's technology needs improvement, but has a solid foundation, makes a case for the state to maintain VHC. There are some stipulations. As discussed in this paper, the exchange should not expand to include large group employers, because this would contribute to premium increases. VHC should also continue to address the information technology problems that hamper its functionality. Finally, in a broad effort to contain health care costs in Vermont and thus aid in the effectiveness of the exchange, the state should move forward with its initiative to encompass different populations under the all-payer model (see Appendix 2) in order to assess the feasibility of such a policy.

Appendix 1 – Informational Interviews

For this research project I conducted three informational interviews with leaders in health care reform policy work in the State of Vermont. Conversations lasted from 30-90 minutes. Two out of the three interviews were held over the phone and one took place in person. The citations used in the text of this thesis are sourced from audio recordings of the phone interviews and my own handwritten notes taken during the in person interview. The interviewees included:

- Michael Costa, who served as the Deputy Director of Health Care Reform under Governor Shumlin, and serves as the Deputy Commissioner of Health Services and Managed Care at the Department of Vermont Health Access in the Scott administration.
- Robin Lunge, Director of Health Care Reform under Governor Shumlin and current member of the GMCB.
- Lawrence Miller, Chief of Health Care Reform in the Shumlin administration.

I obtained permission to conduct these interviews from the University of Vermont's Institutional Review Board in the Research Protections Office. My project was granted an Exemption under Category 2 with the following parameters:

"Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior, unless: (a) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation."

Interviewees were provided with the information below in the form of an electronic handout prior to the scheduled interview. This material outlined the purpose of my research and advised the interviewees of their rights as participants in the project.

Introduction

You are being invited to take part in this research study because you have been identified as an expert in the field of health care policy in Vermont. This study is being conducted by Ashlynn Doyon, a student at the University of Vermont, writing an Honors Thesis to be completed for May 2017.

Purpose

A summary of this research project is as follows: The implementation of Vermont's state health exchange has been at the forefront of political debate since the passage of the Green Mountain Care Act in 2011. Despite the fact that Vermont Health Connect faces criticisms, little in the way of academic evaluation has been written. This is a critical issue as it affects the livelihood of Vermonters and will likely be subject to greater confusion in the wake of the 2016 election. This paper will analyze whether the implications of Vermont Health Connect fulfill its policy objectives.

Study Procedures

This Honors Thesis project seeks to determine whether or not the policy objectives of Vermont's State Healthcare Exchange have been fulfilled. I have approached the project by first assessing the policy objectives and goals of implementing Vermont Health Connect in Vermont, followed by an assessment of whether or not those initial goals and objectives have been met, and am also seeking to offer ideas about how these goals might be met in the future. In doing so, I have used several types of materials including the Affordable Care Act legislation itself, journals of the Vermont House and Senate, Legislative Reports, and information sourced from the National Conference of State Legislatures. In order to make such an analysis I plan to have informational interviews with people working in the field. In the interviews I will ask the following prescribed questions, as well as any relevant follow-up questions based on the responses received:

What do you think were the objectives for the establishment of Vermont's own healthcare exchange?

What aspects of exchange and/or Vermont Health Connect are considered to be successes?

In your opinion, are there ways in which the exchange has failed?

Given your response to the objectives question above, do you think that the exchange has fulfilled that original policy intent?

What changes do you expect to be made to the exchange in the coming year?

How do you think Vermont Health Connect can be improved?

The respondent may choose which questions to answer and in what capacity. Participants will be made fully aware of the research project and that answers given will be used for the project's analysis. They will also be identified in order to demonstrate the credibility of their responses based on their professional standing and will be notified of this as well, before and during the interview. Interviews might last between 15 and 45 minutes depending on the availability of the respondents to participate.

Costs

There will be no costs to you for participation in this research study.

Compensation

You will not be paid for taking part in this study.

Confidentiality

All information collected about you during the course of this study will be stored with your name as an identifier so that we are able to match you to your own answers. Your responses will not be confidential unless you decide to withdraw or change your mind later about your participation in this research. See sections on Study Procedures and Voluntary Participation/Withdrawal.

Records of the informational interviews will be kept for the duration of my research project to be completed in May of 2017. The final product may or may not be published on the University of Vermont's Honors College website. During the research period, records of the interview may be accessed by Ashlynn Doyon, or by Professor Eileen Burgin in the Department of Political Science.

Voluntary Participation/Withdrawal

Taking part in this study is voluntary. You are free to not answer any questions or to withdraw at any time. You may choose not to take part in this study, or if you decide to take part, you can change your mind later and withdraw from the study. If you choose to withdraw from the study early, the record of your interview will be destroyed and will not be used in the research analysis.

Questions

If you have any questions about this study now or in the future, you may contact me, Ashlynn Doyon, at the following phone number: (802)-793-7712. If you have questions or concerns about your rights as a research participant, then you may contact the Director of the Research Protections Office at (802) 656-5040.

Participation

Your participation is voluntary, and you may refuse to participate without penalty or discrimination at any time.

Appendix 2 – Outcomes of Act 48

The development and implementation of VHC is not the only health care reform action put forth in Act 48. The other outlined provisions include the creation of a prospective financing plan to fund a single-payer health care system in Vermont and the development of a means to contain costs and improve the quality of care. Since the law's passage in 2011, there have been developments with respect to these provisions. It is helpful to understand the advances in Vermont's health care reform arena that have taken place over the past six years as context for an analysis of VHC.

Financing a Single-Payer Health Care System

The attempt to finance a single-payer health care system in Vermont failed. Michael Costa served as the Deputy Director of Health Care Reform under Governor Shumlin, with the primary task of trying to devise a way to fund a single-payer health care system.¹³² This effort was in response to both the governor's "lofty" ambitions for health care reform as well as a component of Act 48.¹³³ A single-payer system is one in which everyone is insured in a publicly financed way; it is paid for through taxes rather than private or employer payment.¹³⁴ A single-payer system has less to do with health care delivery and more to do with coverage and how you pay for that coverage.¹³⁵

Costa asserts that the funding of single-payer health care was an issue at the "intersection of health care and taxation in the state budget process," in more specific terms, this meant that he needed to find a way to take the money that consumers currently

¹³² Michael Costa (Deputy Director of Health Care Reform) in discussion with the author, March 1, 2017.

¹³³ Lunge, March 1, 2017.

¹³⁴ Ibid.

¹³⁵ Ibid.

pay for health care through employer-sponsored insurance, copayments, coinsurance, and qualified health plans, and put it into an “equitable public financing mechanism.”¹³⁶

Other teams of policymakers worked on the logistics of things such as the benefits package or population rules under this theoretical system, but Costa sought to answer the question of how to pay for it.¹³⁷ One of the most complicated aspects of this effort was the attempt to create a financing system that would maximize federal contributions. For example, employer-sponsored health plans constitute a large federal tax break for those enrolled; when you convert a tax-free benefit you then have to find a way to preserve the value of that federal tax incentive.¹³⁸

Governor Shumlin rejected the financing proposal that Costa came up with, due to his analysis that at that point in time, single-payer was not feasible for Vermont.¹³⁹ The experience led Costa to conclude that if universal coverage is the goal under a single-payer system, then financing is the wrong thing to focus on.¹⁴⁰ He notes that as a result of the process he found that there are two conditions that must be met before a publically financed system has the opportunity to be successful. First, cost containment must be under control because it would be disastrous to convert health care to a tax-based system while premiums are still rising and health care spending is surpassing economic growth.¹⁴¹ Second, Medicaid must be properly funded; contributions need to increase in order to adequately cover costs.¹⁴² Costa claims that the administration needed more time

¹³⁶ Costa, March 1, 2017.

¹³⁷ Ibid.

¹³⁸ Ibid.

¹³⁹ Ibid.

¹⁴⁰ Ibid.

¹⁴¹ Ibid.

¹⁴² Ibid.

to examine the modeling and implications of financing single-payer than the deadlines allowed, because health care financing is so complicated.¹⁴³ Policymakers can take the lessons learned from the Shumlin administration’s failed efforts at devising a way to finance single-payer and apply them to an analysis of Vermont’s current situation.

The All-Payer Model

The first listed provision of Act 48 was the creation of the GMCB, set to control costs and improve health care for Vermonters.¹⁴⁴ Many of the GMCB’s efforts came to fruition in 2016 when “continued negotiations between Vermont and the federal government [culminated] in a draft agreement in September 2016 and a signed agreement in October 2016.”¹⁴⁵ This document was the Vermont All-Payer Accountable Care Organization Model Agreement, signed by Governor Shumlin, the Secretary of Human Services, the Chair of the GMCB, and the federal government.¹⁴⁶ The All-Payer Model is fundamentally different than the like-named single-payer model. It focuses on the way that hospitals and doctors are paid.¹⁴⁷ In laymen’s terms, the concept is as follows: In the current system, health care providers typically receive different types of payments from every different payer for the patients that they see in Vermont. This fee-for-service system provides an incentive for providers to simply do more, which increases costs. An all-payer model is a value-based purchasing system. It instead pays providers for the quality of outcome of their service, with the idea behind the model that this type of system might lower costs and improve health care outcomes overall.

¹⁴³ Ibid.

¹⁴⁴ “Brief Summary of Act 48.”

¹⁴⁵ “Vermont Health Care Innovation Project Quarterly Report” (Agency of Administration, Montpelier, VT, November 7, 2016), 3.

¹⁴⁶ Ibid.

¹⁴⁷ Lunge, March 1, 2017.

This all-payer agreement allows Vermont to pursue the kind of accountable care organization structure that the federal government has already been pursuing with Medicare.¹⁴⁸ The goal is that this model will not only help to control cost growth, but will also improve the overall health of Vermonters by increasing access to primary and preventive care and improving outcomes in the categories of substance abuse, mental health, and chronic disease.¹⁴⁹ The Scott administration is continuing the progress begun by the former Governor in this regard. In February 2017, Scott announced that Vermont is working with an accountable care organization called OneCare to bring 30,000 Medicaid patients under an all-payer system.¹⁵⁰ Governor Scott stated that this contract is “a ‘pilot’ that will allow his new administration to decide whether to move forward with additional agreements under the all-payer model.”¹⁵¹

¹⁴⁸ Ibid.

¹⁴⁹ “Vermont All-Payer Accountable Care Organization Model Agreement Draft” (Agency of Administration, Montpelier, VT), <http://hcr.vermont.gov/sites/hcr/files/9-28-16%20%20APM%20Draft%20Agreement%20One%20Page.pdf>.

¹⁵⁰ Erin Mansfield, "State enters \$93 million 'pilot' program for Medicaid care," *VT Digger*, February 8, 2017, accessed May 1, 2017, <https://vtdigger.org/2017/02/08/state-enters-93-million-pilot-program-medicare-care/>.

¹⁵¹ Ibid.

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