

October 20, 2010

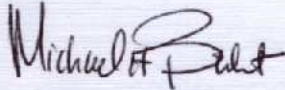
Betsy Forrest  
Department of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, VT 05495

Dear Ms. Forrest,

Please find enclosed Bailit Health Purchasing, LLC's response to the Department of Vermont Health Access Health Benefits Exchange Planning Proposal. The contract terms spelled out in this RFP would be acceptable if a contract were awarded to our firm.

As we have described in our response to this RFP, Bailit has put together a great team with wide-ranging experience with health insurance exchanges and with the State of Vermont.

Very truly yours,



Michael H. Bailit  
President

## Bidder Information Sheet

Name of Company: Bailit Health Purchasing, LLC  
Mailing/Street Address: 56 Pickering Street  
Needham, MA 02492  
Federal Tax ID: 043340991  
Vermont Department of Taxes  
Business Account Number: 430-043340991F-01  
Bid Amount: \$576,946  
Name/Title of Person  
who would sign the contract:: Michael H. Bailit  
President  
781-453-1166

**Proposal to the  
Department of Vermont Health Access  
for Health Benefits Exchange Planning  
Services**

**Submitted by:**

**Bailit Health Purchasing, LLC  
56 Pickering Street  
Needham, MA 02492  
October 22, 2010**

Required Certification: Bailit Health Purchasing, LLC. certifies that the price of this proposal was arrived at without any conflict of interest.

## **2.4.4 Corporate Qualifications Biographies**

### Joshua Slen – Overall Project Lead – Sections 3.1.1.1 and 3.1.6 Lead

Joshua Slen joined Bailit Health Purchasing (Bailit) in January 2009 after 18 years with state government in both Ohio and Vermont. Since joining Bailit, Joshua has worked on a variety of projects including serving as the Interim CEO for the Vermont Information Technology Leaders (VITL), Vermont's Regional Health Information Exchange, assisting the Vermont Program for Quality in Health Care with an in-depth look at Chronic Care Program Evaluations in the State, and drafting the final report for the Vermont Health Information Technology Payment Reform Workgroup. Joshua's extensive background includes a leadership role in designing and implementing many of Vermont's health care system changes since 1999. As Vermont's Medicaid Director Joshua was a key player in the redesign of the health care system in Vermont serving on the Executive Committee of the Blueprint for Health, a statewide public-private partnership to improve the system of care for individuals with chronic illness. During his tenure as Vermont's Medicaid Director Joshua implemented the Catamount Health Program that expanded health care coverage for Vermonter's using the authority under the Global Commitment to Health, a federal 1115 Waiver he negotiated with the Centers for Medicare and Medicaid Services (CMS). Joshua is currently working with the States of Massachusetts and Kansas on their State Medicaid Health Information Technology Plan (SMHP) efforts and with the State of West Virginia's Medicaid Agency on federal health care reform issues. Joshua's in-depth knowledge of state government and his commitment to improving health outcomes for the population are well known.

### Beth Waldman – Section 3.1.1.2 Lead

Beth Waldman has been with Bailit Health Purchasing for four years following over twelve years of service to the Commonwealth of Massachusetts. Beth's expertise is in health care policy, program development and implementation, specializing in Medicaid and SCHIP programs and coverage for the uninsured. Since joining Bailit, Beth has been involved in health reform activity in a number of states, including Arizona, California, Colorado, Maine, Pennsylvania, and Vermont. Beth is currently leading Bailit's work with Maine to implement the Affordable Care Act, with a focus on Exchange design planning and implementation. In addition to health reform efforts, Beth works with state agencies to improve program operations and to develop and implement new programs. Beth's recent work includes eligibility modernization efforts, program measurement, development of care management programs, development of enhanced primary care case management programs, and development of managed behavioral health program procurements. Beth also led Bailit's work with the Massachusetts Health Care Quality and Cost Council to develop a Roadmap to Cost Containment. Immediately prior to joining Bailit, Beth served as the Commonwealth's Medicaid Director. As Medicaid Director, Beth was responsible for the administration of the Massachusetts Medicaid program, MassHealth, which covers over 1 million Massachusetts residents and has a budget exceeding \$8 Billion. Beth played a key role in the formation of Governor Romney's proposed health care legislation that culminated in April 2006 with the historic passage of the Commonwealth's Health Reform Law. Beth negotiated the federal waiver and oversaw the implementation of several MassHealth population and service expansions as well as the implementation of the newly created Commonwealth Care program for the formerly uninsured with incomes at or below 300% of the federal poverty level. Beth

also served as a member of the Board of the Commonwealth Health Insurance Connector Authority.

Michael Bailit – Section 3.1.5 Lead

Michael Bailit is the founder and president of Bailit Health Purchasing, LLC. He works with a wide array of government agencies and purchasing coalitions across the U.S. Michael's professional interests focus on how purchasers and regulators can influence health care markets to operate as effectively and efficiently as possible. He has worked with clients on performance assessment activities, vendor management, Chronic Care Model/Medical Home strategy design and implementation, and payment reform and reimbursement system design. Michael's work has also included assistance with strategic planning activities for systems and programs. Michael's knowledge of the health care market in Vermont is informed through the 14 years he has been working with BISHCA to assist the state in the implementation and administration of Rule 10 and assist the Department's efforts to provide ongoing oversight of Vermont managed care organizations using the state's managed care quality assurance and consumer protection regulations. Over the past three years he has worked hand-in-hand with the Department to update Rule 10 to meet today's challenges, resulting in the recently promulgated Rule H-2009-03 ("Rule 9-03"). Prior to founding Bailit Health Purchasing in 1997, he served as the Assistant Commissioner for Benefit Plans in the Massachusetts Division of Medical Assistance, the state Medicaid agency.

Amy Lishko – Section 3.1.1.3 Lead

Amy has over 20 years of experience conducting applied research in state health policy and health services research. She has held senior management positions in Massachusetts state government where she managed several large HRSA-funded grants as PI and Co-PI. She has extensive experience interpreting federal and state legislation and assisting policymakers with evaluating the impact of legislation on state programs and policies and in decision-making. Since leaving state government Amy has consulted with other states on health care reform implementation and evaluation activities particularly in the area of Health Insurance Exchanges. Amy was awarded a Commonwealth Fund grant in 2008 to study the Massachusetts Connector, has written and spoken extensively on exchanges, and was recently selected to participate on the NASI Panel on State Health Insurance Exchanges which is charged with developing model language for state exchanges.

Peter Burns – Section 3.1.1.4 Lead

Peter Burns has over 25 years of experience in public policy, with specialties in the areas of rate setting, finance, forecasting, administration, operations, strategic planning and legislation. During his public policy career, Peter has been a senior advisor to three governors and served as a state budget director, the director of a statewide in-house management consulting office, the chief research economist for a legislative body, and a tax manager for a FORTUNE 500 corporation. His expertise and experience extend across a wide range of state programs at various levels, from conceptualization and policy development to program planning, operations, evaluation, budgeting and accounting. Prior to co-founding Burns & Associates in 2006, he worked for another national health care consulting practice for eight years. Peter recently led B&A's engagement to assist the State of Louisiana develop a roadmap for implementing health care reform initiatives and manages B&A's engagement with the Arizona Governor's Office to design and develop the implementation of a health insurance exchange.

#### Mark Podrazik – Section 3.1.1.5 Lead

Mark Podrazik has 14 years of experience in health care consulting, specializing in the operational, reimbursement, and evaluation components of public health care programs. He has managed projects for Medicaid agencies in 13 states. He co-founded Burns & Associates in 2006 and prior to this worked for another national health care consulting practice for 10 years. Mark has been working with Vermont state agencies since 2006, particularly with the Department of Vermont Health Access, on a number of projects. He serves as the Project Manager of B&A's engagement to evaluate the Healthy NY program and previously evaluated the Insure Oklahoma program. Both programs have a number of design and operational features similar to what will be needed in a state health insurance exchange. Since 2005, he has led focus groups or surveyed health insurance carriers, small employers, insured individuals, and low-income working uninsured in Minnesota, New York, Oklahoma, and Pennsylvania.

#### Brian Robertson, Ph. D. – Sections 3.1.2 and 3.1.4 Lead

Brian Robertson has more than 25 years of research experience, with hands on experience managing survey research centers, designing surveys, conducting statistical analyses and reporting the results. Brian has experience in a full range of public policy research areas with a specific focus on health care and health insurance research. His areas of expertise include overall research design, survey design, sampling methodology, survey project management, statistical analysis of data, preparation of reports, and development of policy goals and objectives. Brian earned a Ph.D and a Bachelor of Science in Anthropology from the University of Utah. He is a member of the Market Research Association, and the American Association for Public Opinion Research (AAPOR). He previously served as the president of the New England Chapter of AAPOR. Dr. Robertson was recently appointed as an Associate Research Professor in the School of Graduate Studies at the University of New England.

#### Stacey Lampkin – Section 3.1.3 Lead

Stacey is a consultant in the Actuarial Sector for Mercer Government Human Services Consulting (Mercer) and serves as an actuary on Mercer's Medicaid teams for several states. In addition to rate setting and other Medicaid expense projections, Stacey provides actuarial analysis and support on reform policy and projects related to expanding health insurance coverage. Prior to joining Mercer in 2004, Stacey worked in health care actuarial consulting for six years, primarily in the commercial sector. Stacey's actuarial experience has included developing rates for Medicaid and uninsured populations for use by states in contracting with managed care organizations, using both fee-for-service data and managed care organization (MCO) financial experience, estimating ramp-up and ultimate enrollment patterns for state-coverage initiatives, such as Cover All Pennsylvanians, lead actuary working with the Massachusetts Connector Authority in initial design, contracting and pricing of Commonwealth Care program, modeling medical, dental and pharmacy costs for different types of benefit plan designs and member populations, for both self-funded plans and fully insured products, renewal rating analysis and new product design and pricing for small group and large group products, and modeling health care delivery system reform and National Health Expenditures for the Republic of Cyprus.

### Dr. Ronald Deprez – Section 3.1.7 Lead

As President and Founder of PUBLIC HEALTH RESOURCE GROUP (PHRG), INC., and now as Executive Director of the Center for Health Policy, Planning and Research, Ron provides research and consultation on the development and application of health assessment and evaluation tools for health services planning, health information and disease surveillance systems, quality assurance and public health preparedness, on a scale encompassing rural health systems, urban American regions, and developing nations. He is the primary developer of the population based health planning tools used by CHPPR (formerly PHRG) including specific planning and assessment tools for chronic disease improvement care including cardiovascular health, diabetes, Chronic Obstructive Lung Disease (respiratory health), and adolescent health and behavioral health services. Ron's multi-disciplinary work involves the design and evaluation of health care programs and demonstrations, public health preparedness initiatives and health improvement strategies.

### **Five questions**

1. What is your background and experience, including qualification and areas of expertise related to this request? Provide a full description of the experience you have or had in this or similar work.

#### *Bailit Response*

Bailit Health Purchasing and our partners will be leveraging our Vermont experience and our experience working specifically on Exchange issues in other states to complete the tasks in this section. We have included an Experience matrix below in order to visually display the breadth and depth of the assembled team's experience.

Bailit along with our partners, the University of New England (UNE) Center for Community and Public Health (CCPH), Market Decisions, Mercer, Burns and Associates, Amy Lischko, Sue Frechette, and Erica Garfin bring significant Vermont expertise along with subject matter specialization that allows us to efficiently examine existing data and information on Vermont systems and to compare and contrast that information with other states and with federal requirements. We are able to do this because our team includes individuals and organizations with not one or two encounters with the State of Vermont's health care system and data sources but with literally hundreds of different projects over decades of combined experience working both directly for the State of Vermont and with the State and its health care partners on projects ranging from conducting the VHHIS to negotiating the Global Commitment to Health Waiver with CMS and implementing the Catamount expansion. Our team includes individuals who have worked for fourteen years directly with BISHCA on commercial insurance issues and who have a current and intimate knowledge of the Vermont's commercial insurance market.

A small sampling of our team's individual experience is provided below. We have consciously chosen to build a team that is responsive to each and every section of the Vermont RFP because we believe that a combined team lead by someone that knows the Vermont health care system and who understands how the different tasks need to fit together and collectively feed the Exchange planning process is the best way to approach this large scope of work, period.



*Market Decisions* has conducted significant analysis of data focused on the uninsured and underinsured. This includes data verifications, weighting and analysis on all of the health insurance studies that we have done over the past 10 years, including all of the research conducted on behalf of the state of Vermont.

*Burns and Associates* has been involved in the full cycle of public programs – from conceptualization, financing, implementation, and subsequent evaluation. Its specialties are related to the financing of public programs and providing operational assistance in the implementation of programs. For example, Peter Burns has developed cost and caseload estimates for a number of Medicaid waiver submissions (AZ, LA, MS, NM, NV, OR) and developed upfront and ongoing budgets for the implementation of health care initiatives as part of the development of Nevada’s strategic health plan. B&A also conducts numerous evaluations, most recently for programs serving low-income uninsured individuals not eligible for Medicaid. In the last two years, Mark Podrazik evaluated the Healthy Indiana Plan, the Healthy NY program and the Insure Oklahoma program. In these evaluations, as well as in engagements for the States of Minnesota and Pennsylvania, he conducted focus groups with insurance brokers, small businesses owners who do not offer health insurance to employees, and insurance carriers. Burns has collaborated with Bailit previously.

*The UNE Center for Community and Public Health (CCPH)* is one of four Centers of Excellence at the University of New England. CCPH specializes in health policy, program and services planning through population need studies, best practice assessments, and the design and evaluation of health system improvement projects for the private and public sector. CCPH engages in research on healthcare improvement initiatives in communities, health systems, regions and countries, especially for patients with chronic medical conditions.

*Mercer Health & Benefits LLC* began working with publicly-funded health care programs across the country in 1985, helping states design, develop, and implement innovative solutions to improve quality of care while saving state general fund dollars. In 1992, after seven years of working to meet the specialized needs of publicly-sponsored health and welfare programs such as Medicaid, high-risk health insurance pools, and statewide health care reform initiatives, Mercer formally established a separate consulting practice, Mercer Government Human Services Consulting. The lead Mercer staff identified in this proposal are either members of Mercer Government Human Service Consulting practice, members of the Health and Benefits commercial practice, or members of its sibling company, Oliver Wyman. In addition, Mercer has the ability to draw on the research and intellectual capital development capability of Mercer’s Washington Resource Group, which is currently steeped in information research and analysis of national health care reform legislation. Mercer’s Health & Benefits commercial practice helps Vermont employers with health and benefits strategy, annual program management and administration. Employers have access to a disciplined, consistent approach to planning, benchmarking, data analytics, plan design and pricing, financial management, vendor performance management, program marketing, renewal management, communication, compliance and administration. Mercer has collaborated with Bailit previously.

*Erica Garfin* has worked in Vermont's health care and social service systems for 25 years. As an independent planning consultant since 1996, she has assisted numerous state agencies, non-profit organizations, and communities to achieve their goals in health care and social services. Her areas of expertise include qualitative research (special interest in focus group research), strategic planning, project coordination and management, public policy, and organizational planning and development. She is frequently sought for her skill in developing and facilitating group processes and discussions designed to assist multi-disciplinary groups with diverse viewpoints to set goals, develop priorities, and reach agreements., and has collaborated with Bailit previously.

*Sue Frechette* is an accomplished consulting executive who brings over 25 years of results-oriented business experience to senior management in healthcare. Much of her work encompasses working with various stakeholders to analyze, plan, design and implement new programs that span private, state and federal entities in response to CMS requirements. She has specific experience with developing governance models and understands the intricate relationships between healthcare quality and cost. As a Vermont based consultant, she is familiar with all health related initiatives underway within the state potentially impacting the exchange.

*Amy Lischko* is currently working in the states of Louisiana, Washington, and Maine directly on Exchange related issues and has previously worked with the states of Minnesota, Rhode Island, and West Virginia directly on exchange related issues. Amy has over 20 years of experience conducting applied research in state health policy and health services research. She has extensive experience interpreting federal and state legislation and assisting policymakers with evaluating the impact of legislation on state programs and policies and in decision-making. Amy is currently collaborating with Bailit in Maine.

2. Describe your experience and your understanding of work within the context of state government. Have you had specific experience working with state government? Please describe.

#### *Bailit Response*

The Bailit team has vast experience working both directly for and with Vermont state government and with and for other state governments around the country. In fact, the team has direct experience with over 30 different state governments. Each individual listed in the experience matrix (provided within this section) has identified their specific areas of experience, including if they have worked directly with Vermont State Government. The Bailit team includes Joshua Slen, a former Medicaid Director in Vermont, Beth Waldman, a former Medicaid Director in Massachusetts, Peter Burns, a former state budget director in Arizona, Erica Garfin a 20-year Vermont state employee, Amy Lischko, a Tufts University Professor and nationally recognized expert in the area of Health Insurance Exchange, Brian Robertson who has worked on the VHHIS for over ten years, Ronald Perez who led the RWJ-funded analysis around Catamount, and a number of other senior level team leads that will be available to the State of Vermont and who have too much experience to fully detail here.

A sampling of our collective work within and for state government follows:

- strategic planning and policy option development including Section 1115 and home- and community-based services (HCBS) waivers and managed care programs ;
  - evaluation including external quality reviews, evaluations of care coordination models, surveys, and focus groups;
  - federal compliance and reporting;
  - budget development and analysis including the construction of models to assess the financial impact of proposed policy and rate changes at the service, provider, and consumer levels;
  - development of resource allocation models for HCBS programs serving individuals with intellectual and developmental disabilities;
  - rate-setting for HCBS for the elderly and individuals with physical disabilities, intellectual and developmental disabilities, or mental illness; inpatient and outpatient hospital services; and physician and professional services;
  - revenue maximization initiatives, and
  - Exchange design and modeling.
3. How were prior relevant projects successful? Please provide examples.

*Bailit Response*

We believe successful projects are those that are implemented on time and within budget and achieve the intended goals of the project. Using this standard the Bailit team has a long track record of successful projects both within the State of Vermont and around the country. A few examples are provided below:

*Bailit Health Purchasing* has worked in 26 different states but none longer than the 14-year relationship we have with the BISHCA in Vermont. Over the course of the past 14 years Bailit has successfully delivered analyses, conducted reviews, provided advice, interpreted federal policies, and assisted in aspect of commercial insurance regulation and oversight. In addition to this work, Joshua Slen has an intimate knowledge of the State's public health care programs and has successfully managed state-wide public input processes, large stakeholder meetings, interactions with state legislators, and large scale program implementations within the Vermont context.

*Burns and Associates* has seen success in all of our engagements since its founding, and the Principals have a solid track record even prior to B&A. Our engagements have been renewed or new engagements have been started after our initial engagement in six states (AZ, IN, LA, MN, NV, and VT).

*Center for Community and Public Health (CCPH) at UNE*, in its 30+ years of planning and conducting health evaluation projects it has garnered a long and successful track record of ensuring quality products that are on-time, even under time-constrained environments. Most recently, its work evaluating the State of Vermont's recent

healthcare reform efforts, particularly the 2006 Health Care Affordability Acts (HCAA), has provided critical insights to stakeholders into what has worked well and what needs improvement.

*Mercer's* Government Human Services Consulting practice has contracts with eight of the 13 states with the highest Medicaid expenditures (California, New York, Pennsylvania, Florida, Texas, North Carolina, New Jersey, and Massachusetts). Its relationship with these states has been long term, attesting to the strength of its consulting relationship with its clients and its ability to provide sound pricing estimates. Mercer has worked with Massachusetts since 1992, Missouri since 1993, New York, New Jersey and Pennsylvania since 1995, North Carolina since 1996, Florida since 2001, and California and Texas since 2005. Mercer currently manages 13 state contracts valued at more than \$1 million per year. Its successful, long-term relationships with these large, complex clients are a testament to Mercer's excellent project management and high-quality work product.

*Market Decisions* has conducted the Vermont Household Health Insurance Survey (VHHIS) since 2000, providing data on nearly 25,000 households to guide health care and health insurance policies. Since 2000, VHHIS has become one of the primary data sources for looking at issues of health insurance and health care access. Market Decisions has been the primary source for analysis of these data sets and providing key analysis to the state to help in the formulation of policies. Market Decisions maintains a working relationship with many agencies in Vermont, providing ongoing analytical support when there is a need for data to help inform policy decisions.

4. Who will perform the work for each task included in your bid? Please include resumes for key personnel.

#### *Bailit Response*

The key personnel for this project are listed below, their biographies are included above, and their resumes are attached in Appendix A. In addition, the full team for each task included in our proposal is identified within the appropriate RFP response section.

Joshua Slen – Overall Project Lead – Sections 3.1.1.1 and 3.1.6 Lead  
Beth Waldman – Section 3.1.1.2 Lead  
Michael Bailit – Section 3.1.5 Lead  
Amy Lishko – Section 3.1.1.3 Lead  
Peter Burns – Section 3.1.1.4 Lead  
Mark Podrazik – Section 3.1.1.5 Lead  
Brian Robertson, Ph. D. – Sections 3.1.2 and 3.1.4 Lead  
Stacey Lampkin – Section 3.1.3 Lead  
Ronald Deprez – Section 3.1.7 Lead

In addition to the team leads identified above the following listing provides the State with members of each team assigned to complete tasks identified with in the RFP and their roles. All of the resumes are included in Appendix A.

A detailed listing of the individuals performing specific tasks is included in the task list that follows on the next page.

RFP Task Matrix																		
Section #	Title	Joshua Slen	Beth Waldman	Amy Lischko	Michael Bailit	Michael Joseph	Mark Podrazik	Peter Burns	Stephen Pawlowski	Karen Bender/ Ed Fischer/ Stacy Lampkin/ Sheree Swanson	Curtis Mildner/ Brian Robertson, Ph.D.	Jason Maurice, Ph.D./ Patrick Madden	Ronald Deprez	Karen O'Rourke	Carry Buterbaugh	Hank Stabler	Sue Frechette	Erica Garfin
3.1.1	Study of Exchange Design Options, Development, Design, and Implementation Plan																	
3.1.1.1	Roadmap for Planning	X	X	X	X	X	X										X	X
3.1.1.2	Exchange Design Options	X	X	X	X		X	X	X								X	X
3.1.1.3	Creation of an Implementation Plan	X	X	X	X	X	X	X									X	X
3.1.1.4	Recommendation for Exchange Financial Sustainability	X	X	X	X	X	X	X	X	X								
3.1.1.5	Recommendations related to Exchange Finance Functions	X	X	X			X	X	X									
3.1.2	Study of the uninsured and underinsured	X									X	X						
3.1.3	Actuarial Services									X								
3.1.4	Formal Stakeholder Study	X					X				X	X		X				X
3.1.5	Study of Current Insurance Market	X	X		X	X				X								
3.1.6	Assessment of Current Programs and Integration Activities	X	X	X	X	X	X			X							X	
3.1.7	Formal Assessment of "Churning"	X											X		X	X		

5. What is your organization's size and structure?

Bailit Response

The Bailit Team assembled in response to this RFP encompasses a number of different individuals and organizations. Each organization's corporate description is provided below.

Bailit Health Purchasing, LLC. is a six-person consulting firm headquartered in Needham Massachusetts. Bailit Health Purchasing is organized as limited liability company (LLC). In addition to the staff in Massachusetts, Bailit also has staff located in Vermont.

Bailit is the lead contractor on this bid and our proposed team consists of the following organizations and individuals:

*Market Decisions* is a Maine-based Limited Liability Corporation founded in 1977. Its twelve-person professional staff includes four Ph.D. social science researchers. Its field and data collection staff includes a field services manager, 3 field supervisors, and 40 interviewers and data entry staff.

*Mercer Health & Benefits LLC* is a wholly-owned subsidiary of Marsh McLennan Companies (MMC). Oliver Wyman employees involved in this project are working as part of the Mercer team. Oliver Wyman is also a wholly-owned subsidiary of MMC. Marsh McLennan Companies is a public company (NYSE) with 2008 revenue over \$11.5 billion. With regard to infrastructure, Mercer employs more than 19,000 people worldwide with more than 4,000 dedicated to health and benefits work. Mercer operates in more than 180 cities worldwide. With more than 4,000 employees dedicated to health and benefits work, Mercers has the depth and breadth of staff necessary to accomplish the goals set out in this Request for Proposal (RFP).

While the legal entity is Mercer Health & Benefits LLC, we intend to deploy a cross-functional team, which will use colleagues in three specialty practices within Mercer to meet your needs: the Government Human Services Consulting specialty practice, the Health and Benefits commercial practice, and employees from sibling company, Oliver Wyman. We believe this specialized cross-functional team of experts can most efficiently and effectively meet your needs.

*The University of New England (UNE)* is an independent, coeducational university with two distinctive campuses in two Maine coastal cities. UNE has degree programs in health sciences, natural sciences, human services, management, education and the liberal arts. The University includes Maine's only medical school, the UNE College of Osteopathic Medicine.

The Center for Community and Public Health (CCPH) at UNE brings together unique groups representing many different disciplines to integrate their own areas of expertise into a greater mission to build community and public health programs.

These programs, housed at the Westbrook College campus, include the

- \* The Center for Health Policy, Planning and Research
- \* The Health Literacy Institute
- \* The Maine AHEC Network
- \* The UNE-Maine Geriatric Education Center
- \* The Graduate Programs in Public Health
- \* The Maine Harvard Prevention Research Center

The Principals at *Burns and Associates* guide a team of seven consultants as well as subcontractors who are used as subject experts when needed on projects to provide the highest quality service to clients. The principals remain actively involved in all of B&A's engagements.

*Sue Frechette* is the owner of Northfield Associates LLC which is a Vermont-based consulting firm with two employees.

*Erica Garfin* is a Vermont-based independent contractor.

As summary of key experience for the individuals and firms discussed above is included in the experience matrix that follows on the next page.



Experience Matrix															
	Health Policy Development	Meeting Facilitation	Public Planning	Program Implementation	Strategy Development	Actuarial/Rate Setting	Survey Design	Stakeholder engagement	Model Building	Project Management	Federal HCR analysis	Exchange Design	SMHP Design	Evaluation of Exchange-like Programs	Experience with VT State Agencies
Individual															
Joshua Slen	X	X	X	X	X			X	X	X	X	X	X		X
Beth Waldman	X	X	X	X	X			X		X	X	X	X		X
Amy Lischko	X	X	X	X	X			X	X		X	X		X	
Michael Bailit	X	X	X	X	X			X		X					X
Michael Joseph	X				X		X		X	X					X
Sue Frechette		X		X	X			X	X	X	X				
Erica Garfin	X	X	X	X	X			X		X					X
Mark Podrazik	X	X	X	X	X	X	X	X	X	X	X			X	X
Peter Burns	X	X	X	X	X	X	X	X	X	X	X				X
Stephen Pawlowski	X		X	X	X				X	X	X				
Ed Fischer	X	X		X	X	X		X	X	X	X				
Stacey Lampkin	X	X	X	X	X	X	X	X	X	X	X	X	X		
Sheree Swanson	X	X	X	X	X	X			X	X	X	X	X		
Gary Hartnett	X	X	X	X	X	X		X	X	X					
Karen Bender	X	X	X	X	X	X	X	X	X	X	X	X	X		X
Ronald Deprez	X				X		X			X	X				X
Karen O'Rourke		X					X	X		X					X
Carry Buterbaugh							X								
Hank Stabler					X						X				X
Brain Robertson							X	X							X

Timeline												
Section #	Title	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011	July 2011	August 2011	September 2011
3.1.1	Study of Exchange Design Options, Development, Design, and Implementation Plan											
3.1.1.1	Roadmap for Planning											
3.1.1.2	Exchange Design Options											
3.1.1.3	Creation of an Implementation Plan											
3.1.1.4	Recommendation for Exchange Financial Sustainability											
3.1.1.5	Recommendations related to Exchange Finance Functions											
3.1.2	Study of the uninsured and underinsured											
3.1.3	Actuarial Services	As needed throughout the project										
3.1.4	Formal Stakeholder Study											
3.1.5	Study of Current Insurance Market											
3.1.6	Assessment of Current Programs and Integration Activities											
3.1.7	Formal Assessment of "Churning"											

## 2.4.5 References

Trish Riley  
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Sarah Iselin  
Blue Cross Blue Shield of Massachusetts Foundation  
(formerly, Commissioner, Massachusetts Division of Health Care Finance and Policy and  
Member of the Massachusetts Health Care Quality and Cost Council)  
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Additional references, including references of any of Bailit's subcontractors, are available upon request.

### **Section 3.1.1**

This section provides the overview for the Bailit Health Purchasing approach. The subsequent subsections within 3.1.1 (e.g., 3.1.1.1, 3.1.1.2, 3.1.1.3, 3.1.1.4, and 3.1.1.5) provide details specific to each area of the Exchange planning process.

#### **Team Composition**

Lead: Joshua Slen

Subject Matter Experts: Beth Waldman, Amy Lischko, Mark Podrazik, Peter Burns

Facilitation Support: Sue Frechette, Erica Garfin

Modeling: Stacey Lampkin and Sheree Swanson

Liaison to the State Steering Committee: Joshua Slen

#### **Experience**

As a former Vermont Medicaid director, Joshua Slen brings unique insight and expertise to the development of an Exchange in Vermont. He is a proven leader and implementer of previous health reform efforts in Vermont. In addition to Joshua, the team includes Beth Waldman and Amy Lischko, both former senior officials in Massachusetts who played key roles in the development and implementation of the Commonwealth Health Insurance Connector Authority. Since leaving state government, both Beth and Amy have continued to actively participate in state health reform efforts and have been engaged in assisting states in efforts to design an Exchange under the ACA. Likewise, Mark Podrazik brings significant knowledge of the Vermont landscape combined with current experience in Exchange development. Stacey Lampkin and Sheree Swanson will provide modeling and actuarial support of the financial sustainability portion of the Exchange planning process. Erica Garfin and Sue Frechette will assist the team in supporting the facilitation of the meetings that will occur as part of the tasks contained throughout 3.1.1.

#### **Approach**

The Bailit team will bring its considerable experience to bear in working closely with Vermont officials to facilitate the design of an Exchange that meets the goals and priorities of Vermont. As a first step, the Bailit team will design, in collaboration with Vermont officials, a strategic planning process as described in Section 3.1.1.1. As described further below, the strategic planning process will include the development of a roadmap for necessary decision making to shape the design of the Exchange and its specific functions. The process will consider and describe what key design questions need to be answered, where additional work and consultation is necessary, how to collaborate with other health reform efforts and related initiatives that are ongoing in Vermont, and how to incorporate stakeholder feedback into the design process, from high-level decisions that may involve large groupings of stakeholders to operational functions that impact very specific stakeholders. As the first section to be tackled, the roadmap will also consider how to incorporate the results from the formal stakeholder study required in Section 3.1.4 into the final design model for the Exchange and the implementation process.

The Bailit team, from our existing experience working with other states on the very same issues Vermont is facing, proposes that a standing State Steering Committee be established or identified (perhaps using an existing state group) to manage the Exchange planning process.

We see this group as responsible for meeting once a month throughout the Exchange planning process to receive deliverables, discuss options and opportunities, and to provide direction to all aspects of the project. We propose that the team consist of senior level individuals responsible for program design, implementation, and oversight. It should include individuals from DVHA and BISHCA and, to the extent that the State envisions broadly exploring Exchange-related activity options, individuals representing other departments and agencies potentially impacted. The Bailit team will staff this committee throughout the contract. This is the group that will discuss and approve the vision and goals as part of the roadmap (section 3.1.1.1) at the start of the project.

Through the strategic planning process, the Bailit team will work in coordination with Vermont officials and stakeholders to identify Vermont's specific goals and priorities for the Exchange and to determine how to prioritize the many questions that need to be answered by the State as part of its design process. To that end, the Bailit team will work with Vermont officials to categorize the questions included in Vermont's Exchange planning grant application, included in Section 3.1.1.2. As described further below, the answers to these questions will help to shape the design of the Exchange. To assist the State in making decisions, the Bailit team will develop white papers and/or presentations for a series of option meetings with Vermont officials and key stakeholders to help shape the design. The Bailit team will create a "straw man model" based on the Vermont goals and priorities discussion. This "straw man model" will allow for the discussion to occur around the key decisions that the State must make. The design of the Exchange will be an iterative process as different decisions along the way will impact future decisions and result in additional questions to be answered.

Based on feedback from these meetings, the Bailit team will develop a detailed implementation plan, as required in Section 3.1.1.3, in close collaboration with state officials. In addition to answering key design questions, the implementation plan will make recommendations for the organizational structure of the Exchange, the entity's infrastructure and staffing needs, and coordination of Exchange planning with other health system reform efforts ongoing in the State. The implementation plan will provide a clear roadmap to have an operational Exchange by January 2014 and will include key milestones and the timing for those milestones, a strategy for measuring the success of the implementation process and a method for evaluating the design post-implementation to allow for modifications to the design as necessary, based on a review of outcomes. As with the development of the strategic planning process and the design decisions, the development of the implementation plan will also rely on close coordination, sharing of ideas and incorporating feedback of key stakeholders, as described in Section 3.1.1.3 below.

The strategic planning process required in Section 3.1.1.1 will anticipate the requirement for the Exchange to be financially self-sustaining beginning in January 2015. As part of its Exchange planning efforts it will be essential for Vermont officials and stakeholders to include financial sustainability in the design of the Exchange. As per Section 3.1.1.4 requirements, the Bailit team will work closely with Vermont officials to model the financial sustainability of the Vermont Exchange after just a year of operation. The Bailit team will consider the Massachusetts model, which includes the cost of the operation of the Health Connector in the premium price of plans offered through the Health Connector to fund its administrative activity, as well as other alternatives for funding the Exchange in Vermont. In completing this analysis, the Bailit team will draw from its experience and expertise in the Vermont budgeting process, and the funding

for the Catamount Health program. As part of the financial sustainability model, the Bailit team will analyze the Essential Health Benefits required under the Exchange (upon release of HHS regulations that fully describe these requirements) and compare these benefits to the State's mandated benefits. The analysis will include the potential cost of continuing to require state-mandated benefits that are not included as an Essential Health Benefit and how they may be funded for subsidized plans offered through the Exchange.

Finally, in designing the Exchange the Bailit team will make specific recommendations as to the financial functions to be performed by the Exchange, as required in Section 3.1.1.5. These activities will also be delineated in the implementation plan developed under Section 3.1.1.3, and will address the day-to-day financial operations of the Exchange, including collecting premiums, reconciling subsidies and tax credits, complying with transparency and reporting requirements, and implementing activities to ensure program integrity and eliminate the potential for fraud, waste and abuse within Exchange offerings.

### **Integration**

In addition to the Tasks delineated in Section 3.1.1 of the RFP, the additional tasks in the RFP will all play a significant role in informing the Exchange design process. To that end, the strategic planning process and detailed work plan required in Section 3.1.1.1 will necessarily include the interdependencies of the other initiatives (e.g., churning report, actuarial analysis) on the Exchange design work and will incorporate the appropriate timeframes and integration tasks within the work plan. The design work included in Section 3.1.1.2 will be informed by the outcomes of specific studies, including the study of the uninsured and underinsured described in Section 3.1.2, actuarial support provided through Section 3.1.3 to assist in answering many of the proposed questions, incorporation of the formal stakeholder study required under Section 3.1.4, consideration of the insurance market study required in Section 3.1.5 on the design of the Exchange, including how robust the Exchange will be and how similar the markets will be in and outside of the Exchange, the consideration of the many ongoing health reform initiatives and how they can be developed to work in concert with the Exchange as required in Section 3.1.6, and the impact of the churning study required in Section 3.1.7 on the design of the Exchange model based on how individuals might be expected to move between other public programs and the Exchange.

### **Timeline of Activities/Deliverables**

#### Overall Project management and oversight

Proposed Activity Start Date: November 10, 2010

Proposed Activity End Date: September 31, 2011

This includes the Liaison duties from each project team to the State Steering Committee as well as overall integration responsibilities across tasks in the Exchange planning process.

#### State Steering Committee Meetings

Proposed Activity Start Date: November 10, 2010

Proposed Activity End Date: September 31, 2011

This entails meetings with the appropriate group of decision makers once a month throughout the term of the contract.

#### Final Report

Proposed Activity Start Date: June 1, 2011

Proposed Activity End Date: September 1, 2011

The final report document is to be delivered to the State upon project completion.

### **3.1.1.1 Roadmap for planning**

#### **Team Composition**

Lead: Joshua Slen

Subject Matter Experts: Beth Waldman, Amy Lischko, Mark Podrazik

Facilitation Support: Sue Frechette, Erica Garfin

Modeling: Stacey Lampkin and Sheree Swanson

Liaison to the State Steering Committee: Joshua Slen

#### **Approach**

To facilitate Vermont's roadmap for Exchange planning, the Bailit team will start by developing a detailed strategic planning document and work plan that provides state policymakers with a clear path to make key decisions in Exchange design with appropriate input from stakeholders. In developing this deliverable, the Bailit team will review Vermont's Exchange planning grant application and incorporate its early thinking into a developed blueprint for the shaping and design of Vermont's Exchange.

As part of its Exchange planning grant application, Vermont has developed a comprehensive list of questions, included in Section 3.1.1.2 of the RFP, to be researched and answered during the design phase. The Bailit team will bring its considerable strategic planning experience to develop a framework to answer of these and other questions raised during the Exchange design planning process with appropriate stakeholder input balanced with needed efficiency of time and resources. The strategic planning document will detail a proposed decision making hierarchy that allows for early advice from Vermont officials, input from stakeholders throughout the process, and a final recommendation for approval by Vermont officials. To the extent possible, the Bailit team recommends that the framework for decision making leverage existing structures and strategies in Vermont.

It will be essential for Vermont to finalize a decision making process quickly and to implement it from the beginning of its design work. Through this framework, the Bailit team will prioritize a series of meetings that describe minimum functions under the Exchange, discuss options for the Exchange's goals and priorities, and answer key design questions in an order that allows for grouping of like questions and answering questions that will result in further questions and analysis early on in the process.

The strategic planning document will begin with an overview of the minimum Exchange requirements included in the ACA and the potential options for expanding the reach of an Exchange. This will provide an understanding of the potential possibilities and opportunities of

an Exchange that will serve as a useful backdrop to a key first step in the Exchange planning process – identifying the State’s goals and priorities for its Exchange. Once Vermont has identified these goals and priorities, the strategic planning process will focus on governance issues so that legislation enabling an Exchange may be drafted as soon as possible in the planning process. To determine the goals and objectives of the Exchange, the Bailit team will facilitate a discussion focusing on how state leaders and stakeholders view an Exchange (e.g., minimalist or robust); and, if robust, what types of larger system issues does Vermont want to tackle within the Exchange (e.g., improved quality, payment reform). Following this discussion, the Bailit team will prepare certain key framing questions for the Exchange that need to be decided early on in the process to set the framework, including:

- confirming that Vermont wants to develop its own Exchange, rather than allowing the federal government to develop it;
- determining what type of entity should run the Exchange (e.g., governmental vs. non-profit), and if governmental, should the entity be quasi-independent, a full governmental entity, or part of an existing governmental entity;
- determining whether Vermont will have a separate Exchange for individuals and businesses, and whether there is any interest in having regional Exchanges across Vermont;
- determining what functions currently exist in Vermont (both inside and outside of state government) to perform the requirements of the Exchange, and
- determining the level of interest in Vermont in collaborating with neighboring states on the development of the Exchange, purchasing of key infrastructure, and/or in operation and administration of the Exchange.

For this and all of the decision meetings, the Bailit team will develop a white paper and/or presentation that will detail the questions to be answered, potential options, opportunities and barriers to each option, stakeholder input needed and/or feedback received, and final recommendations. To the extent practicable, the analysis will be based on available data and will leverage ongoing work in Vermont as well as other states in which the Bailit team is working to design Exchanges. The strategic planning document will identify the types of data necessary to answer specific questions detailed in the Exchange planning grant and Section 3.1.1.2, including demographic information on individuals and employers, results of the study of the uninsured and underinsured required in Section 3.1.2 and the churning report required in Section 3.1.7, as well as actuarial analysis of potential questions.

The answers to the first set of critical questions detailed above will inform the drafting of enabling legislation for an entity to serve as Vermont’s Exchange, will inform future direction for the design of the Exchange and will likely raise additional questions for the State’s consideration. In addition, the answers to these questions will also inform if, and to what extent, the direction of the Exchange overlaps or is similar to other health reform initiatives ongoing in Vermont and whether planning activities or initiatives can and should be combined. As a partial list, activities of the HIT-HIE stakeholders group, activities of the Health Care Reform Committee, activities of the Blueprint for Health, and activities of the numerous advisory boards within the Agency of Human Services including the Medicaid Advisory Board, all contain some overlapping areas of interest that will need to be addressed within the Exchange planning process. As described above, the strategic planning document and



associated work plan will anticipate the need to analyze available quantitative data and feedback from focus groups as part of its detailed work plan to inform the Exchange design. The work plan accompanying the strategic planning document will move the strategic planning document into action through use of detailed tasks and associated timelines that delineate when and how options will be considered, questions will be researched, data will be collected, stakeholders will be consulted, focus groups will be utilized and recommendations will be made. Although the Exchange is not expected to be operational until January 2014, the timeframe for making key design decisions and working towards implementation of the Exchange is tight.

### **Specific Tasks**

- 3.1.1.1.1 Hold kick off meeting on Exchange with key Vermont state officials (November)
- 3.1.1.1.2 Develop initial draft of strategic planning document and related work plan (November)
- 3.1.1.1.3 Finalize framework for decision making and obtaining stakeholder input (November)
- 3.1.1.1.4 Review initial options and recommendations set out in the strategic planning document with key Vermont state officials and stakeholders (November- December)
- 3.1.1.1.5 Determine what aspects of Exchange planning can and should be integrated with other ongoing health reform efforts in Vermont. (November-December)
- 3.1.1.1.6 Finalize strategic planning document and work plan for Exchange planning efforts based on feedback from key Vermont state officials and stakeholders. (December)

### **Timeline of Activities/Deliverables**

Draft Strategic planning document and work plan  
Proposed Activity Start Date: November 10, 2010  
Proposed Activity End Date: December 10, 2010

Presentation: Exchange Requirements, Goals, Key Questions  
Proposed Activity Start Date: November 10, 2010  
Proposed Activity End Date: December 15, 2010

Final Strategic planning document and work plan  
Proposed Activity Start Date: November 10, 2010  
Proposed Activity End Date: December 20, 2010

### **3.1.1.2 Exchange Design Options**

#### **Team Composition**

Lead: Beth Waldman

Subject Matter Experts: Amy Lischko, Mark Podrazik, Peter Burns, Joshua Slon

Facilitation Support: Sue Frechette, Erica Garfin

Modeling: N/A

Liaison to the State Steering Committee: Joshua Slon

### **Approach**

Utilizing the strategic planning process as described in Section 3.1.1.1, the Bailit team will identify and explore the pros and cons to potential models for the Vermont Exchange. During each step of the development process, the Bailit team will focus on developing an Exchange that meets the specific goals and objectives for the Vermont Exchange as identified in the early stages of work.

The Bailit team anticipates grouping the questions included by the State and other questions raised along the way into specific categories or topic areas that are analyzed and presented together as a package for consideration to Vermont officials and stakeholders. Specifically, Bailit recommends grouping the questions into the following major categories:

- governance;
- interaction with and impact on public programs, including Medicaid, CHIP and Catamount Care (including consideration of a Basic Health Plan and streamlining of eligibility and enrollment);
- interaction with BISHCA and insurance requirements in Vermont (including consideration of the use of a public option);
- business operations (including staffing, contractual, financial and infrastructure needs);
- role of the Navigators (including impact on businesses and brokers), and
- role of the Exchange in forwarding public health and system reform strategies (including interaction with Blueprint for Health, HIE activities, payment reform, and population health activities).

While some questions will fall squarely into one grouping, a number of decisions will impact other questions that need to be answered or create new questions in a different category. A Bailit team member will be assigned to lead each of these categories. The Bailit team leads will work closely and collaboratively with each other and state officials to ensure that there is an ongoing feedback loop and a running policy issues list that identifies the categories for potential impact.

As the Bailit team works with the State to design the Vermont Exchange, it will be essential to consider feedback from the stakeholder study required in Section 3.1.4 and coordinate with that effort to ensure that stakeholders are being asked to weigh in on key Exchange design questions. While the strategic planning process will define a way to get ongoing stakeholder input on Exchange design as decisions are being made, the stakeholder study will allow for use of focused meetings with stakeholders to understand the impact of potential Exchange policy decisions on them.

For all of this work, it will be essential for the Bailit team to work hand-in-hand with key Vermont officials. Given the location of several team members in Vermont and their long-standing relationships with key participants in the Exchange planning process, the Bailit team will be able to have regular face-to-face meetings with Vermont officials and other stakeholders that will help move this work forward efficiently.

The Bailit team will leverage our intimate knowledge of the state public and private health care system to provide unparalleled support to the States' Exchange Design process. We understand the strengths that are present in the Vermont system from the national level leadership represented by such efforts as the Blueprint for Health, the VITL HIE, the strong regulatory environment, the expansive public health care offerings at DVHA, the relatively healthy population base, and the significant amount of quality data that is available on the health care system. We understand the weaknesses from the aging eligibility and MMIS systems, to the tight financial times, and the competing priorities around health care quality, cost, and access. We also see the opportunities to leverage VHCURES, to mine VHHIS, to realize the promise of the Blueprint for Health, to extend the successful outreach efforts under Catamount, and to address some of the small group and individual insurance issues in the market, among many opportunities.

The Bailit team will begin all state-level interactions by using the State Steering Committee described in Section 3.1.1 to present interim and final information and to determine the appropriate avenues for presentation of materials produced as part of the Exchange planning process. As part of the Exchange design process we are prepared to provide PowerPoint presentations as requested by the Steering Committee to the Health Care Reform Committee, the Medicaid Advisory Board, the Agency of Human Services Commissioner's meeting, and other forums as determined in concert with the State Steering Committee.

The Bailit team will incorporate all of its work in this section into a final Exchange model for review by Vermont officials and key stakeholders. This model will provide the basis for the implementation plan described in Section 3.1.1.3 below.

### **Specific Tasks**

- 3.1.1.2.1 Categorize questions and prioritize the need for decisions within those categories (November)
- 3.1.1.2.2 Assign a Bailit team lead for each category of questions (November)
- 3.1.1.2.3 For each category, develop a white paper/presentation with policy options, pros and cons, data analyses, and recommendations (December - March)
- 3.1.1.2.4 Present findings to Vermont officials and stakeholders for feedback (December - March)
- 3.1.1.2.5 Develop a draft Exchange model based on feedback (April)
- 3.1.1.2.6 Finalize the Exchange model with Vermont officials (April)

### **Timeline of Activities/Deliverables**

#### Category of questions for Vermont's review and approval

Proposed Activity Start Date: November 10, 2010

Proposed Activity End Date: November 20, 2010

#### For each category, white paper/presentation

Proposed Activity Start Date: November 20, 2010

Proposed Activity End Date: April 15, 2011

#### Draft Exchange model

Proposed Activity Start Date: January 1, 2010  
Proposed Activity End Date: April 15, 2011

#### Final Exchange model

Proposed Activity Start Date: April 15, 2011  
Proposed Activity End Date: April 30, 2011

### **3.1.1.3 Creation of an Implementation Plan**

#### **Team Composition**

Lead: Amy Lischko

Subject Matter Experts: Beth Waldman, Joshua Slen

Facilitation Support: Sue Frechette, Erica Garfin

Modeling: N/A

Liaison to the State Steering Committee: Joshua Slen

#### **Approach**

Following the development of an Exchange design that incorporates feedback from stakeholders and is approved by Vermont officials, the Bailit team will develop a detailed implementation plan for the Exchange.

The implementation plan will detail the key milestones required to implement the Exchange by January 2014 and will prioritize the activities to ensure that the work is done in an efficient and orderly manner. At a minimum, key milestones in the implementation plan will include:

1. drafting and enacting enabling legislation for the administration of an Exchange that details the entity to serve as the Exchange and how it will be governed;
2. appointing Board members to oversee the Exchange;
3. hiring an Executive Director and key staff to direct the work of the Exchange;
4. building or purchasing the necessary infrastructure to operate the Exchange, including streamlining eligibility across the Exchange and the Medicaid/CHIP programs;
5. developing regulations, policies and procedures, as necessary to detail the requirements of the Exchange, and
6. designing systems for financial oversight of the Exchange, including activities necessary to become financially self-sustaining by January 2015.

The implementation plan will include objective measures of success, including meeting timelines laid out within the plan, involvement of key stakeholders in the process, coordination with other state initiatives related to the Exchange, leveraging of resources where appropriate, and testing of systems to be used within the Exchange.

As with the development of the strategic planning process and the modeling for the Exchange described in Sections 3.1.1.1 and 3.1.1.2 above, the Bailit team will follow the same framework for working collaboratively with Vermont officials and stakeholders in the development of the implementation plan once the model for the Exchange is defined. Throughout the implementation planning process, it will be essential to have ongoing meetings with Vermont staff and with targeted groups of stakeholders. One purpose of the meetings will be to ensure

that the impacts of particular design decisions are recognized and that the implementation plan of the Exchange includes the development of the Exchange entity and its specific functions. In assessing the impacts of the Exchange, the meetings will focus on the responsibilities on other state agencies and initiatives, as well as on other stakeholders, particularly businesses and individuals that will be interacting with the Exchange.

### **Specific Tasks**

- 3.1.1.3.1 Draft implementation plan
- 3.1.1.3.2 Meet with Vermont officials and stakeholders to receive feedback on plan
- 3.1.1.3.3 Final implementation plan

### **Timeline of Activities/Deliverables**

#### Draft implementation plan

Proposed Activity Start Date: June 1, 2011

Proposed Activity End Date: July 1, 2011

#### Meet with Vermont officials and stakeholders to receive feedback on plan

Proposed Activity Start Date: July 1, 2011

Proposed Activity End Date: August 30, 2011

#### Final implementation plan

Proposed Activity Start Date: August 30, 2011

Proposed Activity End Date: September 15, 2011

### **3.1.1.4 Recommendation for Exchange Financial Sustainability**

#### **Team Composition**

Lead: Peter Burns

Subject Matter Experts: Joshua Slen, Beth Waldman, Amy Lischko

Facilitation Support: N/A

Modeling: Mark Podrazik, Stephen Pawlowski, Mercer

Liaison to the State Steering Committee: Joshua Slen

#### **Approach**

The Affordable Care Act (ACA) defines sustainability in terms of the administrative costs of the Exchange which must be self-supporting by 2015. Ultimately, the sustainability of Vermont's Exchange or any other states exchange will be dependent on:

- control of administrative costs;
- a source of revenue for administrative costs;
- the volume handled by the exchange and the ability to spread those administrative costs;
- the extent to which the Exchange avoids adverse selection such that healthier individuals remain outside the Exchange (e.g., a high percentage of insurer business is handled through the Exchange, regulatory requirements are the same both inside and outside the Exchange, grandfathered plans are not allowed to push high cost individuals

into the Exchange or are required to purchase through the Exchange, healthier plans self-insure, etc.);

- the premium cost to the employer/employee to purchase coverage through the Exchange compared to premium outside the Exchange is comparable or lower, and
- the ability of the Exchange to limit premium growth.

Vermont faces a number of unique challenges in designing a sustainable Exchange given its size and few uninsured. First, among these challenges is the probability that there are many plans in Vermont that are “grandfathered plans” with little incentive to purchase coverage through the Exchange. Second, Vermont estimates that the number of uninsured who are not already eligible for a public program but not enrolled is fewer than 23,000. As a result, Vermont cannot expect a large influx of businesses or individuals into the Exchange to meet mandatory coverage requirements. Experts have suggested that Exchanges with fewer than 100,000 members will not be sustainable. Third, Vermont’s mandatory minimum benefits are likely to exceed the essential health benefit requirements.

Vermont’s status, however, also presents opportunities. Unlike other states, Vermont will not have to grapple with large numbers of newly eligible Medicaid clients. Many of the individuals eligible under the ACA up to 133% of FPL are already eligible through Medicaid or subsidized through Catamount, making the offering of a public option through the Exchange possible. Vermont will also have a new eligibility system in place that meets many of the ACA requirements as well as a public and private insurer database on claims experience.

If waiver options through the ACA were available prior to 2017, Vermont likely would take advantage of them sooner. However, Vermont can refocus its objectives for the Exchange on affordability, cost control, and quality in the small group and individual markets. This focus will hopefully entice the small employer market into the Exchange.

The analysis in Task 3.1.1.4 ultimately focuses on the ability of the Exchange to fund its administrative costs subject to the considerations described above. In this task, we must define the functions the Exchange will perform and the source(s) of revenue to support those functions. We must also examine the additional cost of state-mandated insurance benefits and their impact on financing options. Because of the existing infrastructure in Vermont, functions already performed by another entity should build on that capacity to minimize the administrative costs born exclusively by the Exchange.

The functions that are either mandated or allowed within the Exchange include (but are not limited to):

- process applications for both coverage and for subsidies using a standardized application;
- implement procedures to certify, recertify, and decertify health plans;
- operate a toll-free telephone hotline to respond to requests for assistance;
- maintain an Internet website for prospective enrollees to compare information on plans;
- assign a rating to each qualified health plan in accordance with the Secretary’s criteria;
- utilize a standardized format for presenting health benefits plan options in the Exchange;

- inform individuals of eligibility requirements for the Medicaid, CHIP and any other applicable State or local public program and enroll such individuals if they are eligible;
- establish and make available an electronic calculator to determine the actual cost of coverage after the application of any premium tax credit or cost-sharing reduction;
- grant certifications for exemption from the individual responsibility penalty;
- transfer required information to the Secretary of the Treasury;
- provide to each employer the name of each employee who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);
- establish the Navigator program;
- conduct consumer and employer satisfaction surveys;
- facilitate the enrollment of individuals and small businesses in qualified health plans;
- premium collection and billing;
- conduct financial reconciliations, such as tax credits and cost sharing subsidies;
- perform financial reporting to the federal government;
- pay commissions to brokers;
- perform marketing and outreach activities, and
- provide training to brokers, human resource staff of employers and navigators.

What is particularly challenging about this list of mandatory and potential functions is the range of capacities, systems and skill sets required to perform them. What is also challenging is that some of these costs are fixed and some are variable. Most challenging is that some of these functions are required pre-implementation, potentially before there is an identified ongoing revenue source.

The design options for the Exchange will start to be considered and formulated during Month 1 and 2 of the project and the functions assigned to the Exchange will be defined. We recognize that this will be an iterative process. Some functions will clearly be the sole responsibility of the Exchange while others may be shared responsibilities or may be placed with some other entity (e.g., a state agency, insurance carriers).

It is understood that the functions of the Exchange may not be clearly articulated until later in the final Exchange design process. We anticipate that those making design and function decisions will want input on the estimated cost associated with those functions throughout the Exchange design process.

As noted above, this task results in the definition of Exchange functions and identification of revenue sources for those administrative activities. While the functions assigned to the Exchange will depend on design decisions, stakeholder input and Task 3.1.6 (identification of integration opportunities), the team assigned to this task will initially focus on developing funding options. These options may include:

- adding administrative costs as a percent of premium or a PMPM cost through the Exchange – which is only viable if the overall premium remains competitive and the volume is adequate to spread these costs;
- assessing both users of the Exchange and those outside the Exchange through a premium tax and/or assessment;

- charging back to other agencies functions the Exchange performs on their behalf;
- provider taxes, since uncompensated care will be lower;
- assessing the self-insured, but not ERISA plans, if data show a healthier population, and
- counter-balancing administrative costs of the Exchange with lower broker/agent fees, particularly on individual coverage.

In order to assess funding options, we will build a revenue cost model that includes:

- insurer participation;
- enrollment assumptions based on Task 3.1.3, including employer take-up rates;
- enrollment phase-in;
- take up rates over time, and
- pricing options for administrative costs.

As the Exchange design features become more concrete, the Bailit team will start to price out the operational functions required to implement these features. For many functions, this will include alternative budgets depending upon who performs the function (e.g., hired staff or a contractor). Our second interim deliverable in this task will walk through cost estimates to complete each Exchange function identified to date along with high and low revenue requirements to sustain ongoing operations.

After consulting with the State about Exchange expense options, we will continue to refine financial estimates as decisions become finalized. For the final deliverable under this task, we will develop two financing options (each option may include revenues from multiple sources). The Exchange expenses will include separate budgets for upfront costs and ongoing costs during the first three years of implementation. Separately, our actuary team will provide a separate expense estimate for the cost of state-mandated insurance benefits.

### **Specific Tasks**

- 3.1.1.4.1 Meet with state leadership on the state budgeting process and the current financing for Catamount Health and other public programs (December)
- 3.1.1.4.2 Using data from Tasks 3.1.2, 3.1.3 and 3.1.5, build a revenue model of covered lives of the insured, public and private separate, as well as the uninsured for use in financing options for the Exchange (January)
- 3.1.1.4.3 Outline mandatory and optional Exchange functions and begin to build high-level estimates of both upfront fixed costs and ongoing implementation costs- (January-February)
- 3.1.1.4.4 Prepare and deliver first draft deliverable for this task (Options Deliverable) (March 1)
- 3.1.1.4.5 Meet with state staff to go over the Options Deliverable and obtain feedback (March 15)
- 3.1.1.4.6 Refine cost estimates for operational functions based on iterative design decisions made for the Exchange (March-April 2011)
- 3.1.1.4.7 Incorporate information learned from outside stakeholders, CMS and other state agencies as part of the integration task to help inform cost options for performing each task required, whether it is inside or outside the Exchange (April)



- 3.1.1.4.8 Gain consensus with the state leaders on what, if any, changes are required to a state-mandated insurance benefit (April 2011)
- 3.1.1.4.9 Price out the additional costs of state-mandated insurance benefits (April-May 2011)
- 3.1.1.4.10 Build the final Exchange sustainability model for CY 2013 and the first three implementation years, ensuring that the Exchange is financially sustained by the end of CY 2014 (June-August)
- 3.1.1.4.11 Deliver final Exchange sustainability options models (September 1)
- 3.1.1.4.12 Walk through sustainability options with the State (September 15)
- 3.1.1.4.13 Finalize models based on sustainability decisions by the State (September 30)

### **Integration**

Our team will utilize the information reported in Task 3.1.2 (Study of the uninsured and underinsured) as well as Task 3.1.5 (Study of the current insurance market) and the actuarial estimates in Task 3.1.3 to build the caseload model for assessment of sustainability on revenue options that assess only users of the Exchange. We will depend also on the actuarial analysis in 3.1.3 to determine cost and take-up rates.

As decisions are made in the design of the Exchange in Task 3.1.1.2, we will integrate these decisions into the expense budget for the Exchange. For many design decisions, we anticipate that a few options will need to be priced out to help inform the final design decision. Information learned from Task 3.1.6 (Assessment of current programs and integration opportunities) will inform the process for where economies of scale can be gained for functions that may be picked up by other state agencies.

### **Timeline of Activities/Deliverables**

#### Options Deliverable

Proposed Activity Start Date: January 2, 2011

Proposed Deliverable Date: March 1, 2011

We will provide a number of financing options to support the financial sustainability of the Exchange as well as the expense categories that need to be considered as part of the Exchange budget, with specifications for those that are mandatory and those that are optional.

#### Refined Sustainability Options Deliverable

Proposed Activity Start Date: March 2, 2011

Proposed Deliverable Date: June 1, 2011

Based on feedback from key decision makers and other stakeholder feedback, the responsibilities for the Exchange that need to be considered in a budget will be refined. Final options for the financing of these responsibilities will be presented.

#### Final Exchange Financial Sustainability Options Deliverable

Proposed Activity Start Date: June 2, 2011

Proposed Deliverable Date: August 1, 2011

No more than two financing options will be included for consideration. Cost estimates, both for upfront costs and ongoing operations, will be developed. Any costs associated with state-mandated insurance benefits will also be presented in this final version of the deliverable. The sustainability model will show revenues and outflows for pre-implementation (CY 2013) and the first three years of implementation and (CYs 2014-2016).

### **3.1.1.5 Recommendations Relating to Exchange Finance Functions**

#### **Team Composition**

Lead: Mark Podrazik

Subject Matter Experts: Joshua Slen, Beth Waldman, Amy Lischko

Facilitation Support: N/A

Modeling: Mark Podrazik, Stephen Pawlowski

Liaison to the State Steering Committee: Joshua Slen

#### **Approach**

Many of the mandatory functions that the Exchange must assume are financial in nature, including:

- financial reporting to the federal government including DHHS, Treasury, and Homeland Security;
- reconciling tax credits and cost-sharing;
- reporting violations of the False Claims Act to the DHHS;
- calculation of exemption to the individual mandate;
- development of the electronic calculator that determines the actual cost of coverage after tax credits and cost-sharing reductions for applicants to the Exchange;
- premium billing and collection (individuals and employees);
- development of accounting and audit systems and protocols;
- value ratings of plans (in part, financial);
- submittal of an annual accounting report to DHHS;
- submission to an annual audit by the Secretary, and
- controlling waste, fraud, and abuse.

A number of the functions that are not mandatory but which the Exchange may assume to attract small employers and insurers to the Exchange are also financial in nature, including:

- aggregated billing to employers;
- consolidated payments to qualified health plans (employer/employee share);
- consolidated payment of broker/agent commissions;
- assisting small employers applying for tax credits and management of COBRA coverage, 125 plans, health savings account, etc., and
- implementation of payment reforms aimed at controlling cost.

Ultimately, the financial functions of the Vermont Exchange will depend on the design options selected in 3.1.1.2 and the results of the sustainability analysis in 3.1.1.4. While these tasks are in progress, however, the range of finance functions can be identified along with options for performing these functions and a preliminary assessment of the relative cost of such options.

The first step in our analysis is to examine the financial system and functional capacity in Vermont. At a minimum, it is likely that the Exchange will need an accounting system that performs premium billing and collection, calculates and reconciles tax credits and cost-sharing, provides detailed accounting of administrative costs, tracks administrative costs against revenue and charge backs to other entities, and synthesizes required federal reporting to DHHS, Treasury, and Homeland Security. A central question is whether to build or buy such a system and whether resources could be combined across several states with similar system needs.

### **Specific Tasks**

- 3.1.1.5.1 Examine the finance functions and systems of Catamount Health and other public programs and assess capacity (December)
- 3.1.1.5.2 On an ongoing basis, establish input channel from stakeholders, design decisions in 3.1.1.1 and sustainability requirements in 3.1.1.4 (December through August)
- 3.1.1.5.3 Review the results of 3.1.5 Study of the Current Insurance Market (December)
- 3.1.1.5.4 Develop a preliminary matrix of mandatory and “potential” finance functions (January)
- 3.1.1.5.5 Monitor CMS guidance regarding financial reporting and accounting requirements (ongoing throughout project)
- 3.1.1.5.6 Meet with state financial management staff and leadership to review preliminary finance functions (January – March)
- 3.1.1.5.7 Develop preliminary options and responsible party list for matrix finance functions (January)
- 3.1.1.5.8 Draft the first deliverable: “Matrix of Mandatory and “Potential” Finance Functions” (March)
- 3.1.1.5.9 Review deliverable with state leadership and staff and determine financial system options to pursue (March)
- 3.1.1.5.10 Examine internal state, commercial off-the-shelf, or collaboration options for financial systems (April)
- 3.1.1.5.11 Develop the second deliverable: “Finance Options Analyses” (May)
- 3.1.1.5.12 Incorporate input from 3.1.1.1 design decisions, stakeholders, CMS and sustainability requirements (May-July)
- 3.1.1.5.13 Prepare requirements document based on input and selected options/responsible parties (July)
- 3.1.1.5.14 Develop the third deliverable: “Requirements and Cost Analysis of Exchange Finance Functions” (August)

### **Integration**

Task 3.1.1.5 is dependent on the design decisions made in 3.1.1.1., sustainability requirements in 3.1.1.4, the analysis of the small and individual insurance markets in 3.1.5 and Task 3.1.6 Assessment of current programs and integration opportunities. The extent that financial processes for other programs, particularly Catamount Health, can be reviewed for adaptability to the Exchange will be seriously considered.

### **Timeline of Activities/Deliverables**

Matrix of Mandatory and “Potential” Finance Functions

Proposed Activity Start Date: January 15, 2011  
Proposed Deliverable Date: March 15, 2011

A matrix will be developed that outlines mandatory and potential Exchange finance functions, responsibilities within each function, and potential responsible parties to complete each function

#### Finance Options Analyses

Proposed Activity Start Date: March 16, 2011  
Proposed Deliverable Date: May 15, 2011

The second deliverable is an analysis of the advantages and disadvantages of identified options and responsible parties using input from the analysis of integration opportunities in 3.1.6. This deliverable will include finance functions assigned to the Exchange at this juncture as well as those that may be considered for the Exchange. System options are presented in detail in this deliverable. The deliverable will also include a high level estimate of potential costs.

#### Requirements and Cost Analysis of Exchange Finance Functions

Proposed Activity Start Date: May 16, 2011  
Proposed Deliverable Date: July 15, 2011

Based on input from the Exchange design task 3.1.1.1, the sustainability task, and the options and responsible party analysis in this task, the third deliverable describes the requirements for the finance functions assigned to the Exchange and the cost of those functions. The refined requirements are presented in operational flow diagrams as well as narrative discussion. This information will feed into the final deliverable for Task 3.1.1.4.

### **3.1.2 Study of the Uninsured and Underinsured**

#### **Team Composition**

Lead: Brian Robertson, Ph.D.

Subject Matter Experts: N/A

Facilitation/Support: Karen O'Rourke

Modeling: Jason Maurice, Ph.D, Patrick Madden, Curtis Mildner

Liaison to State Steering Committee: Joshua Slon

#### **Experience**

Bailit has partnered with Market Decisions to provide the most qualified vendor to conduct this portion of the analysis related to the uninsured and underinsured population in Vermont. Market Decisions has conducted significant analysis of data focused on the uninsured and underinsured. This work has been conducted on behalf of a number of states over the course of the past 10 years including Maine, Vermont, Rhode Island, Pennsylvania, and Georgia, among others. This Bailit team partner, with its experience in analysis across a broad range of states as well as our long history of analysis in Vermont focusing on the uninsured and underinsured, is uniquely qualified for this study of the uninsured and underinsured.

Market Decisions has been working with the State of Vermont since 2000, developing, administering, analyzing data, and reporting results from a number of large scale health insurance surveys conducted on behalf of BISHCA's Division of Health Care Administration. Market Decisions has also provided ongoing analytical and technical services to the Division of Health Care Administration and other Vermont state agencies since 2005, providing ad-hoc analytical services to answer specific issues that have arisen during policy discussions especially those focused on health care reform.

### **Approach**

Market Decisions is already familiar with the data sources that will be of most value to this analysis and, in fact, has been using these data sets on an ongoing basis. Among existing data sources, the most useful are the Vermont Household Health Insurance Surveys (VHHIS). The data sets from the 2005, 2008, and 2009 survey provide the most comprehensive assessment of health insurance coverage and related issues available to the State. The data sets incorporate important measures that allow an analysis of the uninsured population. Further, the 2008 and 2009 surveys were specifically designed to include measures that would allow the development of models to better understand the underinsured population in Vermont. Market Decisions will use the results from the VHHIS in this study of the uninsured and underinsured, as they represent the most comprehensive and useful data sources. Market Decisions will also look at other data sources to determine whether they may also provide useful supplemental information. These might include the Vermont BRFSS, the Current Population survey and its annual supplement and other sources identified during a review of existing data in Vermont.

### *Analysis of the Uninsured Population*

Market Decisions has already conducted analysis of the uninsured population in Vermont and thus is familiar with the types of information that are available. This analysis will focus on a better understanding the demographics and needs of the uninsured population. The analysis of the uninsured will examine:

- demographic characteristics;
- employment characteristics;
- health access and barriers to care;
- eligibility analysis - eligibility of current state health insurance programs;
- eligibility analysis - potential eligibility for the Health Benefits Exchange and eligibility for subsidies;
- health care utilization;
- health care status and characteristics, and
- trending analysis of the uninsured.

These analyses will provide a comprehensive view of the uninsured population in Vermont. The results will be tailored to relate to the design of the Exchange and fed into the Exchange design process. In order to make this work most useful the analysis will be completed early in the contract period, with work commencing in December and results available to inform the Exchange Design Process in early 2011.

The VHHIS also includes other data that may help inform the design of the health benefits. The VHHIS surveys included a series of questions on knowledge and awareness of current state

health programs, pricing sensitivity, barriers to enrollment in current state programs, and problems experienced with enrolling in or receiving benefits through current state health insurance programs. The analysis of these types of information may provide insight into the development of marketing efforts as well as identifying potential difficulties any exchange may face. Bailit will work directly with state leaders during the roadmap development portion of the project and will coordinate any further analysis that the State believes is important to the overall Exchange design process.

#### *Analysis of the Underinsured Population*

To adequately measure underinsurance, it is important to first define what it means. In simplest terms, underinsurance is the absence of adequate health insurance coverage. It is often linked to the amount of out-of-pocket costs relative to income, the level of covered health benefits, and the inability or ability to access care.

Beyond this general description there is currently no consensus on the definition of underinsurance or how to measure it. Researchers seem to agree, however, on a conceptual framework of underinsurance. This framework focuses on three aspects of adequate health care coverage including:

Economic: Does an insured person have the ability to pay for health care needs and out of pocket costs (premiums, co-pays, deductibles). For example, did out-of-pocket costs or insurance deductibles exceed a certain percentage of a family's income, did medical expenses cause financial hardships for the family or did a person delay or not get care due to the cost of care?

Structural: Does an insured person's coverage provide a set of benefits that sufficiently meets their health care needs? For example, does the person's coverage pay for needed prescription drugs or behavioral health needs or did the person delay or not seek care because health care providers would not accept their insurance?

Attitudinal: Is an insured satisfied with their health care coverage or their perception of unmet health care needs? For example, self-ratings of one's insurance or concerns about a loss of insurance coverage are ways to assess this dimension.

Bailit has partnered with Market Decisions, in part, because the firm understands the aspects of adequate health coverage which factor into the modeling of the underinsured. Market Decisions has included questions in its health insurance survey research which address each of these factors using multiple indicators and have, in fact, developed models of the underinsured using this information. Bailit and Market Decisions staff will work with State staff to identify data sources and develop models of the underinsured suitable for the purposes of the State. As an initial data source we will develop models using appropriate questions from health insurance data collected by Market Decisions in previous administrations of the Vermont Household Health Insurance Survey. Similar to analyses conducted with the uninsured, Market Decisions would propose analyses by:

- demographic characteristics;
- employment/ employer characteristics;

- eligibility analysis – potential eligibility for the Exchange (for example eligibility for subsidies);
- health care utilization, and
- health care status and characteristics.

These analyses will provide a comprehensive view of the underinsured population in Vermont. The results will be tailored to relate to the design of the Exchange. Once again, this effort will begin early in the project, in December, and will be available to inform the Exchange design process.

**Specific Tasks**

- 3.1.2.1 Provide a proposed outline of specific analysis to be conducted to the State during initial meetings and obtain approval for approach
- 3.1.2.2 Conduct data analysis as approved by the State using existing data sources
- 3.1.2.3 Produce a draft report on uninsured and underinsured Vermonters from the data analysis
- 3.1.2.4 Review a draft report with the State Steering Committee
- 3.1.2.5 Produce a final report and PowerPoint for use in the Exchange design process

**Integration**

The analysis of the uninsured and underinsured populations of Vermont provides an important source of information in the design of the Exchange. Bailit therefore proposes a timeline that produces the analysis early on in the project so that it may be used during the Exchange design process. The uninsured and underinsured represent groups that will be among those most impacted by the Exchange, its benefits design, and its implementation. Understanding the characteristics of these populations will help the State tailor the Exchange to best meet their needs. Further, the analysis will also help the State potentially model eligibility for the Exchange and assess the level of subsidies that might be given to residents by the State.

Finally, it should be noted that this effort is not independent of the churn analysis and the stakeholder study specified in sections 3.1.7 and 3.1.4. All of these pieces will inform the Exchange design and Exchange implementation processes. The results of the existing data analysis, as proposed here in response to RFP section 3.1.2, will assist the Bailit team in facilitating discussions with state leaders around the type and timing of the efforts proposed in 3.1.7 and 3.1.4, and among all the areas that will help to inform the final Implementation Plan for the Exchange.

**Timeline of Activities/Deliverables**

Comprehensive Analysis

Proposed activity Start Date: November 15, 2010

Proposed Activity End Date: December 15, 2010

Bailit will leverage Market Decisions’ intimate knowledge of the VHHIS to provide the necessary analysis of results at the front end of the Exchange process.

Report of findings

Proposed activity Start Date: November 15, 2010

Proposed Activity End Date: December 15, 2010

Bailit will provide the State with a comprehensive report of all analyses. This report will include an executive summary of the analyses along with a more detailed discussion of findings. This report will be used to inform the overall Exchange process and can be used during the Exchange design phase by both the state-level steering committee and any stakeholder groups to provide the necessary baseline information for level setting any discussions.

### **Potential Sources of Data to Update Analysis of the Uninsured and Underinsured**

It is important to note that the State may re-administer the Vermont Household Health Insurance Survey in 2011. If the State does move forward with this new survey administration, this will become the key source of data for an analysis of the uninsured and underinsured. If the State does administer a new survey, it may wish to consider adding questions to the survey that focus specifically on Exchange. This would provide a very cost-effective method of obtaining data about the Exchange from residents without the need for a separate large scale survey. If the survey does move forward and the State decides to add questions, Market Decisions will work with the Department to develop these survey questions and provide the Department with analysis and reporting based on these additional questions. If any additional questions are added, Bailit will provide the State with a cost estimate for the additional survey items, analysis, and reporting.

### **Potential Follow-Up Research among the Uninsured and Underinsured**

Other optional sources of data may include follow-up research studies conducted among the uninsured and underinsured. The use of such follow-up studies would allow the State to target specific populations of interest and allow them to ask these groups specific questions about policies and their impact on residents. Such follow-up could be conducted by telephone or in person using structured interviews or focus group process. Beginning in 2005, Market Decisions created a mechanism on behalf of the Division of Health Care Administration to allow follow-up research among key segments of the population by integrating a question into the VHHIS that asked respondents for permission to contact them in the future for research purposes. This created a pool of respondents for follow-up research that could be targeted based on important characteristics. Market Decisions has already conducted one such follow-up study among the uninsured on behalf of the Vermont Office of Health Care Access using this pool of residents.

If the need arises for data from important population segments during the planning process for the Exchange, Bailit and Market Decisions could work with the State to define key population segments and conduct research among any identified groups. Market Decisions would then conduct research among such groups and provide a reporting of findings to the State. This could be a particularly valuable source of information if Vermont does administer the VHHIS in 2011. The use of such follow-up research would provide an opportunity to obtain detailed information from those likely to use the Exchange on key factors such as benefits design, the enrollment process, and how to inform and educate the public, among other topics.

If the Department does see the need for such follow-up research, Bailit and Market Decisions will work with the State to develop a research methodology, implement the research to gather



the data, and provide analytical and reporting services. Once a research methodology is developed, Market Decisions will provide the Department a cost estimate for the additional research, analysis, and reporting.

### **3.1.3 Actuarial Services in Support of Exchange Planning**

#### **Team Composition**

Lead: Stacey Lampkin

Subject Matter Experts: Karen Bender, Ed Fischer

Facilitation Support: Gary Hartnett

Modeling: Sheree Swanson

Liaison to State Steering Committee: Joshua Slen

#### **Experience**

For actuarial services, Bailit has partnered with Mercer, the world's largest employer of actuaries, with almost 900 on staff in North America alone. Mercer's Government Human Services specialty unit includes 16 actuaries, as well as several actuarial students. Mercer provides actuarial services for public programs all over the country and counts a number of the largest state programs as long-term clients. The assembled team consists of actuaries with experience in every aspect of insurance, health system design, and state level modeling. The team is designed to provide comprehensive actuarial services in support of Exchange Planning.

Mercer has significant experience evaluating and implementing components of federal health care reform, and all primary proposed team members have experience with large scale system reform. Even before passage of PPACA in March 2010, Mercer has been working with its state and employer clients to understand potential implications of federal health care reform proposals. Subsequent to PPACA passage, the firm has been incorporating consideration of reform implications into all work with state Medicaid clients. For example, recent state client reform on-going support has included:

- discussions regarding new Medicaid optional populations for immediate implementation as well as budgeting, rate setting and program implementation for 2014;
- development of a new 1115 demonstration which was recently approved to allow the implementation of optional populations prior to 2014;
- staffing weekly agency workgroup meetings on implementing PPACA requirements regarding behavioral health;
- assisting with identifying and applying for PPACA grants;
- communication and strategy regarding new requirements for family planning optional populations;
- understanding new requirements for pharmacy rebates and other ACA cost implications, working with States to address needed State Plan changes and testing the associated financial impact;
- communication and strategy regarding new local contribution rules (ARRA and PPACA), and
- training state staff on the PPACA implications for 1915i waivers.

#### **Approach**

Most of the ad hoc actuarial tasks under Section 3.1.3 call for a multi-disciplinary project team with in-depth knowledge and experience in the areas of health insurance, Medicaid, information systems, and state and federal regulations. Mercer's experts from Mercer Health & Benefits and Oliver Wyman can provide that wide-ranging expertise, taking advantage of years of experience working with state Medicaid agencies, state employee benefits agencies, employers, and health plans and providers across the country.

Mercer's experience valuing different benefit packages will also be critical for Vermont's reform policy development. The Mercer actuarial team has extensive experience testing the implications of different benefit and cost-sharing designs on premium levels and consumer behavior. This skill will be important both for estimating costs of expansion populations through the use of benchmark or benchmark-equivalent plan designs, as well as for estimating cost impact of requirements for Exchange products. Through work with CHIP programs and the new application of the benchmark-based designs through DRA, Mercer is very familiar with benchmark requirements and CMS's application of them. Mercer's commercial teams are very experienced with employer-sponsored benefit designs and how consumer behavior may change with changes in benefit coverage, contribution levels, and cost sharing.

In yet another PPACA key area, Mercer's experience with the theory, design, and implementation of risk adjustment mechanisms will be invaluable as Vermont determines the best way to meet federal requirements to risk adjust small group and individual plans both inside and outside the Exchange. The firm has established a team consisting of actuaries, consultants, and information technology analysts who are dedicated to completing each risk-adjustment assignment Mercer undertakes. To date, Mercer has helped 10 states implement or administer some form of risk adjustment in their Medicaid managed care programs. Mercer risk adjustment consultants have spoken at national risk adjustment conferences about emerging applications using risk adjustment tools. Mercer has experience with all the major risk adjustment groupers available for both risk-adjusting capitation payments and other purposes, including CRG, ACG, DCG, CDPS, Medicaid pharmacy, and Episode Treatment Group (ETG). With this team, Mercer can assure that Vermont will have access to the latest thinking regarding risk-adjustment concepts, policies, models, and applications.

Mercer will provide technical assistance and expert consultation on federal regulatory actions related to actuarial services for the Exchange and advise the State on the potential impact on State Operations.

To a large extent, several of the anticipated issues under the Exchange have similar requirements to the below approaches that Mercer has used for expansion coverage pricing:

**Identify usable data:** From the universe of possible information sources we will identify which agencies from other States best meet the needs of Vermont and utilize a regular survey process to gather information on HCR progress and ideas. We also recommend that we identify a subset of states that have the greatest similarity to Vermont in terms of characteristics and approach.

**Determine participation levels and enrollment ramp-up projections:** Some of the most challenging elements in designing and budgeting for a coverage initiative is understanding the enrollment levels likely to be attained, the speed at which they will be achieved, and the

potential for adverse selection. Mercer consultants have developed scenario models that draw on price elasticity of demand research, the demographic details of the target population, and customized elements of the planned program to provide insight into what these patterns might look like and the resulting budget implications.

To estimate ultimate participation rates and enrollment “ramp up” patterns, we use published research on price elasticity of demand for health insurance, population details obtained from the most recent health insurance survey, and the U.S. Census Bureau’s Current Population Survey (CPS). To those research indicators, we make adjustments that assume that all else being equal, younger and lower income individuals are less likely to take up health insurance than older and higher income individuals. We also consider the structure of the existing commercial market and other health insurance options reasonably available. In addition, we consider the premium contributions that will be required and level of outreach and marketing planned.

***Design the benefit package:*** Mercer consultants have assisted clients in developing coverage packages that are designed to address the needs of targeted subpopulations within the uninsured population. With the exception of specialized programs like high risk pools, uninsured programs generally should be carefully structured to minimize the impact on the existing commercial health insurance marketplace while meeting the needs of the uninsured. Eligibility rules, benefit packages, and cost sharing elements must work together to ensure the targeted populations receive the services they need while providing incentives to seek care in the most appropriate setting. These programs should be carefully positioned in comparison to existing commercially offered products so as not to generate undesirable impacts on the existing market.

***Utilization and Cost Analysis:*** Mercer actuaries use a wide array of professional experience and proprietary modeling tools to help clients understand the fiscal impact of the programs they consider. Using cost models developed specifically to estimate medical, dental, and pharmacy costs of low-income populations, your Mercer team can provide insight into expected costs associated with particular benefit packages and cost sharing structures – not only plan costs and premium levels, but also the implications for enrollee out of pocket cost sharing. We can quickly test the impact of changes in covered benefits or cost sharing so that you have the information you need to understand the trade-offs that exist between benefit comprehensiveness, covered populations, and budget implications.

As a final note, peer review at various steps in product development is a Mercer standard professional practice. Mercer ensures work is consistent with best practice and conforms to an objective of delivering work that is both excellent and error-free. Peer review plays a pivotal role in protecting and enhancing the reputation of Mercer overall, as well as individual consultants. All professional work must be thoroughly peer reviewed by properly qualified colleagues before being released to the client.

All work products will be peer reviewed for:

- technical accuracy of all calculations and work products including overall reasonableness;
- consulting appropriateness to ensure soundness of the approach and that the appropriate issue/question has been completely addressed in a clear manner;
- editorial correctness, and

- final look to ensure a professional work product appearance that meets delivery and other specifications.

### **Integration**

The work being performed under Section 3.1.3 will be driven in large part by the decisions made during the planning work performed under Section 3.1.1.

Bailit and Mercer have current and prior experience working together as prime and sub contractors, with great success in using a coordinated and collaborative well-defined communication process to ensure efficiency and added-value in a multi-firm approach.

### **Timeline**

Timelines for the ad hoc actuarial services will vary based on the tasks at hand. Mercer will be proactive and responsive, ensuring that we leverage the opportunity to add value through timely provision of actuarial services as needed.

### **Deliverables**

The deliverables for the ad hoc actuarial services will vary based on the tasks at hand. Actuarial deliverables are typically comprised of a methodology letter that reviews the data, approach, assumptions and limitations along with pricing exhibits. Additionally, Mercer will provide a presentation deck or other deliverables as needed, based on the audience.

## **3.1.4 Formal Stakeholder Study**

### **Team Composition**

Lead: Brian Robertson, Ph.D.

Subject Matter Experts: N/A

Facilitation/Support: N/A

Modeling: Jason Maurice, Ph.D, Patrick Madden, Curtis Mildner

Liaison to State Steering Committee: Joshua Slen

### **Approach**

Bailit Health Purchasing and Market Decisions agree that stakeholder involvement in the planning for the insurance exchange is crucial to acceptance and support of the ultimate design. Ongoing, iterative feedback from stakeholders will need to take place as part of regularly scheduled meetings. Many and perhaps all of which already exist as standing meetings (e.g. Health Care Reform Committee, Health Access Oversight Committee, The Medicaid Advisory Board, and the HIT-HIE Exchange stakeholders group led by Hunt Blair. This section is focused on a formal stakeholder engagement and as such must add to the regular iterative feedback obtained in other forums. We have therefore approached this exercise by population and designed an approach that can be modified based on the needs of the State as identified early on in the Roadmap and Design phases.

The State has identified more than a dozen important stakeholder groups, including:

- people covered by health insurance programs;
- people covered by private health insurance programs;
- state legislators;

- individuals with disabilities and special health needs;
- small and large employers;
- non-profit organizations;
- insurance companies;
- insurance producers;
- community-based organizations;
- health care providers (including primary care, as well as other physical and mental health providers);
- brokers and agents, and
- stakeholders involved in public health.

To completely collect feedback from each of these groups would require a survey and perhaps focus groups from each. This magnitude of work would be extremely costly and is probably not necessary. To meet a reasonable budget it is necessary to identify the most important stakeholders and focus resources and attention on these.

A key consideration in the design of stakeholder feedback is the timing of it. Is it feedback that is important before, during or near completion of Exchange design and planning? If input from a group is important early in the process of design and planning then more qualitative research such as focus groups and in-depth interviews are advised. If the feedback is intended to determine preferences for options or the level of approval for a design then a quantitative survey such as an online survey or a telephone survey would be better.

Whatever stakeholder group is selected as a priority for feedback or whatever the timing of the input, Bailit partner Market Decisions is prepared to employ the most technically appropriate and cost effective data collection methodology. Market Decisions is a full-service research firm that conducts focus groups, in-depth interviews, telephone surveys or e-mail surveys, using own in-house staff, technology and other resources. Bailit and Market Decisions propose the use of four different data collection methodologies.

#### *The Uninsured (and optionally the insured)*

Since the Exchange is designed to provide insurance to the uninsured, this is a particularly important stakeholder group. The uninsured are focused entirely on their own needs and are likely to have more practical concerns than other stakeholder groups, such as those representing them in politics or in government and non-profit social service agencies. The uninsured should have input into the mechanics of the Exchange.

Bailit believes that input from the uninsured at the beginning of the Exchange is essential, so we propose conducting at least four focus groups among them. If a final check on the design or a selection from design options based on preferences of the uninsured is desired, then a telephone survey could be subsequently be conducted among the uninsured (this telephone survey is not budgeted in the proposal and is provided as an option).

Both the focus groups and a potential telephone survey could use the sample of uninsured that exists from the Vermont Household Health Insurance Study conducted by Market Decisions in 2009. This sample, however, is already two years old, and is only sufficient for a telephone

survey of perhaps 100 respondents and/or 2-4 focus groups. Bailit proposes here conducting focus groups and optionally a telephone survey.

Additional research may be conducted using a pool of respondents drawn from the Vermont Household Health Insurance Study if the survey is repeated in 2011. This would provide an update to the research based on respondents drawn from the 2009 survey and provide the opportunity to obtain information later on in the design process. If the survey is indeed administered in 2011, Market Decisions will work with the Department to determine the need for additional research, identify important populations, and develop an appropriate research methodology. Market Decisions will also provide a cost estimate for any additional research efforts once they are defined. As an option, the survey of the uninsured could be expanded by including a random sample of Vermont residents, posing many of the questions in the survey administered to the uninsured. This sample would include those on both private and public insurance plans (once again, this option is not budgeted in the current proposal).

#### *Stakeholder input options*

- Proposed: Four focus groups among the uninsured for input
- Optional (not budgeted): 100 sample telephone survey among the uninsured
- Optional (not budgeted): 200 telephone surveys among private and public insured

In designing the focus groups, Market Decisions will:

- develop a discussion guide in consultation with the State;
- identify appropriate respondents for participation in the sessions in consultation with the State;
- identify potential participants and secure sample lists for such participants;
- identify dates for the groups in consultation with the State;
- coordinate facility arrangements for the groups;
- develop participant selection criteria and "screeners" for use by interviewers;
- recruit participants by senior interviewers;
- facilitate the groups with a RIVA Institute-trained moderator;
- provide incentives to participants;
- provide the State with DVD recordings of groups, and
- provide a full analytical report which includes a summary of key findings and detailed findings annotated and illustrated with respondent comments.

#### *Insurance Companies*

Since the insurers will be providing the insurance input from this group will be critical. We propose that input from this group be solicited up front, in the form of one-on-one in-depth interviews with insurance company executives. We find that with executives, a series of 6-10 in-depth interviews are optimum number to gather complete and useful information. Interviews beyond this number are often duplicative, and below this number are too few to capture divergent views. For this assignment we will send a pre-survey outline of questions to facilitate the interviews. All interviews would be conducted by senior interviewers who are experienced and can relate to senior executives.

These initial interviews can become a “panel” of respondents who can be tapped later in the design and planning process. We propose as design options are contemplated, that we can send an e-mail invitation to complete an online questionnaire to these same executives. This survey would include both close-ended questions (Example: Do you support?) and open-ended questions (Example: Why do you say that?) to provide specific input into the Exchange design.

#### *Stakeholder input options*

- Proposed: Set of 6-10 in-depth interviews
- Proposed: Follow-up online survey

In conducting the in-depth interviews, Bailit will:

- develop a custom qualitative interview in consultation with the State;
- training and brief interviewers on the study;
- develop or receive a sample with the names and telephone numbers of prospective respondents to be interviewed in the project;
- conduct up to 20 interviews each approximately 15-20 minutes in length using trained and monitored senior interviewers;
- transcribe interviews in notes style;
- code and edit open-ended comments;
- provide a full analytical report which includes a summary of key findings and detailed findings annotated and illustrated with respondent comments.

In conducting the online survey, Bailit and Market Decisions will:

- develop a custom survey questionnaire in consultation with the State;
- program an Internet survey;
- prepare a sample for e-mail invitations and send invitations to potential respondents;
- send E-mail reminders to non-respondents;
- collect completed surveys;
- code and edit open-ended comments;
- program software to produce tabulations of response frequencies and cross tabulations of responses by characteristics of interest to the State;
- provide frequencies and cross tabulations to the State, and
- provide a full analytical report with key findings, detailed findings including charts or graphs on all questions and cross tabulations by respondents’ descriptive characteristics.

#### *Non-profit Organizations, Community-based Organizations and Stakeholders Involved in Public Health*

These groups are likely to have the greatest on-the-ground knowledge of health insurance issues among the people they serve. While they have a different perspective than the uninsured, their experience serving and protecting the interests of the uninsured is unique. It will be important and productive to involve each of these groups in discussions early in the planning and design process. .

We propose a series of 12-20 in-depth interviews to inform the exchange design and planning process. As with the insurance company executive interviews we would send a pre-survey outline of questions and all interviews would be conducted by senior interviewers to make them as productive as possible. We propose to allow input as design options present themselves, thus we would suggest a follow-up online survey. Such a survey could also include additional members of these stakeholder groups

*Stakeholder input options:*

- Proposed: Set of 12-20 in-depth interviews
- Proposed: Follow-up online surveys

*State Legislators*

This stakeholder group can be most productively reached with an online survey, since e-mail addresses for legislators are complete and readily available. Given the ease of reaching them we propose two surveys be conducted, one survey early in the process and one near the end. The initial survey will seek input and the final survey would determine final options and seek approval.

*Stakeholder input options:*

- Proposed: Initial online survey
- Proposed: Follow-up online survey

*Optional Populations to Include in the Formal Stakeholder Study*

The following group is not currently budgeted in the proposal but could be included in the stakeholder analysis at the discretion of the state, and at additional cost.

*Insurance Brokers and Insurance Producers*

For this group we suggest a series of 12-20 in-depth interviews. To make these interviews as productive as possible, a pre-survey outline of questions would be sent and all interviews would be conducted by senior interviewers .

To allow input as design options present themselves the in-depth interviews could be followed up with an online survey.

*Stakeholder input options:*

- Optional: Set of 12-20 in-depth interviews
- Optional: Follow-up online surveys



### **Specific Tasks**

- 3.1.4.1 Identify needs during the Roadmap and early Exchange Design process using the State Steering Committee and by tapping into existing stakeholder groups.
- 3.1.4.2 Develop Work plan and time line that best aligns with overall Exchange Design efforts.
- 3.1.4.3 Develop interview tools, online questionnaires, and follow-up protocols.
- 3.1.4.4 Review the interview tools, online questionnaires, and follow-up protocols with the State Steering Committee.
- 3.1.4.5 Field the online questionnaires and interview tools.
- 3.1.4.6 Follow-up as planned.
- 3.1.4.7 Develop reports and Power point presentations of results.
- 3.1.4.8 Feed the results back into the Exchange Planning Process.

### **Integration**

The stakeholder process will be fully integrated in order to align timing and content with the overall Exchange design process and with the other tasks such as the churning assessment in section 3.1.7. The stakeholder work will take place over four months between January and April. The information obtained during the stakeholder process will be fed into the overall Exchange design process at key points. In addition, the churning assessment will be closely connected to the work being conducted within the stakeholder analysis to assure that we leverage information gleaned in one setting to improve targeted outreach for the next event. The telephone survey and subsequent key informant interview processes described in our response to section 3.1.7 will occur in January and March, respectively. While there will be a considerable amount of coordination necessary, we believe that the stakeholder process and the key informant interviews as part of the churning analysis can be accomplished over the January - April timeframe such that one piece informs and supports the other and both feed into the Exchange design process.

### **Timeline of Activities/Deliverables**

#### Determine timing and content to align with existing Vermont stakeholder efforts

Proposed Activity Start Date: November 10, 2010

Proposed Activity end Date: December 1, 2010

#### Produce Draft interview tools, online questionnaires, and follow-up protocols Presentation to the State Steering Committee

Proposed Activity Start Date: December 1, 2010

Proposed Activity end Date: January 1, 2011

#### Field the interview tools, online questionnaires, and follow-up as appropriate

Proposed Activity Start Date: January 2, 2011

Proposed Activity end Date: March 15, 2011

#### Feedback the information gained iteratively into the Exchange Planning process

Proposed Activity Start Date: January 2, 2011

Proposed Activity end Date: July 30, 2011

### Produce draft and final reports

Proposed Activity Start Date: March 15, 2011

Proposed Activity end Date: July 30, 2011

## **3.1.5 Bailit Response**

### **Team Composition**

Lead: Michael Bailit

Subject Matter Experts: Beth Waldman

Facilitation Support: N/A

Modeling: Michael Joseph, Gary Hartnett, and Stacey Lampkin

Liaison to the State Steering Committee: Joshua Slen

### **Experience**

Bailit has direct and ongoing experience monitoring the performance of the Vermont health insurance market since 1997. Bailit advised the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) on the implementation of Rule 10, the State's consumer protection and quality requirements for managed care organizations, beginning in 1997. Since 1999 Bailit has performed the following oversight activity:

- analysis of annual insurer data filings
- triennial reviews insurer compliance with state regulations
- periodic focused reviews of insurers in areas of concern to BISHCA;
- market conduct reviews of insurers in areas of concern to BISHCA, and
- monitoring of mental health reviewer compliance with Regulation 95-2 (since 2002).

Beginning in 2007, Bailit began work to assist BISHCA with rewriting Rule 10 to reflect changes that had occurred in the health insurance industry in Vermont since Rule 10 was conceived a decade earlier. This resulted in Regulation H-2009-03, Consumer Protection and Quality Requirements for Managed Care Organizations, which replaced Rule 10 and became effective in December of 2009.

We will use this experience as a platform for conducting the insurance market assessment.

### **Approach**

Our first step will be to profile the health insurance market in Vermont, by examining the predominant products currently being sold in the state. We are aware that there are currently no capitated Medicaid managed care plans, and that the Medicare Advantage market is quite small. Therefore we will focus on the commercial market, which is dominated by Blue Cross Blue Shield of Vermont, with two other insurers, CIGNA and MVP Health Care, playing lesser but considerable roles. We will also recognize the role of other, smaller market share insurers who have historically played a role filling niches within the insurance market, including for limited benefit plans. As has already been demonstrated within other states, some of the insurers serving niche markets are leaving those markets in reaction to the ACA.

In looking at these commercial insurers, we will seek to understand the most prevalent products being sold by market segment, and the designs of those products, including covered

benefit provisions and enrollee cost-sharing provisions. We will assess how those product designs comport with the ACA, and how those designs might be maintained or modified within an Exchange. Whereas in some states existing Medicaid managed care plans are considered to be the most likely Exchange insurers, that will not be an option in Vermont given the State's use of a primary care case management program for Medicaid managed care.

We will also examine the payment arrangements that insurers are employing with providers. From our 14 years of working in Vermont, we know that fee-for-service payment is the overwhelmingly predominant model, with limited risk-based payment arrangements with entities such as Vermont Managed Care. We are also aware, however, that there are changes underway in payment systems, including the following:

- Vermont Blueprint for Health: The Blueprint is implementing a new system for paying for primary care. Having begun in three communities, it is now following a phased implementation in order to transform Vermont primary care practices into medical homes. Practices receive supplemental payments in return for medical home recognition. In addition, the three largest commercial insurers help to fund complementary Community Health Teams.
- Accountable Care Organization (ACO) Pilots<sup>1</sup>: After conducting a feasibility study in 2008, the State began work in 2009 to develop ACO pilots. These arrangements are initially to be implemented with payers setting budgets for a population for which an ACO will be responsible, and then sharing any savings that the ACO may produce.

Based on this analysis, and an assessment of the likelihood of any new insurers entering the market as a result of Exchange creation, we will evaluate the Exchange design and implementation questions enumerated within the RFP, including:

- quality and quantity of grandfathered plans;
- premium impact of reforms;
- the breadth and future of the limited benefit plan market;
- pros and cons of allowing a catastrophic health plan;

In addition, we will consider the following additional Exchange design and implementation questions that we have identified based on our team's experience with Exchange implementation in Massachusetts, and with Exchange design in Maine.

- will there be an active insurance market outside of the Exchange?
- who will be able to purchase through the Exchange? Will large businesses be able to enroll?
- who will serve as Navigators and how will it impact the role of brokers in the insurance market?

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<sup>1</sup> J. Hester, J. Lewis, and A. McKethan, The Vermont Accountable Care Organization Pilot: A Community Health System to Control Total Medical Costs and Improve Population Health, The Commonwealth Fund, May 2010

- what are the potential incentives/disincentives for employers to continue to provide coverage in an Exchange environment?
- how can Vermont avoid adverse selection inside and outside of the Exchange?

In order to evaluate the aforementioned Exchange design and implementation questions, Bailit will rely on the following resources. First, we will consider the practical experience of Massachusetts. While the Vermont and Massachusetts insurance markets are quite different, Massachusetts provides one of the few operational examples of a functioning Exchange and there are lessons to be taken from that experience. <sup>2</sup>Second, we will utilize our recent work in Maine to inform our analysis. Third, we will consider available published analyses of the ACA impact on health insurance markets. There are many of these, and we will critically consider them. Fourth, we will consider the existing product offerings of Vermont health insurers and interview executives from the three largest insurers in the state, Blue Cross Blue Shield of Vermont, CIGNA, and MVP Health Plan, as well as two carriers specializing in the limited benefit plan market. Finally, Bailit personnel will consult with our actuarial partner Mercer to model likely impact based on information gathered from all of the above activities.

### **Specific Tasks**

- 3.1.5.1 Profile existing insurance market
- 3.1.5.2 Assess how existing products comport with ACA
- 3.1.5.3 Examine payment arrangements between insurers and providers
- 3.1.5.4 Leverage Massachusetts experience to draw information into the Vermont analysis
- 3.1.5.5 Model with our Mercer partners
- 3.1.5.6 Produce a draft report for presentation to the State Steering Committee
- 3.1.5.7 Produce a final report after obtaining feedback from the State Steering Committee. This report will be used to inform the Exchange Design process.

### **Integration**

Recognizing that analysis of these policy issues and resulting policy decisions will impact many Exchange design and implementation decisions, Bailit will complete the health insurance market assessment within 60 days of the contract start date, producing a first draft for the State within 45 days, and the final draft within 60 days.

### **Timeline of Activities/Deliverables**

#### Conduct Analysis of VT Insurance Market

Proposed Activity Start Date: November 10, 2010

Proposed Activity end Date: December 15, 2010

#### Produce Draft Report for Presentation to the State Steering Committee

Proposed Activity Start Date: December 15, 2010

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<sup>2</sup> For an example of Exchange comparisons please see Appendix B for a comparison of the Massachusetts and Utah Exchanges.

Proposed Activity end Date: December 25, 2010

Produce Final Report

Proposed Activity Start Date: December 25, 2010

Proposed Activity end Date: January 10, 2010

### **3.1.6 Assessment of Current Programs and Integration Opportunities**

#### **Team Composition**

Lead: Joshua Slen

Subject Matter Experts: Michael Bailit, Beth Waldman, Amy Lischko

Facilitation Support: Sue Frechette

Modeling: Michael Joseph, Mark Podrazik, Sheree Swanson

Liaison to State Steering Committee: Joshua Slen

#### **Experience**

As discussed in other sections of this proposal Bailit and its partners will be leveraging Bailit's deep Vermont experience and experience working specifically on Exchange issues in other states to complete the tasks in this section.

Bailit's partners, The University of New England, Market Decisions, Mercer, and Burns and Associates all bring significant Vermont expertise along with subject matter specialization that will assist not only in the other sections, but which we can leverage in answering the questions posed by the State as part of this portion of the scope of work.

#### **Approach**

The State has asked for a comprehensive assessment of health care benefit programs across the private and public sectors with the anticipate goal of aligning or standardizing benefit packages in order to minimize coverage disruptions and to maximize care continuity. The State has further requested that where integration is not possible the State would like assistance in examining the best methods to explain benefit and other program feature differences to maximize consumer understanding and participation. The State wishes to answer the following questions:

- How does the "essential health benefit" package as described in ACA compare to current coverage in Vermont for Medicaid and CHIP beneficiaries, beneficiaries with income between 100% FPL and 133% FPL (currently enrolled in Vermont's VHAP program), and federally-defined "benchmark coverage." How do other programs, such as Catamount Health, compare to ACA benefit packages that may be designed for the Exchange?
- How can Vermont standardize plans, or approach standardization, such that beneficiaries moving among plans will have maximum continuity of coverage?
- Would the adoption of the Basic Health Plan for people between 133% and 200% provide greater continuity of coverage than private plans offered through the Exchange? What are the costs and benefits of developing a Basic Health Option in Vermont?

In addition to these questions, Bailit suggests that the State may want to consider the following additional questions related directly to the integration of care:

- How can the State leverage the HIE infrastructure and the VHCURES multi-payer database to measure outcomes over time?
- What reporting structures can be put in place today to assist the State in measuring goal achievement related to standardized benefit packages, outreach and education regarding coverage options to the general population and to targeted populations, and quality benchmarking for health outcomes of different plan designs offered through the Exchange?
- What can be learned from other states regarding best practices around continuity of coverage?
- What information can be gleaned from existing Vermont data sources about the uninsured, underinsured, and those who move in and out of coverage that would assist in designing plans that improve the overall insured rate among the Vermont population?
- What impact will the individual mandate alone have on continuity of coverage without any other action?

As part of our review of benefit design we will look not only at the structure of the covered services offered by the insurers, state programs, and within the ACA, but also at the current commercial and public outreach, eligibility processes, enrollment and disenrollment processes, care coordination programs, claims payment activities, information systems, and quality standards. We will leverage our knowledge of the commercial insurers' quality activities in Vermont to direct information into the Exchange process over the entire term of the project. We view these activities as interconnected to all the other sections of the report. Therefore, there are dependencies on both sides and opportunities for us to leverage work in other sections to inform work here. There are also numerous opportunities to channel information into the Exchange design process over the course of the contract period. As a result, we propose two interim reports and one final report with comparisons across private and public programs in Vermont and to ACA benefit designs. These will include recommendations that will assist in guiding the discussion at the State Steering Committee level around the design and implementation of the Exchange.

At the onset of the contract we will use the State Steering Committee to discuss the approach to this section and to finalize a work plan within the first 30 days of contract signing.

The interdependencies are numerous between how we plan to complete the Exchange tasks under 3.1.1 and that which the State seeks in this section of the RFP. The State will note that some of the questions asked above are in fact presented within our response to other sections, including 3.1.1 as questions that we intend to answer when completing the work on those sections. For example, we have previously discussed comparing existing benefits in Vermont's public programs to ACA benefit packages. This is work that Joshua Slen is currently doing in West Virginia for that state's Medicaid agency in developing a model for early expansion options within that state. In section 3.1.5 we discussed our depth of experience with Vermont's commercially insured marketplace and our approach to providing an in-depth comparison of ACA to Vermont's current commercially available products. This section (3.1.6) asks for additional but related analysis. We will leverage existing information from sections dealing

with the uninsured and underinsured as well as the stakeholder and churning analyses to inform and guide the work here.

We will begin by utilizing the work performed for the section 3.1.5 tasks to provide a baseline regarding the benefit packages available in the commercially insured market. We will compare the commercially available benefit packages to those available through Vermont's public programs. We will leverage the work we are currently doing in other states on federal health care reform to allow us to extend these Vermont specific comparisons to compare against the "essential health benefit package" as described in the ACA. We will produce a crosswalk that shows the similarities and differences between benefit packages offered on the commercial market and within Vermont's public programs and between both of these and the ACA benefit packages.

All of the work completed under this section will be organized under the broad category of benefit design comparison and then into each of the following subcategories as identified by the State in the RFP:

- outreach;
- eligibility processes;
- enrollment and disenrollment processes;
- care coordination programs;
- claims payment activities;
- information systems, and
- quality standards.

The work in this section will be further organized to provide recommendations in each of two interim reports and a final report addressing:

1. opportunities for integration of efforts across the system in each area above, and where that is not possible, and
2. opportunities for information dissemination to Vermonters.

There is much that we already know. For example, a quick view of the VHHIS information shows that there was a drop in uninsured young adults at the same time that Catamount rolled out an aggressive outreach campaign targeted at young adults (including direct partnership with Vermont's colleges and universities to get graduating seniors to understand the importance of insurance). There are many other such examples to be identified in Vermont's existing data and fed into the Exchange design process.

### **Specific Tasks**

3.1.6.1 Create a matrix comparing benefit design across outreach, eligibility processes, enrollment and disenrollment processes, care coordination programs, claims payment activities, information systems, and quality standards between commercial and public programs in Vermont and ACA benefit options.

3.1.6.2 Model the impact of different benefit package designs on enrollment

- 3.1.6.3 Extend the churning analysis to include the potential impact of benefit design churning within the Exchange
- 3.1.6.4 Provide and interim report with recommendations to the State Steering Committee
- 3.1.6.5 Analyze the information available within from VHHIS as part of section 3.1.2 work to identify opportunities for outreach to specific populations
- 3.1.6.6 Design an integrated work plan that allows the work under this section to benefit from the work in the other sections and vice versa
- 3.1.6.7 Leverage the stakeholder meetings conducted in response to section 3.1.4 requirements to obtain necessary information to complete this task
- 3.1.6.8 Meet with Blueprint for Health staff to discuss statewide care coordination activities and feed the results of these meetings (we anticipate several meetings over the course of the project) into the overall Exchange discussion
- 3.1.6.9 Work with the State to design the appropriate opportunities for state program-level input into the Exchange Design and Implementation process. This will include not just DVHA but other Agency of Human Services staff along with BISHCA, Workers Compensation, and Human Resources (State Employee Health Plan).
- 3.1.6.10 Draft two separate interim reports under this section in January and April to inform the Exchange design and implementation processes, respectively
- 3.1.6.11 The final output from this effort will be in the form of matrices comparing different options and recommendations and will be provided to the State Steering Committee. These final recommendations will be made in report format in June.

### **Integration**

As described throughout this section, we see the work here as completely intertwined with the work to be accomplished throughout the other sections of the RFP. We anticipate taking advantage of work in other sections to assist in moving the work forward in response to this section's requirements. We also see the work to be accomplished here as work that will greatly benefit the Exchange design and implementation planning activities. For this reason we propose two interim reports and a final report that will feed off of other sections and into the Exchange process throughout the contract period.

### **Timeline of Activities/Deliverables**

#### Matrix Comparing Commercial and Public Benefit Designs with ACA Options

Proposed Activity Start Date: November 10, 2010

Proposed Activity Deliverable Date: December 31, 2010

#### First Interim Report with Recommendations

Proposed Activity Start Date: January 1, 2011

Proposed Activity Deliverable Date: January 15, 2011

#### Second Interim Report with Recommendations



Proposed Activity Start Date: April 1, 2011  
Proposed Activity Deliverable Date: April 15, 2011

Final Report with Recommendations

Proposed Activity Start Date: June 1, 2011  
Proposed Activity Deliverable Date: June 15, 2011

**3.1.7 Formal Assessment of “Churning”**

**Team Composition**

Lead: Dr. Ronald Deprez  
Subject Matter Experts: Carry Buterbaugh, Hank Stabler  
Facilitation/Support: N/A  
Modeling: N/A  
Liaison to the State Steering Committee: Joshua Slen

**Experience**

As the investigators of a two-year comprehensive evaluation funded by the Robert Wood Johnson Foundation (RWJF) examining the impact of health care reform in Vermont initiated by the 2006 Health Care Affordability Acts (HCAA), University of New England staff from the Center for Community and Public Health (CCHP) staff have preeminent knowledge and experience examining issues related to enrollment in public and publicly subsidized health insurance programs in Vermont, including churning. The findings from the two most recent reports have been used – and will continue to be used – to inform necessary changes in public policy related to the provision of health insurance in Vermont.

Churning, which is the enrollment and subsequent disenrollment from and between State programs, was found to be occurring among Catamount Health enrollees at a higher than expected rate; Catamount Health enrollees have coverage, on average, for only 6-7 months. In interviews with state stakeholders, many cited the complicated renewal process, as well as the cost of the program, as leading factors for the higher-than-expected levels of churning. This churning finding will have critical implications for the cost of the program in terms of administrative expense as well as for the continuity of care received by program enrollees. This is an area that requires further research and has implications of federal health insurance reform, especially in the development of the Exchange.

**Approach**

Bailit Health Purchasing and CCHP will use the 2005, 2008, and 2009 results from the Vermont Household Health Interview Survey (VHHIS) conducted by Market Decisions, as well any available administrative enrollment data from DVHA, to expand on these findings and further explore issues related to churning. Specifically, CCHP will develop survey tools and follow up with individual consumers who responded to the VHHIS survey and consented to be contacted again - both those who have dropped coverage and those who remain covered – to explore their experiences in Catamount Health and the primary reasons for dropping or retaining coverage. We will share these findings with a core group of state officials and other key stakeholders to inform the development of recommendations to ameliorate the problem in the Exchange. We also will analyze churn rates in states with comparable health insurance programs and explore how these states have attempted to mitigate the health benefit disruptions for consumers and

administrative burdens associated with churning. Our final report containing recommendations for addressing churning will follow shortly thereafter.

### **Specific Tasks**

- 3.1.7.1 Meet with state officials / consultant team to finalize work plan for Churning analysis (November)
- 3.1.7.2 Identify, develop and analyze data from any additional secondary data (e.g. administrative enrollment data from DVHA) (December)
- 3.1.7.3 Develop consumer survey instrument (December)
- 3.1.7.4 Identify consumers willing to be contacted from VHHIS survey (December)
- 3.1.7.5 Administer the telephone survey with identified consumers (January)
- 3.1.7.6 Analyze the results and prepare draft report on survey results to inform the Exchange Design process (February)
- 3.1.7.7 Conduct key informant interviews (aligned and integrated with the stakeholder study effort described in response to section 3.1.4) (April)
- 3.1.7.8 Identify steps and improvement processes that could be successfully adapted in Vermont to mitigate the effects of churning (May)
- 3.1.7.9 Prepare draft and final report with recommendations (May-June)

### **Integration:**

This task will inform the overall Exchange process and will specifically contribute to the Implementation Plan portion of the Exchange process. Information obtained and refined in the churning analysis will allow for state-level planning to proceed around implementation options that are most likely to be effective at reducing the churn rate in the State's public programs. To the extent that this is determined during the roadmap phase of the project to be a priority in Exchange design it will be important to feed the results of this analysis into the Exchange process during discussions about design and, most importantly, during the implementation discussions. Due to the timing of activities it is likely that some pieces of information will be available during the Exchange design phase while the final report will not be available until the implementation phase of the Exchange planning process.

### **Timeline of Activities/Deliverables:**

#### **Analyze existing data:**

Proposed Activity Start Date: November 15, 2010

Proposed Activity End Date: December 20, 2010

Produce an analysis of existing data available on the population from the VHHIS survey along with enrollment data from DVHA.

#### **Develop survey tool for consumer analysis:**

Proposed Activity Start Date: December 1, 2010

Proposed Activity End Date: December 31, 2010

A copy of the survey tool will be made available to key stakeholders prior to conducting consumer analysis.

#### **Draft report on findings:**

Proposed Activity Start Date: February 15, 2011  
Proposed Activity End Date: February 28, 2011

Once consumer analysis has been completed, CCHP will provide an overview to key stakeholders that will be used to inform the Exchange design process.

**Key informant interviews:**

Proposed Activity Start Date: March 1, 2011  
Proposed Activity End Date: April 30, 2011

Results will be shared with key stakeholders and will be used to inform the Exchange design process.

**Final Report with recommendations:**

Proposed Activity Start Date: May 1, 2011  
Proposed Activity End Date: June 15, 2011

The team will produce a draft final report for review with the State Steering Committee. This draft final report will encompass each objective, and include recommendations for action. After review with the State Steering Committee we will produce the final report.

## Cost Proposal

	Name	Joshua Slen	Beth Waldman	Amy Lischko	Michael Bailit	Michael Joseph	Mark Podrazik	Peter Burns	Stephen Pawlowski	Karen Bender/Ed Fischer/Stacy Lampkin/Sheree Swanson	Curtis Mildner/ Brian Robertson	Jason Maurice/ Patrick Madden	Research Support Staff	Senior Interviewing Staff
	Hourly Rate	\$ 232	\$ 232	\$ 225	\$ 232	\$ 150	\$ 200	\$ 250	\$ 190	\$ 300	\$ 125	\$ 100	\$ 65	\$ 35
Section #	Title													
3.1.1	Study of Exchange Design Options, Development, Design, and Implementation Plan													
3.1.1.1	Roadmap for Planning	48	48	48	8	8	8							
3.1.1.2	Exchange Design Options	96	96	96	20		40	36	24					
3.1.1.3	Creation of an Implementation Plan	40	32	32	4	32	8	8						
3.1.1.4	Recommendation for Exchange Financial Sustainability	24	24	16	8	16	40	32	40	60				
3.1.1.5	Recommendations related to Exchange Finance Functions	20	12	12			40	16	24					
3.1.2	Study of the Uninsured and Underinsured	15									72	112		
3.1.3	Actuarial Services	0								0				
3.1.4	Formal Stakeholder Study	60			40		32				200	80	85	100
3.1.5	Study of Current Insurance Market	15	24		40	30				20				
3.1.6	Assessment of Current Programs and Integration Activities	60	40	20	40	40	40			60				
3.1.7	Formal Assessment of "Churning"	20												
TOTAL		398	276	224	160	126	208	92	88	140	272	192	85	100

	Name	Interviewing Staff	Data Entry/ Clerical Staff	Ronald Deprez	Karen O'Rourke	Carry Buterbaugh	Hank Stabler	Sue Frechette	Erica Garfin	TOTAL hours	Total Direct Labor Costs
	Hourly Rate	\$ 28	\$ 35	\$ 238	\$ 119	\$ 85	\$ 63	\$ 200	\$ 125		
Section #	Title										
3.1.1	Study of Exchange Design Options, Development, Design, and Implementation Plan										
3.1.1.1	Roadmap for Planning							8	48	224	\$ 45,328
3.1.1.2	Exchange Design Options							48	100	556	\$ 114,444
3.1.1.3	Creation of an Implementation Plan							40	16	212	\$ 43,232
3.1.1.4	Recommendation for Exchange Financial Sustainability									260	\$ 60,592
3.1.1.5	Recommendations related to Exchange Finance Functions									124	\$ 26,684
3.1.2	Study of the Uninsured and Underinsured									199	\$ 23,680
3.1.3	Actuarial Services									0	\$ -
3.1.4	Formal Stakeholder Study	75	20		50				60	802	\$ 87,838
3.1.5	Study of Current Insurance Market									129	\$ 28,828
3.1.6	Assessment of Current Programs and Integration Activities							20		320	\$ 72,980
3.1.7	Formal Assessment of "Churning"			20		130	130			300	\$ 28,640
TOTAL		75	20	20	50	130	130	116	224	3126	\$ 532,246

## Bailit Health Purchasing - DVHA Health Benefits Exchange Planning Proposal

### Travel and Focus Group Costs

	Other Expenses	Travel	Focus Group (Rooms, Recording, Incentives)	Details
Section #	Title			
3.1.1	Study of Exchange Design Options, Development, Design, and Implementation Plan			
3.1.1.1	Roadmap for Planning	\$2,700		Six meetings over eight weeks with two to three Bailit Team members attending
3.1.1.2	Exchange Design Options	\$10,800		Twenty-four meetings over 16 weeks with two to three Bailit Team members attending
3.1.1.3	Creation of an Implementation Plan	\$2,700		Six meetings over twelve weeks with two to three Bailit Team members attending
3.1.1.4	Recommendation for Exchange Financial Sustainability	\$2,700		Six meetings over twenty four weeks with two to three Bailit Team members
3.1.1.5	Recommendations related to Exchange Finance Functions	\$1,800		Four meetings over sixteen weeks with two to three Bailit Team members
3.1.2	Study of the Uninsured and Underinsured	\$1,350		Two meetings over eight weeks with two to three Bailit Team members
3.1.3	Actuarial Services			
3.1.4	Formal Stakeholder Study	\$1,350	\$4,200	Seven meetings over eight weeks with two to three Bailit Team members. This includes four focus group sessions.
3.1.5	Study of Current Insurance Market	\$900		Two meetings over eight weeks with two to three Bailit Team members
3.1.6	Assessment of Current Programs and Integration Activities	\$13,500		Thirty meetings over 30 weeks with two to three Bailit Team members
3.1.7	Formal Assessment of "Churning"	\$2,700		Six meetings over eight weeks with two to three Bailit Team members
TOTAL		\$40,500	\$4,200	
Grand Total		\$44,700		

For each meeting we assume that two to three Bailit Staff will be attending "in-person." In most instances one or two of these individuals will be Vermont based and therefore the only cost is mileage. We assumed here that 70% of the time that one member of the team will be traveling from out-of-state to attend the meetings. On average we estimate actual travel costs for each meeting at \$450.

The meetings above include the monthly State Steering Meetings and attendance at legislative hearings as well as in-person working meetings with state staff as needed throughout the project. On average we have budgeted for two meetings a week. Some of these will be large stakeholder meetings with multiple Bailit Team members on-site while others will be one-on-one working sessions between on or two Bailit team members and a one or two state staff.

**Summary of Cost Proposal**

Direct Labor Costs	\$	532,246
Travel and Focus Group Costs	\$	44,700
Total	\$	576,946



## Appendix A: Resumes of Key Staff

## MICHAEL H. BAILIT

### PROFESSIONAL EXPERIENCE

1997-present     **BAILIT HEALTH PURCHASING, LLC**     Needham, MA  
**President**

- Since founding Bailit, has worked with over 50 state, federal, county, and purchaser coalition clients to: design new purchasing programs; structure and conduct procurements; design systems to measure, monitor, and manage contractor and provider performance, create performance incentive systems, and train client staff in the conduct of vendor management practices.
- Consulted and published widely on strategies to improve quality through the use of Value-Based Purchasing, including the use of incentives and rewards.
- Assisted Massachusetts' Special Commission on Health Care Payment to develop recommendations to reform health care payment for all Massachusetts providers.
- Assisting the Governor's Office of Health Care Reform of Pennsylvania and the Massachusetts Executive Office of Health and Human Services in the development and implementation of statewide multi-payer initiatives to implement the Chronic Care Model and Patient-Centered Medical Home, and the Texas Health and Human Services Commission to pilot medical homes for children served by Medicaid.
- Provided or providing consultation to other medical home initiatives in Colorado, Idaho, Maine, Missouri, Montana, Nebraska, Ohio, and Washington.
- Assisted The Leapfrog Group and other leading national employer organization to develop a purchaser toolkit to implement HHS Secretary Leavitt's Four Cornerstones of Value-Driven Health Care.
- Advised the Minnesota legislature on strategies for reducing health care program coverage costs without removing covered services, covered populations or cutting provider rates.
- Created quality oversight specifications for behavioral health and physical health managed care plans in Virginia and Vermont; conducting reviews over many years in Vermont.
- Led Bailit's projects assisting state agencies in Colorado, Iowa, Maine, Massachusetts, New Jersey, New York, and Texas in crafting large managed care RFPs, including the development of procurement documents, performance measures and linked financial incentives and disincentives.
- Supported the Minnesota Long-Term Task Force as an expert consultant and as a stakeholder liaison through a widely hailed successful system change process.
- Assisted the state of Vermont with the development of a capitated, integrated acute and long-term care program for adults with disabilities and the elderly through stakeholder process facilitation and agency consultation.
- Assisted the Massachusetts Department of Developmental Services with a redesign of its rate systems for residential services, community-based day services and implementation of value-based purchasing.
- Assisted state agencies in Maryland, Michigan, New Mexico and Pennsylvania and the Center for Medicare and Medicaid Services (CMS) with strategies and preparations for organizational changes required to manage contracted HMO and behavioral health vendors.
- Analyzed performance data for program design and strategy (CA, NH, TX, VT).

1991-1997

**MASSACHUSETTS DIVISION OF MEDICAL ASSISTANCE** Boston, MA  
**Assistant Commissioner, Benefit Plans** (1994-1997)

- Directed the management of all of the benefit plans offered to Medicaid recipients in Massachusetts, including the Senior Care Plan, the HMO Program, the Mental Health/Substance Abuse Program, the Primary Care Clinician Plan, and CommonHealth.
- Trained and directed contractor staff to implement aggressive provider network performance profiling and management for quality improvement purposes. The resulting programs were considered to be among the best in the nation.
- Initiated and directed all new program development, including two Section 1115 waivers (one a health reform managed care expansion, the other for dual eligibles) and three grant-funded programs to develop models for better serving adults with disabilities and children with special health care needs.
- Designed and conducted a joint procurement for behavioral health services for, and with, the state mental health agency.
- Implemented HEDIS measurement with contracted HMOs and primary care case management program and developed market-tested “report cards” for Medicaid recipients to utilize when selecting managed care plans.

**Director, Managed Care** (1991-1994)

- Implemented Massachusetts’ statewide section 1915(b) managed care waiver in 1992, including the PCC Plan, the first-in-the-nation statewide mental health substance abuse carve-out, and an expanded HMO program, together enrolling 450,000 AFDC and disabled recipients.
- Dramatically intensified Massachusetts’ HMO management efforts, creation and using purchasing specifications, improvement goals, and quality measures.
- Implemented the first contracted enrollment broker program in the country to outreach, educate, and enroll recipients into managed care plans.

1988-1991

**DIGITAL EQUIPMENT CORPORATION** Maynard, MA  
**Manager, Welfare Benefits Finance**

- Recommended and helped implement move from indemnity to managed care.
- Designed and implemented Digital’s nationally recognized quality management approach to HMO contract management.
- Participated in the HMO-employer work group design of HEDIS 1.0.

1987-1988

**STATE MUTUAL LIFE ASSURANCE COMPANY** Worcester, MA  
**Manager, Group Managed Care**

- Developed a PPO product, the Mutual Alliance Plan, for Worcester County. Negotiated provider contracts, designed utilization management and quality management programs, and developed plan design.
- Represented State Mutual as a partner in Private Health Care Systems to develop a national network of PPOs.

1986-1987      **MEMORIAL HEALTH PLAN**      Worcester, MA  
**Finance Manager**

- Negotiated provider rates and contracts.
- Tracked plan utilization and expense to budget.

## EDUCATION

1984-1986      **KELLOGG GRADUATE SCHOOL OF MANAGEMENT**      Evanston, IL  
**NORTHWESTERN UNIVERSITY**  
M.B.A. in hospital and health services management, policy and marketing

1980-1984      **WESLEYAN UNIVERSITY**      Middletown, CT  
B.A. in religion

## PUBLICATIONS

Koller C, Brennan T and Bailit M. "Rhode Island's Novel Experiment To Rebuild Primary Care From The Insurance Side." *Health Affairs*, 29:5, May 2010.

Slen J, Bailit M and Houy M. "Value-Based Purchasing and Consumer Engagement Strategies in State Employee Health Plans: A Purchaser Guide" AcademyHealth, Washington, DC, April 2010.

"Interview with a Quality Leader: Michael Bailit on Pay-for-Performance." *Journal for Healthcare Quality*, 32:1, January/February 2010.

Bailit M and Koller C. "Using Insurance Standards and Policy Levers to Build a High Performance Health System." The Commonwealth Fund, New York, NY, November 2009.

Bailit MH and Hughes C. "Pay-for-Performance in the Medi-Cal Managed Care and Healthy Families Programs: Findings and Recommendations." California HealthCare Foundation, Oakland, CA, August 2009.

Bailit Health Purchasing (Bailit M and Hughes C). "The Purchaser Guide to the Patient-centered Medical Home." Patient Centered Primary Care Collaborative, July 2008.

LLanos K, Rothstein JR, Dyer MB, Bailit M. "Physician Pay-for-Performance in Medicaid: A Guide for States." Center for Health Care Strategies, Lawrenceville, NJ, March 2007.

Bailit Health Purchasing (Bailit M and Joseph M). "The Purchaser Guide to Value-Driven Health Care." Partnership for Value-driven Health Care, February 2007.

Hurley R, McCue M, Dyer MB and Bailit M. "Understanding the Influence of Publicly Traded Health Plans on Medicaid Managed Care." Center for Health Care Strategies, Lawrenceville, NJ, November 2006.

Bailit Health Purchasing (Bailit MH, Dyer MB, Joseph MS). "Incentives and Rewards Best Practices Primer: Lessons Learned From Early Pilots." The Leapfrog Group, Washington, DC, July 2006.

Bailit M and Dyer MB. "Putting Quality to Work: Rewarding Plan Performance in Medi-Cal Managed Care." California HealthCare Foundation, Oakland, CA, May 2006.

Bailit M. "As Employers Pull Their Money Out: The Failure of Health Care Cost Control." The Piper Report (piperreport.com), June 21, 2005.

Bailit M and Dyer MB. "Beyond Bankable Dollars: Establishing a Business Case for Improving Health Care." Commonwealth Fund, New York, NY, September 2004.

Bailit M, Burgess L, and Roddy T. "State Budget Cuts and Medicaid Managed Care: Case Studies of Four States." National Academy for State Health Policy, Portland, ME, June 2004.

Bailit Health Purchasing (Dyer MB, Bailit MH), "Ensuring Quality Health Plans: A Purchaser's Toolkit for Using Incentives." National Health Care Purchasing Institute, Washington, DC, May 2002.

Bailit Health Purchasing (Dyer MB, Bailit MH), "Ensuring Quality Providers: A Purchaser's Toolkit for Using Incentives." National Health Care Purchasing Institute, Washington, DC, May 2002.

Dyer MB, Bailit MH, Hurley R. "Forecasting the Future of Medicaid and SCHIP Purchasing: Using Current Trends and Challenges to Develop New Opportunities." Center for Health Care Strategies, Lawrenceville, NJ, April 2002.

Bailit Health Purchasing (Dyer MB, Bailit MH, Burgess LL), "Provider Incentive Models for Improving Quality of Care." National Health Care Purchasing Institute, Washington, DC, March 2002.

Dyer MB and Bailit MH, "Are Incentives Effective in Improving the Performance of Managed Care Plans?" Center for Health Care Strategies, Lawrenceville, NJ, March 2002.

Bailit Health Purchasing and Sixth Man Consulting (Dyer MB, Bailit MH, Hughes R). "The Growing Case for Using Physician Incentives to Improve Health Care Quality." National Health Care Purchasing Institute, Washington, DC, December 2001.

Burgess LL, Bailit MH, Gray N, and Pernice C. "A Snapshot: Performance Monitoring in SCHIP Administrative Services Contracting." National Academy for State Health Policy, Portland, ME, April 2001.

Bailit MH and Kokenyesi C. "Financial Performance Incentives for Quality: The State of the Art." National Health Care Purchasing Institute Monograph, Washington, DC, September 2000.

Bailit MH and Burgess LL. "Dissecting the Carve-Out." *Behavioral Healthcare Tomorrow*, December 1999.

Kaye N and Bailit MH. "Innovations in Payment Strategies to Improve Plan Performance" in "Medicaid Managed Care: A Guide for States, 4<sup>th</sup> Edition." National Academy for State Health Policy, Portland, ME, October 1999.

Bailit MH and Burgess LL. "Competing Interests: Public Sector Behavioral Health Care." *Health Affairs* September/October 1999.

Bailit MH, Kokenyesi C, and Burgess LL. "Purchasing in a Turbulent Market: An Assessment of Medicaid Managed Care in the Mid-Atlantic States." Center for Health Care Strategies, Inc., Princeton, NJ, September 1999.

Stone E., Bailit MH, Greenberg MS, Janes GR. "Comprehensive Health Data Systems Spanning the Public-Private Divide: The Massachusetts Experience." *American Journal of Preventive Medicine* 14 (3S), 40-45, 1998.

Bailit MH. "Ominous Signs and Portents in an Era of Bliss: A Purchaser's Perspective on Health Market Trends." *Health Affairs* November/December 1997.

Bailit MH. "Why Purchasers are Interested in Physician Profiling." *Worcester Medicine* 60:8, 16-21, 1997.

Bailit MH, Burgess LL. "Group Purchasing: A Timely Strategy for State Medicaid Agencies." Paper for the Center for Health Care Strategies, Inc., Princeton, NJ, 1996.

Friedman MD, Bailit MH, Michel JO. "Vendor Management: A Model for Collaboration and Quality Improvement." *Joint Commission Journal of Quality Improvement* 21:635-645, 1995.

Jordan HS, Straus JH, Bailit MH. "Reporting and Using Health Plan Performance Information in Massachusetts." *Joint Commission Journal of Quality Improvement* 21:167-178, 1995.

Bloomberg MA, Jordan HS, Angel KO, Bailit MH, Goonan KJ, Straus JH. "Development of Clinical Indicators for Performance Measurement and Improvement: An HMO/Purchaser Collaborative Effort." *Joint Commission Journal of Quality Improvement* 19:586-595, 1993.

#### **REFEREED LETTERS**

Bailit MH. "Letter on Quality and the Medical Marketplace", *New England Journal of Medicine* 336:11, 808, 1997

#### **REVIEWER**

Academy for Health Services Research and Health Policy 2001 Annual Meeting  
Health Affairs  
Milbank Memorial Fund  
Milbank Quarterly

## MICHAEL S. JOSEPH

### PROFESSIONAL EXPERIENCE

2005-Present     **BAILIT HEALTH PURCHASING, LLC**     Needham, MA

**Senior Consultant**

- Responsible for the analysis of data for the evaluation of the Texas Health Home pediatric medical home pilot.
- Analyzed annual managed care organization data filings, and compared plan quality performance to external benchmarks; identified key trends and opportunities for improvement for the state of Vermont.
- Researched the experience of leading pay-for-performance programs and used information to create a toolkit and primer for The Leapfrog Group.
- Co-authored the "Purchaser Guide to Value-Driven Health Care" on behalf of the Partnership for Value-driven Health Care.
- Developed a performance indicator dashboard for the California Medicaid program on behalf of the California HealthCare Foundation.
- Assisted with financial viability analysis of Massachusetts Managed Care Organizations for the Massachusetts Executive Office of Health and Human Services.
- Performed survey and statistical analysis for the Massachusetts Department of Developmental Services, worked closely with state agency staff and stakeholders, to develop a new rate system for group residential services and for certain day supports.
- Made recommendations to improve the application process for the Rhode Island Pharmaceutical Assistance to the Elderly for the Department of Elderly Affairs. This involved interviewing employees, managers and outside vendors, creating a process flow model and analyzing the effect of changes in organization structure and work flow on application through-put.
- Developed a spreadsheet tool for comparing total health insurance costs, including projected employee out-of-pocket costs, for municipalities and employees under different coverage scenarios to facilitate the renewal process for the Massachusetts Interlocal Insurance Association.
- Developed a health equity scorecard that measured the health care status and the health care environment for LA County for the Community Health Councils.

2001-2004

**Research Consultant**

- Developed market models of Medicare Supplemental Insurance market for major health insurer: assessed size of market and financial viability of markets.
- Developed a statistical algorithm to assign enrollees to HMOs based on quality measures for the state of California. This work involved testing for statistically significant differences between quality measures of competing HMOs and assigning scores based on performance.
- Conducted a statistical analysis of service and financial data in order to develop and refine a new reimbursement strategy for group residential services for the Massachusetts Department of Developmental Services. This project included the modeling of new reimbursement formulas and examining the impact on providers.

- 1999-2001 **BE FREE, INC.** Marlborough, MA  
**Competitive Analyst**
- Founded Competitive Intelligence Program.
  - Developed competitive strategy and product positioning.
  - Trained and supported 45 person global direct sales force on competitive objection handling and tactics.
  - Created and maintained competitor profiles and product feature competitive matrix.
  - Wrote regular competitive updates distributed to senior management and the sales force.
  - Identified product requirements and worked with product management to incorporate features into release plan.
  - Created sales tools, including sales presentations and product data sheets.
- 1996-1999 **AMR RESEARCH** Boston, MA  
**Market Research Analyst**
- Co-founded Primary Research department, a new strategic direction; grew to more than \$1.2 million in new revenue, exceeding expectations.
  - Developed, managed, and edited Market Analysis and Review Series (MARS), an annual service focused on reporting and analyzing market share for Enterprise Applications software markets. Designed database to collect and report on market share data for MARS reports. Created marketing plan for the MARS reports.
  - Advised clients, on market trends and forecasts.
  - Designed, executed, and analyzed surveys on Supply Chain software adoption
- 1994-1996 **INTERNATIONAL DATA CORPORATION** Framingham, MA  
**Associate Market Analyst**
- Authored reports, bulletins, and white papers on a range of topics including: The Internet, data warehousing, OLAP, and data mining.
  - Forecasted market size, assessed vendor positioning and market share for software vendors in the OLAP, executive information systems, end-user query and reporting tools, and technical data analysis markets.
  - Analyzed end-user survey data using SPSS; wrote survey-based research reports.
  - Contributed to numerous consulting projects for established and emerging companies, including Business Objects, Fujitsu, IBM, Sagent Technologies.
- 1992-1994 **VOICE RECOGNITION SOFTWARE CONSULTANT** New York, NY  
**Beth Israel Medical Center**  
**Kurweil Applied Intelligence**
- Provided on-site training and support for voice recognition driven pathology reporting system at Beth Israel Medical Center
  - Provided pre-sales support for regional sales representatives
  - Trained residents, attending physicians, and medical technologists at hospitals across the United States in the use of voice recognition systems for pathology and radiology reporting
  - Developed, tested, and customized Kurzweil VoicePATH knowledge base
  - Demonstrated products at trade shows and medical conferences



## **EDUCATION**

- 2001-2003      **F.W. OLIN GRADUATE SCHOOL OF BUSINESS**      Wellesley, MA  
                    **AT BABSON COLLEGE**  
                    Master of Business Administration Degree, Magna Cum Laude, 2003
- 1986-1990      **BARD COLLEGE**      Annandale-On-Hudson, NY  
                    Bachelor of Arts degree in the History of Photography, 1990

## **PUBLICATIONS**

Bailit Health Purchasing (Bailit M and Joseph M). "Purchaser Guide to Value-Driven Health Care" Partnership for Value-driven Health Care, February 2007.

Bailit Health Purchasing (Bailit MH, Dyer MB, Joseph MS). "Incentives and Rewards Best Practices Primer: Lessons Learned From Early Pilots" The Leapfrog Group, Washington, DC, July 2006.

## JOSHUA N. SLEN

### PROFESSIONAL EXPERIENCE

2009-present    **BAILIT HEALTH PURCHASING, LLC**    Stowe, VT  
**Senior Consultant**

- Assisting the State of West Virginia Medicaid Office in the review of federal health care reform legislation. Work has included vision and goal setting, as well as detailed analysis of policy options. Drafted a memo specific to health insurance exchange guidance for the Medicaid Director.
- Provided advice and support to the Kansas Medicaid Agency in support of the planning necessary to implement a provider survey and to hire a vendor to write the State Medicaid Health Information Technology Plan.
- Provided strategic advice to the State of Rhode Island Medicaid Office regarding Long Term Care system transformation options.
- Created guiding documentation for the Medicaid Agency in Pennsylvania to assist in the initial discussions around federal health care reform as they related to decision making for the health insurance exchange.
- Produced a roadmap for the Vermont Program for Quality Health in Care that served to identify commonalities and differences among State human service program evaluations for programs specifically designed to serve individuals with chronic health conditions.
- Drafted recommendations for the Vermont Department of Banking Insurance and Health Care Administration around federal health care reform as it relates to state level insurance regulation and assisted the Department in the annual review of carrier filings.
- For AcademyHealth, co-authored the Value-Based Purchasing and Consumer Engagement Guide for State Employee Purchasers.
- Reviewed options and drafted the final report for the Vermont Health Information Technology Payment Reform Workgroup.
- Provided strategic and technical guidance to the State of Kansas in the preparation of their Health Information Technology - Planning Advance Planning Document (HIT - PAPD) for receipt of federal money by the State Medicaid Agency.
- Drafted the Request for Proposals (RFP) for the Colorado Medicaid Accountable Care Collaborative (ACC) Program.
- Developed scoring tools and selection criteria for the State of Iowa in its formal selection process for a state-wide provider of mental health services.
- Produced recommendations for the Massachusetts Health Care Quality and Cost Control Council regarding areas where waste could be eliminated from the health care system.
- Conducted detailed analysis for the Insurance Commissioner of Rhode Island on options for redesigning regulatory oversight.
- Acted as the Interim CEO for the Vermont Information Technology Leaders (see below).

2009 **VERMONT INFORMATION TECHNOLOGY LEADERS** Montpelier, VT  
**Interim CEO (March - August)**

- Managed the strategic development process for Vermont's Regional Health Information Exchange including leading the first ever strategic retreat for the organization.
- Provided detailed planning in response to the Federal Stimulus Legislation (ARRA) in order to prepare Vermont to receive federal dollars for the State's Health Information Exchange and to assist in the rapid adoption of Electronic Health Records.
- Developed the plan for connecting 80% of the primary care practices in the state and 100% of the 14 acute care hospitals through the Health Information Exchange in two years.

2003-2008 **OFFICE OF VERMONT HEALTH ACCESS** Williston, VT  
**Director, Office of Vermont Health Access (2004 - 2008)**

- Managed the Medicaid program for the State of Vermont.
- Reengineered the Office from a bill payer to a modern managed care organization.
- Coordinated the delivery of health care benefits to 147,000 Vermonters.
- Served on state-wide Executive Committee for the Blueprint for Health.
- Revitalized the Medicaid Advisory Board.
- Implemented a comprehensive chronic care management program.
- Provided public testimony on multiple initiatives to the state legislature.
- Negotiated the first in the nation Global Commitment to Health Waiver with the Federal Government.

**Deputy Director and Acting Director, Office of Vermont Health Access/**  
**(2003 - 2004)**

- Managed the Medicaid program for the State of Vermont.
- Coordinated the delivery of health care benefits to 147,000 Vermonters.
- Responsible for the consolidation of Medicaid operations in one location.
- Redesigned and retooled the reporting relationships within the Vermont Medicaid program.
- Instituted a performance measurement system.

1999-2003 **DEPARTMENT OF FINANCE AND MANAGEMENT** Montpelier, VT  
**Deputy Commissioner (2002 - 2003)**

- Responsible for management of the Governor's budget submission to the Legislature.
- Managed the budget development process.
- Testified in support of the Governor's fiscal year 2004 budget.

**Budget and Management Analysis (1999 - 2002)**

- Responsible for review of the Agency of Human Services budget.
- Tracked the Governor's budget throughout the legislative process.
- Conducted multi-state analysis of Medicaid expenditures.
- Worked closely with legislative staff throughout the year.
- Provided monthly review and analysis of health care funding in Vermont.
- Reviewed and recommended action on a host of departmental requests.

1991-1999

**OHIO LEGISLATIVE BUDGET OFFICE**

Columbus, OH

**Senior Transportation/Public Safety Analyst** (1998 - 1999)

- Responsible for review of the Department of Transportation's \$2 billion annual budget.
- Provided oversight of the Department of Public Safety's \$400 million annual budget.
- Conducted training and provided guidance to new analysts.
- Responsible for staff support of House and Senate Transportation committees.
- Coordinated major office publications.
- Drafted policy recommendations for individual legislators.

**Transportation/Public Safety Analyst** (1997 - 1998)

- Conducted financial analysis of agency budgets and made recommendations to legislators.
- Provided liaison services to legislative committees.
- Created office's first assignment tracking database using Microsoft Access.
- Analyzed emergency requests for funding by agencies.

**Budget Policy Analyst** (1993 - 1997)

- Developed office standards for determining when proposed legislation impacted local governments.
- Conducted in-depth fiscal research on issues impacting the state and its political subdivisions.
- Provided thorough financial analysis on agency budgets to state legislators.
- Utilized spreadsheet, database, and statistical techniques to evaluate programs.

**Research Associate** (1991 - 1993)

- Analyzed proposed legislation for fiscal impact.
- Conducted research on issues impacting state agencies.
- Formulated questions for budget hearings with state agencies.

**EDUCATION**

1993

**THE OHIO STATE UNIVERSITY**

Columbus, OH

Master of Public Administration

Accomplishments:

G.P.A. 3.8.

PAA National Honor Society.

Elected as Treasurer of The Public Administration Student Association.

1991

**WITTENBERG UNIVERSITY**

Springfield, OH

Bachelor of Arts Degree in Political Science/Sociology

## BETH WALDMAN

### PROFESSIONAL EXPERIENCE

- 2007 - present **BAILIT HEALTH PURCHASING, LLC** Needham, MA  
**Senior Consultant**
- Leading Maine planning efforts for implementation of national health reform, including analysis of the PPACA, drafting state health plan chapter detailing implementation efforts, development of policy presentations on key aspects of reform, including design of an Exchange, impact on Medicaid and related policy decisions, and impact on Maine's insurance laws and related policy decisions.
  - Providing strategic direction and drafting for managed behavioral health carve-out procurement in Massachusetts; previously led similar effort for the Iowa Medicaid Enterprise
  - Participating in development of community-first facility plan for MA EOHHS agencies;
  - Facilitating working group on remedial services in Medicaid for the Iowa Medicaid Enterprise;
  - Assisted the Colorado Department of Health Care Policy & Finance on its Eligibility Modernization efforts and Managed Care reform efforts
  - Assisted the Massachusetts Executive Office of Health and Human Services on its Community First Waiver implementation planning, particularly in the design and development of a care management RFP for disabled population
  - Directed the Massachusetts Health Care Quality and Cost Council on its Roadmap to Cost Containment
  - Led drafting of responses to Medicaid managed care procurements for MCOs in TN, WI, CT and RI.
  - Managed readiness review for state of Texas of Integrated Case Management vendor and participated in readiness review for state's Foster Care Managed Care vendor.
  - Assisted states with health reform strategies pre-national health reform: consultation to the Blue Shield Foundation of California's Working Committee on Waiver Development and Medi-Cal expansion, and advice to Arizona, Colorado and Pennsylvania on health reform strategies.
  - Developed a performance indicator dashboard for the California Medicaid program on behalf of the California HealthCare Foundation.
  - Reviewed state of Vermont's Medicaid eligibility and enrollment processes and issued report recommending improvements.
  - Assisted The Leapfrog Group in development of an outreach strategy for state health purchasers.
- 1994 - 2007 **EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES** Boston, MA  
**Medicaid Director (2003 - 2007)**
- Responsible for overall administration and management of MassHealth program, with an annual budget of \$8 billion and over 1 million members.
  - Led complex, matrix organization with approximately 1000 employees across EOHHS and oversaw cross-agency Medicaid Management Team.
  - Served as a member of the EOHHS Management Committee.
  - Set policy, programmatic and purchasing goals for MassHealth program.

- Played key role in the development and implementation of the Massachusetts Health Care Reform initiative, including participating as an active member of team that created Governor's initial plan and legislation; negotiating terms of waiver amendment to implement HCR with CMS; implementing MassHealth expansions and new Commonwealth Care program; participating as a member of the Commonwealth Health Insurance Connector Authority Board (the Massachusetts Exchange); serving on cross-agency implementation team to trouble shoot across the reform; and serving as a spokesman about the reform effort both in Massachusetts and nationally.
- Provided executive leadership to major agency initiatives including implementation of Health Care Reform legislation, program integrity gap analysis and organizational restructuring, and procurement and build of a new MMIS system.
- Managed relationship with CMS, including negotiating terms of Medicaid state plan and waiver.
- Provided testimony to state legislature on annual budget request, MassHealth related bills, and oversight hearings.
- Provided executive direction in the negotiation of the *Rosie D* lawsuit on provision of services for children's behavioral health.
- Participated in press conferences as necessary and respond to press inquiries related to MassHealth program.
- Spoke at numerous conferences and forums on behalf of Massachusetts, both locally and nationally; speaking engagement include Health Care Reform legislation and implementation and strategies to provide quality medical care to children served by the Medicaid program.
- Active participant in National Association of State Medicaid Directors, including serving as co-chair of SCHIP TAG.
- Served on Commissions, Boards and Interagency Councils as required through general laws or executive order, including serving as a member of the Board of the newly created Health Insurance Connector Authority.
- Played lead role in implementation of major reorganization of EOHHS that eliminated the Division of Medical Assistance and moved the administration of the MassHealth program within the EOHHS; created the Office of Medicaid and implemented processes and procedures to allow for management of Medicaid program across several EOHHS agencies.

#### **DIVISION OF MEDICAL ASSISTANCE**

**Acting Deputy Commissioner** (January 2003 - September 2003)

- Managed staff responsible for the 1115 Demonstration Waiver and SCHIP program; Federal/National Policy Management; Evaluation Support; and Constituent Services (including legislation and press).
- Assisted Commissioner in overall administration of the MassHealth program, including playing a lead role in transition planning for an EOHHS reorganization.
- Continued to serve as Director, Waiver Implementation and Administration.

**Director, Waiver Implementation and Administration** (2001 - 2003)

- Administered the Division's 1115 Demonstration Waiver and SCHIP programs, including negotiating amendments and extensions with CMS and monitoring state and federal budget neutrality.

- Recommended and implemented major eligibility policy changes - including Insurance Partnership program and SCHIP.
- Led agency in development of and application for new waivers or amendments to current programs.
- Led major agency policy and program initiatives.
- Led evaluations of agency programs, including annual reports for the 1115 Waiver and the SCHIP program.
- Key agency contact for advocate groups.

**Assistant General Counsel (1994 - 2001)**

- Provided legal counsel for an 1115 waiver and SCHIP expansion - including involvement in shaping of new programs, drafting legislation and regulations for Children's Expansion, Insurance Partnership program and HIV Expansion; negotiating proposed expansions with the Health Care Financing Administration; drafting member and employer notices; procuring vendors; and troubleshooting operational issues.
- Represented Commonwealth in litigation of Medicaid actions, including oral argument before the Supreme Judicial Court.
- Advised Division's Claims Review Board on provider payment issues.
- Honors: Twice awarded Commonwealth Citation for Outstanding Performance: as member of the Pharmacy Program Plus team (2000); as member of the Insurance Partnership implementation team (1999).

1993 - 1994      **BOARD OF REGISTRATION IN MEDICINE**      Boston, MA  
**Litigation Counsel (part-time) (1993 - 1994)**

- Prepared cases for presentation to Complaint Committee of Board for decision of whether to discipline physicians' accused of misconduct.

1993 - 1994      **NATHANSON & GOLDBERG**      Boston, MA  
**Associate (part-time) (1993 - 1994)**

- Served as associate in small general practice.
- Work included personal injury arbitration, worker's compensation hearing, and real estate closings.

**EDUCATION**

1995 - 1997      **HARVARD SCHOOL OF PUBLIC HEALTH**      Boston, MA  
Master of Public Health, June 1997  
GPA: 3.8; Concentration: Law and Public Health

1990 - 1993      **BOSTON COLLEGE LAW SCHOOL**      Newton, MA  
Juris Doctor, May 1993  
G.P.A. 3.3; Top third of class.

1986 - 1990      **UNION COLLEGE**      Schenectady, NY  
Bachelor of Arts, Political Science, June 1990  
Honors: Pi Sigma Alpha, Political Science Honor Society; Dean's List

## **BAR ADMISSION**

1994            **RHODE ISLAND**  
1993            **MASSACHUSETTS**

## **BOARD MEMBERSHIP**

Massachusetts Medicaid Policy Institute, May 2007 to present

## **PUBLICATIONS**

Waldman B. "Massachusetts Health Care Reform", *Health and Human Rights Journal*, April 2010.

Waldman B. "Covering Children and their Parents – The Massachusetts Model and Implications for National Health Reform, *First Focus*, December 2009.

Waldman B. "The State Children's Health Insurance Program in Massachusetts: Achievements, Challenges and Implications for Health Reform", Massachusetts Medicaid Policy Institute, April 2007.



# AMY M LISCHKO, MSPH, D.Sc.

## *Curriculum Vitae*

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### PROFESSIONAL TRAINING

#### Education

1982	BS (Nutrition and Food Science)	University of Massachusetts at Amherst
1988	MSPH (Health Policy and Management)	University of Massachusetts at Amherst
2008	D.Sc. (Health Services Research)	Boston University

#### Additional Training

- Executive Leadership Training, Harvard University, Kennedy School for Government 1997.
- Quality Improvement certificate, Harvard University, 2000.

### WORK EXPERIENCE

2007-present	Assistant Professor, Dept of Public Health and Family Medicine, School of Medicine at Tufts University
2005-2007	Director of Health Care Policy Massachusetts Executive Office of Health and Human Services Boston, Massachusetts
2006-2007	Commissioner, Division of Health Care Finance and Policy Boston, Massachusetts
2003-2006	Assistant Commissioner for Research and Policy, Division of Health Care Finance and Policy, Boston, Massachusetts
1996-2003	Director of Health Systems Measurement and Improvement, Division of Health Care Finance and Policy, Boston, Massachusetts
1993-1996	Policy Manager, Long Term Care, Division of Health Care Finance and Policy, Boston, Massachusetts
1991-1993	Project Director, New England Health and Poverty Action Center, Tufts University School of Medicine, Boston Massachusetts
1989-1991	Project Director, Massachusetts Department of Public Health, Boston Massachusetts
1988-1991	Research Associate and Project Consultant, Massachusetts Eye and Ear Infirmary, Boston Massachusetts

### Professional Affiliations and Board Membership

- Senior Fellow, Pioneer Institute for Public Policy, 2009 -
- State Health Reform Initiative Advisory Group, Engleberg Center for Health Care Reform, The Brookings Institution, Member 2008 -
- Massachusetts Health Quality Partners (MHQP), Executive Committee and Board Member, 2008 -
- State Health Access Data Assistance Center (SHADAC), Board Member, 2001 -
- AcademyHealth member, 2003 -
- National Academy for State Health Policy, Access for the Uninsured Committee, 2004 - 2007

- Council of State Governments, Health Policy Steering Committee, 2006 – 2007
- Institutional Review Board for The Massachusetts Connector, Chair, 2009 -

## **ACADEMIC ACTIVITIES AND RESPONSIBILITIES**

- Member of the PHPD Grievance Committee, 2007 -
- Human Resources Committee for Tufts University, 2009 -

## **TEACHING**

### **Current Courses (Graduate level) at Tufts University:**

- MPH/HCOM 222 Survey Research Methods and Data Management (School of Medicine, Master in Public Health)
- MPH /HCOM 215 Public Health and Health Care: Politics, Policies, and Programs (School of Medicine, Master in Public Health)
- CMPH 151/251/351 Integration of Public Health, small group co-leader
- Epidemiology and Biostatistics, Medical School, small group leader

### **Previous Teaching Experience**

- Tufts University School of Medicine, Boston MA, Adjunct Instructor, Epidemiology and Biostatistics, 1992-2001
- Tufts University and Emerson College, Boston MA, Adjunct Instructor, Biostatistics and Epidemiology, 1996

### **Academic Advisor**

- Academic Advisor for 12 MPH students in the Health Policy and Management concentration

## **RESEARCH INTEREST**

My research interests are focused on increasing access to insurance and developing strategies for constraining health care costs. Before joining Tufts, I managed numerous health research and policy projects for the Commonwealth including large, federally-funded, multi-agency grants. I was one of the key authors of the administration's health care reform proposal. Since leaving state government, I have provided consulting services to AcademyHealth, the National Governor's Association, Mathematica Policy Research, Inc., and individual states including Rhode Island, West Virginia, Minnesota, Washington, and the US Virgin Islands around health care access and health care reform. I'm interested in bridging the gap between academic research and policymaking by making academic research more accessible to policymakers.

### **Current Grants**

- Using Geographic Variation to Identify and Reduce Over-treatment in Massachusetts, Edward M. Kennedy, Health Policy Scholar's grant, The Medical Foundation, Role: Principal Investigator
- Evaluation of Risk Selection in Market-Based State Programs, Robert Wood Johnson Foundation, State Health Access Reform Evaluation Grant, Role: Co-Principal Investigator

## COMPLETED GRANTS

Massachusetts Commonwealth Health Insurance Connector: A Model for State and Federal Health Reform? The Commonwealth Fund, Role: Principal Investigator, 2008 - 2009

State Planning Grants, Health Resources and Services Administration, Roles: Co-PI 2000, PI 2003

State Coverage Initiatives Grant, Robert Wood Johnson Foundation, Role: Principal Investigator, 2002

Employee Input into Health Insurance Decisions, The Commonwealth Fund, Role: Principal Investigator, 2002

## CONTRACTS

- Rhode Island Department of Health Insurance, two contracts to look at merger of individual and small group markets and feasibility of developing an insurance exchange. 2007, 2008
- West Virginia Health Care Authority: contract to assess feasibility of developing an health insurance exchange. 2007
- National Governor's Association: Work with Washington and US Virgin Islands around health care reform proposals and implementation. Author paper on exchanges for National Governor's Association annual meeting. 2007 - 2009
- Massachusetts Medical Society: Author several papers on various topics including costs, quality, and transparency of health care in Massachusetts. 2007 - 2009
- AcademyHealth : Author papers, facilitate and participate in state policy maker meetings as consultant/advisor. 2007 - 2009
- National Academy for State Health Policy: participate as content expert in meetings for state officials, 2008 -

## **PUBLICATIONS**

### **Research Articles**

**Lischko, A;** Seddon, J.; Gragodas, E.; et al. "Evaluation of Prior Primary Malignancy as a Determinant of Uveal Melanoma - A Case Control Study." *Ophthalmology*, 96, 12, December, 1989.

**Lischko, A.;** Burgess, J. Knowledge of Cost Sharing and Decisions to Seek Care, Accepted for publication, *American Journal of Managed Care*, April 2010.

### **Government Reports and Policy Publications**

**Lischko, A;** Manzolillo, K. Evaluation of MA Health Care Reform: Chapter 4 Cost-Effective Quality, Issue Brief, Pioneer Institute, In-press April 2010

**Lischko, A.** Establishing a State-Level Exchange, National Governor's Association Issue Brief, March 2010.

**Lischko, A;** Manzolillo, K. Evaluation of MA Health Care Reform: Chapter 3 Administrative Efficiency, Issue Brief, Pioneer Institute, March 2010

**Lischko, A;** Manzolillo, K. Evaluation of MA Health Care Reform: Chapter 2 Financing, Issue Brief, Pioneer Institute, February 2010

**Lischko, A;** Gopalsami, A. Evaluation of MA Health Care Reform: Chapter 1 Access, Issue Brief, Pioneer Institute, January 2010.

**Lischko, A.** Drawing Lessons: Different Results from State Health Insurance Exchanges, December 2009.

Regan, C., Robbins, A. and **Lischko, A;** *Coverage for Caregivers: Lessons from Massachusetts Health Reform*, October 2009. The Paraprofessional HealthCare Institute policy brief.

Faulkner, D.; **Lischko, A.;** Chollet, D.; Considering a Health Insurance Exchange: Lessons from the Rhode Island Experience. *Academy Health*, State Coverage Initiatives Program, June 2009.

**Lischko, A,** Bachman, S., Vangeli, A., The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions, Commonwealth Fund Publication, May 28, 2009 , Volume 55

Chollet D., Liu S., Stewart K., Wellington A., Barrett A., Kofman M., **Lischko A.**, Health Insurance Exchange, Final Report, 2008. MPR Ref. No. 6392

**Lischko, A.** Health Care Premium Expenditures: Where Does Your Health Care Dollar Go? Massachusetts Medical Society, 2008

**Lischko, A.** Physician Payment Reform: A Review and Update of the Models. Massachusetts Medical Society, 2008

**Lischko, A.,** Bieblehausen, J., Health Plan Financial Data Reporting: A Call for Transparency. Massachusetts Medical Society, 2008.

**Lischko, A.**, Cost Sharing: Do Employees Understand Cost Sharing and Do Increases in Cost Sharing Really Have an Impact on the Utilization of Health Care Services? Dissertation, May 2008.

**Lischko, A** "Connectors & Exchanges: A Primer for State Officials." State Coverage Initiatives publication, September 2007.

Non-Emergent and Preventable Emergency Department Visits, FY05. An Analysis in Brief by the Division of Health Care Finance and Policy, Commonwealth of Massachusetts, February 2007.

The Use of Public Health Assistance in Massachusetts in FY06: Employers Who Have Fifty or More Employees Using MassHealth or the Uncompensated Care Pool, A report by the Division of Health Care Finance and Policy, Commonwealth of Massachusetts, February, 2006 and 2007.

Non-Emergent and Preventable Emergency Department Visits, FY04. An Analysis in Brief by the Division of Health Care Finance and Policy, Commonwealth of Massachusetts, June 2004.

Camberg, L.; **Lischko, A.**; and Brandenburg, J.; "Nursing Home Staff Turnover: Lessons from the Public Sector." VA Practitioner, 9, 6, June, 1992.

Valentine, J.; **Lischko, A.**; "A Client Record Study of the CHANCES and PACE Programs of Crittenton Hastings House." New England Health and Policy Action Center Technical Report, May, 1992.

Dreyer, P. and **Lischko, A.**; "Evaluation of the Prospective Case-Mix Reimbursement System in Nursing Homes in Massachusetts." HCFA contract # 11-C98-924/1-01, June, 1991.

**Lischko, A.**; "Success Stories in Troubled Times." *The Massachusetts Administrator*, 1, 4, September, 1987.

## **Conferences and Seminars**

Massachusetts Health Care Reform: A Case Study. Presented to Georgia Legislators as part of a certificate program in health care policy, Georgia State University. December, 2009.

What Can an Exchange Accomplish? Challenges and Opportunities for National Health Care Reform, SCI Annual Summer Meeting, July 2009

Does Higher Costs equal Higher Quality? Presented at the Affordable Health Care Today forum. Boston MA, June 2008.

Health Care Reform in Massachusetts: Lessons for China. Presented at Fudang University, Shanghai, China. June 2008.

"Massachusetts Health Care Reform: A model for State-wide Coverage." presented at the National Medical Association Annual Colloquium on African American Health. March, 2008.

Connector Update: Findings from SCI Small Group Meetings, SCI Annual Summer Meeting, August, 2007

Connector Small Group Meeting, Austin TX, facilitator and presenter. June, 2007.

Connector Small Group Meeting, Washington DC, facilitator and presenter, April 2007.

Georgetown Policy Conference on National Security. Washington DC, March, 2007.

2007 Coverage Institute, Chicago IL., Faculty. September, 2007.

Health Policy Issues and Options for New York: What Can We Learn from Other States? Empire Center for New York State Policy, September, 2006.

“Health Care Reform in Massachusetts.” Panel presentation at Urban Institute, April 2006.

“State Health Reform Initiatives: Are there Lessons for Federal Policymakers?” Washington, DC. Luncheon Address. November, 2006.

“Health Care Reform in Massachusetts.” Panel presentation at National Health Policy Conference, Annual Meeting, Washington DC., January, 2006.

“Putting Research into Practice: A Discussion with Policy Makers.” Panel discussion at AcademyHealth Spring 2005 meeting.

“Modeling Health Care Reform: What States Need to Know.” Presented at AcademyHealth Workshop on Modeling, Fall, 2004.

Roman, AM., A Hauser and **A Lischko**. “Measurement of the Uninsured Population: The Massachusetts Experience.” Paper presented at the annual meeting of the American Association for Public Opinion Research, May, 2002.

“Making Sense of Data.” Presented at the 1995 New England Association of Homes and Services for the Aging, June, 1995.

## **ABSTRACTS**

**Lischko, A.** Does Employee Understanding of Cost Sharing Matter? AcademyHealth, Research Meeting, 2007.

**Lischko, A.** The Impact of Cost Sharing on Middle-Income Children, AcademyHealth, Research Meeting, 2007.

Schiff, M.; Bachman, S.; Shuster, M., **Lischko, A.**; “Employee Input and Health Care Cost-Containment Strategies.” Presented at AcademyHealth Spring, 2003

Cai, J.; **Lischko, A.**; Schuster, M.; Bachman, S.; “Maternal Outcomes at Massachusetts Hospitals” Presented at AcademyHealth Spring, 2003.

Cai, J.; **Lischko, A.**; London, K.; “Do Medicaid Patients Use More Hospital Resources?” Presented at AcademyHealth Spring, 2002.

Schiff, M.; Cai, J.; **Lischko, A.**; Anderson, B.; “Impact of Current Premium Increases on Health Insurance Coverage in Massachusetts.” Presented at AcademyHealth Spring, 2002.

Cai, J.; Wacks, C.; **Lischko, A.**; Bachman, S.; “Impact of Massachusetts Health Reform on Employer-Sponsored Health Insurance.” Presented at AcademyHealth Spring, 2000.

Valentine, J.; Kulig, J., **Lischko, A.**; Hall, G.; and Mandel, L.; “Adolescent Health Promotion Strategies in the School-Based Clinic Setting.” Presented at the 1993 Prevention Conference, April, 1993.

Kulig, J.; Valentine, J.; **Lischko, A.**; and Spivak, H.; “Role of Gender in the Association Between Risk Behaviors and School-Based Clinic Use.” Presented at the 1993 meeting of the Society for Adolescent Medicine, March, 1993.

Valentine, J.; Kulig, J.; **Lischko, A.**; Spivak, H.; “Tracking Utilization of Comprehensive Primary Care Services by Inner City Adolescents in the School-Based Setting: Methods and Findings.” Presented at the 3rd Primary Care Research Conference, January, 1993.

Dreyer, P.; Flanagan, S.; **Lischko, A.**; and Blake, E.; “Case-mix, Access and Quality: A Demonstration Project in Massachusetts Nursing Homes.” Presented at the 118th Annual Meeting of the American Public Health Association, October, 1990.

Camberg, L.; **Lischko, A.**; Brandenburg, J.; “Factors Associated with Staffing Problems in Public and Private Nonprofit Nursing Homes.” Presented at the 116th Annual Meeting of the American Public Health Association, November, 1988.

## **OTHER PROFESSIONAL ACTIVITIES**

Grant Reviewer for Health Services and Resources Administration (HRSA), Health and Human Services (HHS). Applications from states requesting support for demonstration grants to increase access to health insurance, July 2009.

Grant Reviewer for American Association for the Advancement of Science (AAAS), in conjunction with the Life Sciences Discovery Fund, September 2009.

Community Member for Massachusetts Department of Public Health, Survey Research.  
2008 -

Ad Hoc Reviewer for several journals, including: Health Affairs, American Journal of Managed Care, Health Services Research

**Mark Podrazik, M.B.A.**  
**Principal**  
**Burns & Associates, Inc.**

Mark Podrazik has 14 years of experience in health care consulting, specializing in the operational, reimbursement, and evaluation components of public health care programs. He has managed projects for Medicaid agencies in 13 states. He co-founded Burns & Associates in 2006 and prior to this worked for another national health care consulting practice for 10 years.

**Representative Accomplishments**

- Provided technical assistance to the Department of Vermont Health Access (DVHA) on numerous projects since November 2006 including:
  - Currently assisting in setting rates for professional services to align with the Medicare Resource Based Relative Value Scale (RBRVS) system.
  - Developed and refined the methodology to make disproportionate share payments to hospitals. Assist in calculating annual allotments.
  - Assisted in design and implementation of new reimbursement systems to pay for inpatient and outpatient hospital services.
  - Facilitated meetings with hospital and other professional providers to discuss new payment methodologies.
  - Serve as technical resource to work with the DVHA's fiscal agent to implement new payment systems.
  - Serving as DVHA's technical resource to integrate Medicaid claims into the state's all-payer VHCURES system.
  - Conducted an independent analysis of medical cost savings of the Vermont Chronic Care Initiative.
  
- Manage B&A's engagement to conduct an annual evaluation report of the Healthy NY program which is offered through the New York Department of Insurance. Mr. Podrazik resumed this role in 2009 after previously conducting these evaluations in 2004 and 2005. The 2009 report included results from surveys administered by B&A to members enrolled through small businesses (n=2,600), members enrolled on their own (n=10,600) and small employers (n=2,100). Mr. Podrazik also conducted interviews with representatives from 11 participating health plans. The report also includes a financial analysis of the costs of the reinsurance component of the program which is funded by the State and a longitudinal study of premium changes.
  
- Managed an engagement to conduct an independent evaluation of the Insure Oklahoma program in 2008. This program offers state subsidies to low-income working uninsured residents of the state who purchase insurance through their small employer. The evaluation included in-person interviews with over two dozen stakeholders that were part of the design, implementation and ongoing operation of the program. B&A also completed an onsite review of the operational flows of the entity responsible for administering Insure Oklahoma and offered suggestions for process improvement. A survey of enrolled small business employees was also administered in the evaluation.



- Conducted nine focus groups of small employers who do and do not offer health insurance and insurance agents in November 2007 in three regions in Minnesota. The focus groups were intended to elicit feedback on policy decisions that were being contemplated related to increasing the accessibility and affordability of health care in Minnesota. Findings were summarized in a report to the Minnesota DHS.
- Assisted San Diego County in a redesign of its Medical Services program for the indigent. Tasks included conducting multi-day interviews with functional areas within the Department to determine current processes and the interests of how to change them in the redesign. A strategic plan was developed as well as an outline of work plan activities for a steering committee work group.
- Currently managing aspects of B&A's multi-year engagement with Rhode Island's Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) to assess features of a full redesign. Current tasks in the discovery phase of the project include facilitating and staffing meetings of three workgroups that are creating service definitions, setting rates for services, and developing protocols for assessing individuals. Other activities include working with the Department's fiscal agent on changes to billing operations, developing ongoing monitoring procedures, measuring expenditures against person-specific funding levels, analyzing provider cost reports, and meeting with entities responsible for the case management of the Department's clients.
- Currently assisting Minnesota's Medicaid program reset its physician fee-for-service rates to the Medicare RBRVS system. This engagement is a follow-up to another engagement with the State led by Mr. Podrazik in which B&A measured the impact that rates have on member's access to services throughout the state. As part of this study, other state Medicaid rates were examined, provider availability was measured, and mail surveys were conducted of physicians and members to gain their feedback.
- Project manager for B&A's engagement with Indiana's Office of Medicaid Policy and Planning since 2007 and, prior to this, EP&P Consulting's engagement with the OMPP from 2001 to 2006. Mr. Podrazik has managed and been the lead author on each of the deliverables that have been provided to the OMPP during this time. These have included:
  - The annual independent evaluation of Indiana's Children's Health Insurance Program (2001 to the present)
  - The annual Monitoring Manual that tracks enrollment, utilization, access and expenditure trends (2002 to the present)
  - The External Quality Reviews of the Hoosier Healthwise program (2005, 2007-2010), the Care Select program (2009) and the Healthy Indiana Plan (2009-10)
  - Technical assistance in submitting Indian's annual CMS CHIP report
  - Conducting focus studies of childhood immunization rates, children's access to primary medical providers, and a study of high utilizers in Hoosier Healthwise
  - Managed the administration of surveys to Primary Medical Providers in Indiana's Hoosier Healthwise and Care Select programs in 2009
  - In support of the evaluation of Indiana's Care Select program, managed the administration of a member survey (n=8,600) to Care Select members in 2009.

- Provided assistance to the Arizona Health Care Cost Containment System on a number of projects including:
  - Project manager and lead analyst on AHCCCS’s transition to a new fee schedule-based payment system for outpatient services to Medicaid beneficiaries.
  - Project manager for a project to update AHCCCS’s rates paid to Medicaid fee-for-service providers of nursing home care.
  - Project manager for an engagement to calculate hospital DSH payments.
  - Key analyst on a project to evaluate AHCCCS’s self-funded reinsurance program for acute care and long-term care services.
  
- Managed the successful negotiation of a settlement between a hospital chain and a County government over the payment of outstanding hospital claims for indigents that had crossed a five-year period. The parties accepted Mr. Podrazik’s settlement methodology for evaluating County responsibility.
  
- Key staff member and contributing author of an independent evaluation of Mississippi’s Medicaid program which was delivered to the Mississippi Legislature. Also served as the principal analyst for Mississippi’s waiver application extending eligibility for a population currently covered by Medicaid with state-only funds.
  
- Principal analyst and author of a report for the Ohio Department of Job and Family Services evaluating rates paid to hospitals for inpatient and outpatient hospital services for Medicaid beneficiaries.
  
- Principal analyst on an initiative whereby a Governor-appointed task force in Nevada was commissioned to evaluate and develop recommendations for changing the methodology and updating rates paid to Medicaid providers who serve the developmentally disabled population and those with behavioral health needs. Developed and evaluated the results of cost survey tools administered as part of the process of refining the rates.
  
- Established the rebased rates paid to Ohio’s state-owned homes for the developmentally disabled in 2002. This involved a comparison of the financial structure of each home and the composition and needs of the clients within the home.
  
- Project manager on a financial evaluation of homeless shelter providers paid by the New Jersey Department of Health and Human Services and provided recommendations for adjusting rates paid to these providers.

### **Education & Academic Qualifications**

Johns Hopkins University, Baltimore, MD  
Masters of Business Administration – 2001

Syracuse University, Syracuse, NY  
Bachelors of Science in Finance and Marketing – 1991

**Peter J. Burns, MBA**  
**President**  
**Burns & Associates, Inc.**

Mr. Burns has over 25 years of experience in public policy, with specialties in the areas of rate setting, finance, forecasting, administration, operations, strategic planning and legislation. During his public policy career, Mr. Burns has been a senior advisor to three governors and served as a state budget director, the director of a statewide in-house management consulting office, the chief research economist for a legislative body, and a tax manager for a FORTUNE 500 corporation. Mr. Burns is widely known for his work assisting state developmental disabilities programs in rate-setting and development of individual funding levels.

His expertise and experience extend across a wide range of state programs at various levels, from conceptualization and policy development to program planning, operations, evaluation, budgeting and accounting. Prior to founding Burns & Associates, he worked for another health care consulting firm with a national practice for eight years.

### **Representative Accomplishments**

#### *Experience Specific to Evaluation and Planning*

- Assisted the Nevada Legislative Counsel Bureau's Subcommittee on Health Care in developing a statewide strategic health plan. He managed this effort, which involved writing seven issue papers on facets of the plan, such as Medicaid coverage, private insurance coverage to small businesses, safety net provider coverage, prevention and wellness, behavioral health, medical education and workforce development, and strategic planning. Many of the issue papers required developing financial feasibility studies of proposals. A summit was convened of more than 100 stakeholders in the state to review and adopt the recommendations presented in the issue papers.
- Recently began assisting Arizona's Governor's Office in developing the design and implementation of a health insurance exchange as required by the Affordable Care Act (ACA). Prior to this, he helped Arizona's Medicaid agency (the Arizona Health Care Cost Containment System, or AHCCCS) research options for expanding health insurance through private sector, public sector and public/private mechanisms. AHCCCS hired B&A (and our subcontractor Bailit Health Purchasing) to research and draft policy papers specifically related to:
  - Identifying populations already eligible for Medicaid that are not enrolled
  - Options for implementing a premium subsidy program for low-income workers
  - Developing a high-risk pool product
  - Options for developing a health insurance exchange
  - Opportunities for employees if employers were required to implement Section 125 plans
  - Other cost containment strategies designed to lower premium costs

### *Experience Specific to Budgeting and Reporting*

- Completed a major revision to the Arizona disproportionate share methodology, including developing the DSH methodology revisions based on the CMS Waiver Terms and Conditions, conducting negotiations with CMS, and conducting meetings with hospitals advising them on implementation efforts.
- Assisted the Arizona AHCCCS program in a review of federal Title XIX and Title XXI reimbursement claiming procedures. Activities included review of agency policies and procedures; researching federal regulations, policies and administrative decisions; and reviewing algorithms used in the agency's Federal Funds Participation automation system. He also directed preparation of the Division of Business and Finance Claiming User Manual. Other projects have included the development of various initiatives to maximize federal funding under Titles XIX and XXI including identifying options for the Medicare upper payment limit, SCHIP funding, premium taxes, and modifications to CMS waivers
- While Director of the Arizona Governor's Office of Strategic Planning and Budgeting (OSPB), Mr. Burns oversaw the preparation, presentation and execution of budgets on behalf of three governors. Budget-related activities included:
  - Review and analysis of agencies' budget requests
  - Design and oversight of various forecasts for revenues, expenditures, populations and economic activities
  - Development and implementation of funding mechanisms for various public programs (including intergovernmental funding mechanisms)
  - Conferring with agency management on budget requests
  - Formulating recommendations for the governor
- While at OSPB, Mr. Burns also directed the work of an in-house consulting office that provided consulting services and training to state agencies in the areas of strategic planning, performance measurement, and team-directed business reengineering and process improvement. He oversaw the development of the guidelines, procedure manuals and governing legislation for outsourcing government functions and activities, and directed staff that provided privatization consulting assistance to the agencies. He initiated and managed enterprise-wide engagements relating to data processing planning (which contributed to the creation of a statewide information technology policy office) and human resource planning (which led to the first significant revision in state personnel laws in nearly two decades).

### *Experience Specific to Financing*

- For the Nevada Legislative Committee on Health Care, Mr. Burns conducted a study of indigent health care costs in the state and the existing DSH allocation formula. Recommendations contained in the report included a restructuring of the DSH allocation formula for the hospitals in the state.

- Helped the Louisiana Department of Health and Hospitals develop options to maximize the utilization of the full federal DSH allotment in support of community health initiatives and coverage of the uninsured.
- He has assisted a number of organizations in performing cost and caseload estimates for system reform or expansion initiatives. During these engagements, Mr. Burns was responsible for designing the methodology, collecting and preparing data, and performing program estimates. These estimates were utilized in submissions to CMS, in the preparation of state budget requests, and in implementation planning. Cost and caseload estimates were prepared for the following projects:
  - Arizona Section 1115 and HIFA waiver renewal as well as the original 2001 application to expand Medicaid coverage to all persons below 100% of the FPL
  - HIFA waiver for the Nevada Medicaid program
  - KidsCare, the Arizona SCHIP program
  - Oregon Section 1115/HIFA waivers (Oregon Health Plan 2)
  - New Mexico HIFA waiver program (State Coverage Initiative)
  - HIFA waiver application for the State of Louisiana
  - HIFA waiver study for the Health Care District of Palm Beach County, FL

*Experience Specific to Medicaid Operations*

- Mr. Burns assisted the New Mexico Hospitals and Health Systems Association and its partner, the Medical Assistance Division of the Human Services Department, in the implementation of the New Mexico HIFA waiver program (SCI). Activities included the development of the operational protocol, the identification of system requirements for the state's MMIS and eligibility systems, facilitating issues forums with Medicaid MCOs, and drafting policies and procedures.
- For the State of Arizona, he participated with AHCCCS in the development of the Hawaii-Arizona PMMIS Alliance (HAPA), a joint venture between Arizona and Hawaii to satisfy Hawaii's requirement for a Medicaid Management Information System. Mr. Burns:
  - Assisted in the development of the financial forecasts and fiscal policies and procedures relating to the agreement, the requirements analysis related to federal financial reporting, and the preparation of the financial components of the Advance Planning Document
  - Drafted the enabling legislation
  - Assisted in the preparation, presentation and defense of the Project Investment Justification package for the Information Technology Advisory Committee
  - Assisted in developing the specifications for modifying the AHCCCS Information Services Division's project tracking system

### *Experience Specific to Rate-Setting including Case Rates/Individual Funding Levels*

- In collaboration with the Human Services Research Institute, Mr. Burns has assisted in developing a Supports Intensity Scale (SIS) informed set of resource allocation guidelines for participants in waiver programs. This work has been or currently being conducted with HSRI for state agencies in Georgia, Louisiana, Missouri, Oregon, Rhode Island, and Alberta, Canada. Jointly, B&A and HSRI are also assisting a regional entity that participates in North Carolina's Innovations waiver.

Specific activities in the engagement include: developing the overall strategy for the project; the data collection, validation and review process; compiling and analyzing waiver expenditures by participant; arraying expenditure information by client demographic and SIS assessment characteristics; and developing guideline service packages and fiscal impact analyses.

- Often, a component of projects to set individual funding levels requires setting the rates paid to providers who serve behavioral health or developmentally disabled populations. Mr. Burns has led B&A's engagements in Arizona (DD and behavioral health agencies), Georgia, Louisiana, Oregon and Rhode Island. Tasks usually include:
  - A cost survey of providers
  - Provider training sessions to complete the tool
  - Developing independent rate models based on economic and market data
  - Fiscal forecasting
  - Establishing unit rate policies
- For the Arizona Department of Economic Security's Division of Developmental Disabilities (DES/DDD), additional tasks beyond rate setting included supervising the development of reporting systems to score clinical/environmental assessments and transform scores into unique consumer rates reflecting each individual's need. The rates were developed using cost information collected from providers in conjunction with the collection of market-based, Arizona-specific costs.

### **Education & Academic Qualifications**

M.B.A., Finance, Arizona State University, 1985

B.A., Political Science and Economics, Arizona State University, 1976

### **Professional Memberships**

National Association of State Budget Officers, Past President

### **Publications**

Engquist, G. and Burns, P., "Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States." *State Coverage Initiatives Issue Brief*, August 2002

**Stephen Pawlowski, M.B.A.**  
**Senior Consultant**  
**Burns & Associates, Inc.**

Mr. Pawlowski has more than six years of experience in human services operations and financing, budget development, and government affairs. Prior to joining B&A, Mr. Pawlowski was the Chief Financial Officer for the Arizona Department of Economic Security (ADES), a 10,000 employee, \$5 billion human services agency. ADES is the state agency responsible for delivering services to individuals with developmental disabilities under contract with the single state Medicaid agency, providing non-medical home and community based services to the elderly, managing the child welfare system, operating welfare and child support programs, and administering Department of Labor-funded programs.

Mr. Pawlowski previously worked in the Arizona Governor's Office of Strategic Planning and Budgeting as a Senior Budget Analyst. In this role, he was responsible for providing cost analyses for proposed legislation and program initiatives, as well as developing funding strategies for implementation.

**Representative Accomplishments**

- Provided analysis and implementation assistance for federal health care reform for the Louisiana Department of Health and Hospitals, including:
  - Integrating the legislation and its amendments to compile a “complete, integrated” version
  - Completed a section-by-section analysis of the bill, a timeline of effective dates, and other research requests as requested
  - Organized issues to facilitate the development of Issue Committees tasked with reviewing and implementing all provisions related to a topic area (e.g. Medicaid benefits, public health programs, etc.)
- Led a review of reimbursement rates for home and community based services for individuals with intellectual and developmental disabilities in Illinois and supported rate-setting engagements with Georgia, Missouri, and North Dakota
- Recently assisted the Texas Department of Aging and Disability Services in developing options for structuring pilots to administer services for adults with autism. The project including research of best practices in other states as well as meeting with a variety of stakeholders to vet options that were ultimately proposed in a concept paper.
- As CFO of the ADES, he directed a \$5 billion budget which included:
  - Long term care services for individuals with developmental disabilities
  - Early intervention
  - Eligibility determinations for Medicaid acute care
  - Child protection and child welfare
  - Employment and vocational rehabilitation programs
  - Adult protection and independent living supports for the elderly
  - Benefit programs including supplemental nutrition assistance and cash assistance
  - Child support

- Served as a member of the Arizona Department of Economic Security’s executive leadership team, responsible for agency coordination, strategic planning, and policy implementation.
- Participated in rate-setting projects for providers of services in the developmental disabilities program, including establishment and rebasing of independent cost models (published rates) and negotiations with providers for competitively procured services.
- Served as the liaison to the State Medicaid agency for the financial operations of the long term care program for individuals with developmental disabilities and eligibility determinations for acute care.
- Prepared ADES’ annual budget request for Executive and legislative consideration. Responsibilities included forecasting changes in caseloads, costing program initiatives, preparing summary materials, and presenting to the Governor’s Office, legislative committees, and stakeholders.
- Convened a workgroup to evaluate opportunities to better integrate the developmental disabilities and vocational rehabilitation programs, with the goals of increasing employment supports for individuals with developmental disabilities and maximizing the use of Rehabilitation Act dollars.
- Participated in workgroup to redesign the early intervention system. Activities included:
  - Assessing service delivery modalities
  - Setting provider rates, moving from cost-reimbursement contracts to published rates
  - Evaluating system funding and opportunities to increase revenues including increasing Medicaid’s participation and implementing family cost participation
- Managed various revenue maximization initiatives; major projects included:
  - Becoming the second State in the nation to successfully claim Temporary Assistance for Needy Families (TANF) contingency funds (approximately \$90 million)
  - Identifying Medicaid funding earned in previous years and devising strategy to claim these funds (\$30 million)
  - Amending ADES’ cost allocation plan to increase Title IV-E earnings in the child welfare system (an estimated \$10-plus million annually)
- Reviewed state and federal legislation and regulations for financial implications as well as drafted legislation and amendments to implement policymakers’ initiatives.
- Worked with elected officials on budget and policy issues as a registered public lobbyist
- Oversaw the preparation of quarterly financial statements for the long term care program for individuals with developmental disabilities for the State Medicaid agency.

### **Education and Academic Qualifications**

Master of Business Administration, Arizona State University, 2003

Bachelor of Science in Management, Arizona State University, 2001



## Curtis A. Mildner

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### Education

MBA	University of Virginia	Business Administration	1982
B.S.	Rutgers University	Environmental Science and Biology	1975

### Employment

Market Decisions, LLC	President, Senior Consultant	1999 -present
Central Maine Power Company	Vice President Marketing & Sales	1994-1998
Hussey Seating Company	Vice President Marketing	1987-1994
Dinsmore Communications	General Manager	1983-1987
Lehn & Fink (Now Reckitt Benkiser)	Marketing Manager	1982-1983

### Experience

Mr. Mildner serves as President and Senior Consultant at Market Decisions, providing overall company leadership as well as managing research and leading analysis and reporting for specific projects.

His previous research experience includes new product research at a consumer products company, marketing research at a business to business manufacturing company and public opinion polling, advertising testing and tracking and new product testing at an energy company, Central Maine Power.

Mr. Mildner brings a unique combination of experience conducting research as part of the marketing and communications process and acting on research as a line manager. He has used research to execute successful product launches, organizational development and reengineering, communications programs and branding challenges. He brings a practical perspective to Market Decisions' research to make it more meaningful and useful for clients.

Mr. Mildner personally moderates focus groups for many clients and leads all qualitative research. He was trained in focus group facilitation at the RIVA Institute of Bethesda MD, and is an active member of the Qualitative Research Consultants Association (QRCA).

### Professional Affiliations

Qualitative Research Consultants Association (QRCA)  
American Association Public Opinion Research (AAPOR)  
New England Chapter of American Association Public Opinion Research (NEAPPOR)  
Market Research Association (MRA)

## Brian Robertson

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### Education

Ph.D. University of Utah	Anthropology	1999
B.S. University of Utah	Anthropology	1991

### Employment

University of New England	Associate Research Professor	2010-
Market Decisions, LLC	Research Director	2000-present
Valley Research, Inc.	VP, Director of Research	1995-1999
University of Utah Survey Research Center Survey	Analyst, Project Manager	1986-1996

### Health Care Research and Evaluation Experience

Dr. Robertson has 25 years of health care research and evaluation experience. Dr. Robertson was recently appointed as an Associate Research Professor in the School of Graduate Studies at the University of New England.

### Experience

Dr. Robertson has over 25 years of research experience, with hands on experience managing survey research centers, designing surveys, conducting statistical analyses and reporting the results. Dr. Robertson was employed at the University of Utah Survey Research Center for ten years, initially as a research analyst then as a project manager and finally as acting manager. His private research experience includes five years as Vice President and Director of Research at Utah's largest research company, Valley Research. Dr. Robertson has helped design and manage over 200 studies during the past five years, including large-scale mail and telephone surveys. Dr. Robertson has experience in a full range of marketing and public policy research areas. His areas of expertise include overall research design, survey design, sampling methodology, survey project management, statistical analysis of data, preparation of reports based on collected data, and development of policy goals and objectives.

Dr. Robertson has a Ph.D. in Anthropology and a Bachelor of Science from the University of Utah. He is a member of the Market Research Association, and the American Association for Public Opinion Research (AAPOR). He is a former president of the New England Chapter of the American Association for Public Opinion Research.

### Computer Skills

Analytical Software: SPSS, SAS, SUDAAN

Expertise in CATI/CAPI programming: Ci3/WinCATI and CASES.

Sampling Software: GENESYS Sampling Systems Sample Generation Software

### Professional Affiliations

AAPOR (American Association for Public Opinion Research)

NEAAPOR (New England Chapter, American Association for Public Opinion Research)

MRA (Market Research Association)

## Jason K. Maurice

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### Education

Ph.D. Brandeis University	Social/Developmental Psychology	2004
M.A. Brandeis University	Social Psychology	1998
B.A. University of Southern Maine	Psychology	1995

### Employment

Market Decisions, LLC	Research Associate	2005-present
George Washington University	Adjunct Instructor	2002-2005
Brandeis University	Research Consultant	2004
Brandeis University	Teaching Fellow	1997-2003
Heller School for Social Policy	Research Associate	1997-2001
University of Southern Maine	Research Assistant	1995-1996

### Health Care Research and Evaluation Experience

Dr. Maurice has 15 years of health care research and evaluation experience.

### Experience

Dr. Maurice serves as a Research Associate for Market Decisions. His primary responsibilities include project management, survey and research design, advanced statistical analysis, preparation and writing of reports for healthcare and public policy research projects, SPSS and SUDAAN programming, data editing and coding.

Dr. Maurice has 15 years of experience in survey research regarding health and public policy related issues. He has been involved in several projects examining tobacco, drug, and alcohol use, as well as projects examining physical activity and nutrition.

Prior to joining Market Decisions, he served as Research Consultant for the Social Perceptions Lab at Brandeis University, as Research Associate at the Heller School for Social Welfare at Brandeis University and as Research Assistant at the University of Southern Maine. Dr. Maurice also has extensive teaching experience, teaching research methods for health professionals at George Washington University, research methods, statistics, introductory psychology, and social psychology at Brandeis University.

### Computer Skills

Statistical: SPSS, SAS, SUDAAN

Programming: WinCATI, Ci3,

Other: Ci3, MS Word, Excel, and PowerPoint

### Professional Affiliations

AAPOR (American Association for Public Opinion Research)

NEAAPOR (New England Chapter, American Association for Public Opinion Research)

## Patrick A. Madden

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### Education

MBA	University of Southern Maine	Business Administration	2003
B.S.	University of Southern Maine	Business Administration	2001

### Employment

Market Decisions, LLC	Research Analyst	2003-present
Center for Business & Economic Research	Research Assistant	2000-2003

### Health Care Research and Evaluation Experience

Patrick Madden has 10 years of health care research and evaluation experience.

### Experience

Patrick Madden has been a Research Analyst at Market Decisions since 2003. As such, he manages survey research projects and conducts ad hoc analysis related to healthcare and public-policy related research. Mr. Madden develops survey instruments and sampling methodology, and is responsible for development and administration of internet surveys. He also has expertise in CATI programming, GIS development, and Visual Basic programming. He often performs data analysis and prepares written reports.

Mr. Madden has also worked as a Research Assistant at the Center for Business and Economic Research, at the University of Southern Maine between 2000 and 2003. At the Center, he managed a variety of program evaluation studies, conducted advanced statistical programming and analysis, and prepared extensive reporting on research results and evaluative findings.

Mr. Madden has Bachelor of Science degree in Business Administration and a Masters Degree in Business Administration from the University of Southern Maine. Mr. Madden is a Phi Kappa Phi Honor Society member, a Beta Gamma Sigma Honor Society member and a cum laude graduate of The University of Southern Maine

### Computer Skills

Statistical: SPSS, SAS, SUDAAN

Programming: WinCATI, Ci3, ArcView GIS, Visual Basic, SQL, ColdFusion, JavaScript

Database: Access, SQL Server

Other: MS Office

### Professional Affiliations

AAPOR (American Association for Public Opinion Research)

NEAAPOR (New England Chapter, American Association for Public Opinion Research)

## **Karen Bender, FCA, ASA, MAAA**

**(Milwaukee)**

### **CURRENT RESPONSIBILITIES**

Karen is a Principal in the Oliver Wyman Milwaukee office. She specializes in health care and supports the actuarial needs of risk assuming entities in the insurance and managed care industry. This includes providing services to insurance and managed care companies, governmental entities as well as providers on traditional actuarial matters, underwriting issues, provider contracting and reimbursement arrangements, capitation development, data requirements and reporting, product design and implementation, operational issues, as well as determining the impact of proposed and/or passed legislation.

### **EXPERIENCE**

Prior to joining Oliver Wyman in 1995, Karen worked for insurance companies for twenty years specializing in managed care, health insurance reforms and policies, valuation. Karen is recognized nationally as an expert in the individual and small group health insurance market. Karen is a frequent speaker and the author/co-author of many papers.

Karen's actuarial experience has included:

- Testifying before the U.S. Senate HELP committee November, 2009, regarding the results of Oliver Wyman modeling of proposed federal reforms and anticipated impact on the small employer market.
- Letter to HHS representing American Academy of Actuaries describing actuarial concerns and questions of Interim Final Rules pertaining to guarantee issue for children, elimination of lifetime and annual maximums, etc.
- Modeling of impacts of proposed small group premium subsidies for several states
- Analyses of proposed individual and small group market reforms for various states
- Analyses of emerging experience and development of premium rates for individual, small group and large group products for managed care organizations and insurance companies
- Reviews of rating and underwriting strategies and outcomes for both individual and small group markets

### **EDUCATION**

Bachelor's degrees in Mathematics and Economics, University of Wisconsin, Stevens Point

### **AFFILIATIONS/ DESIGNATIONS**

- Fellow of the Conference of Consulting Actuaries (FCA)
- Associate in the Society of Actuaries (ASA)
- Member, American Academy of Actuaries (MAAA)
- Qualified Health Actuary and, to her knowledge, the only QHA in the country to attain membership in the Society of Actuaries
- Karen is on many American of Academy of Actuaries committees and chairs the Benefits committee and the Small Employer Committee
- Spokesperson for the AAA

## **EDWARD C. FISCHER, MBA**

(Phoenix)

### **CURRENT RESPONSIBILITIES**

Ed is a Principal in the Phoenix office of Mercer Government Human Services Consulting (Mercer). He leads and manages client projects related to healthcare reform and implementation, capitation and fee-for-service rate development, revenue maximization and system improvement.

### **EXPERIENCE**

Before joining Mercer in 1999, Ed was a management consultant for a property/casualty risk retention pool as well as an underwriter/client manager in the financial services industry. He also was a state legislative analyst intern. Overall, Ed has gained relevant experience since 1992. His work has included:

- Overseeing projects on full-risk capitation rate setting, strategic consulting, healthcare reform and affordability, uninsured initiatives, and risk-adjusted rate setting
- Overseeing development of fee-for-service rates for developmentally disabled and mental health services
- Developing data reporting and monitoring tools
- Designing and auditing Health Insurance Payment of Premium (HIPPP) and premium assistance programs and their related cost effectiveness evaluation models
- Completing financial and operational efficiency audits
- Assisting clients with contracting issues, from proposal development to negotiation to contract renewals
- Participating in actuarial projects for over 12 states' Medicaid programs
- Corresponding with the media
- Facilitating discussions with insurers, CMS, affiliated state agencies, legislative and executive members of government on program initiatives
- Facilitating fee-for-service fee schedule discussions with providers and full-risk capitation negotiations with managed care organizations
- Assisting clients with designing and implementing integrated Medicaid and Medicare programs

### **EDUCATION**

- Master's degree in Business Administration, Arizona State University
- Bachelor's degree in Psychology, University of Arizona

## **STACEY LAMPKIN, FSA, MAAA**

(Phoenix)

### **CURRENT RESPONSIBILITIES**

Stacey is a consultant in the Actuarial Sector for Mercer Government Human Services Consulting (Mercer) and serves as an actuary on Mercer's Medicaid teams for several states. In addition to rate setting and other Medicaid expense projections, Stacey provides actuarial analysis and support on reform policy and projects related to expanding health insurance coverage.

### **EXPERIENCE**

Prior to joining Mercer in 2004, Stacey worked in health care actuarial consulting for six years, primarily in the commercial sector.

Stacey's actuarial experience has included:

- Developing rates for Medicaid and uninsured populations for use by states in contracting with managed care organizations, using both fee-for-service data and managed care organization (MCO) financial experience
- Estimating ramp-up and ultimate enrollment patterns for state-coverage initiatives, such as Cover All Pennsylvanians
- Lead actuary working with the Massachusetts Connector Authority in initial design, contracting and pricing of Commonwealth Care program
- Modeling medical, dental and pharmacy costs for different types of benefit plan designs and member populations, for both self-funded plans and fully insured products
- Renewal rating analysis and new product design and pricing for small group and large group products
- Modeling health care delivery system reform and National Health Expenditures for the Republic of Cyprus

### **EDUCATION**

- Master's degree in public administration (emphasis: policy analysis), Florida State University
- Bachelor's degree in political science, Mississippi State University

### **AFFILIATIONS/ DESIGNATIONS**

- Fellow of the Society of Actuaries (FSA)
- Member, American Academy of Actuaries (MAAA)
- Stacey is the vice chairperson of the American Academy of Actuaries Uninsured Work Group

## **Sheree Swanson**

### *Partner and Senior Actuary*

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#### *Current Responsibilities*

Sheree Swanson is a Partner in the Seattle office of Mercer Health & Benefits LLC. She currently serves in a lead consulting role for several government, health care, and retail employer clients in the Seattle office and provides actuarial support to other local office clients. Sheree leads the Mercer Health & Benefits Actuarial and Financial Group Standards of Practice committee, and is a member of Mercer's National Health Care Reform modeling workgroup.

#### *Experience*

Sheree has spent 30 years as a health care consulting actuary. Prior to her current responsibilities with Mercer, Sheree spent four years working exclusively with a Mercer jumbo employer client as their lead health benefits and actuarial consultant. She also worked with several state governments assisting them with employer plan design and pricing, setting reserves, and analyzing the fiscal impact of proposed legislative changes related to health benefits. She has also participated in efforts within the local health care community including the Incentives Work Group of the Puget Sound Health Alliance, and as an advisor to the Washington Artists Health Insurance Project. Before joining Mercer in 1998, Sheree was a principal with an international accounting firm, consulting for 18 years with government clients, health plans/providers, and other employers. Her projects there included:

- Working on health care reform projects for several states
- Participating in a Field Test for the Financial Executives Research Foundation on Retiree Health Benefits
- Advising public and private sector clients on health and welfare plan funding rates, pricing, reserve setting, contributions, renewal negotiations, and related strategies.

#### *Education/ Designations/ Affiliations*

- Bachelor's in applied mathematics, University of California, Berkeley
- Associate of the Society of Actuaries, Member of the American Academy of Actuaries, former participant on several committees on topics of federal and state health care reform and postretirement health care benefits
- Risk adjustment topic team lead of International Association of Actuaries Health Section
- Licensed life and disability insurance broker in Washington and other states



## SUE FRECHETTE

### ***PROFESSIONAL EXPERIENCE***

#### **NORTHFIELD ASSOCIATES LLC**

**2001 - Present**

##### ***Principal, Healthcare Consulting***

Manages a consulting firm focused on the design, development and implementation of business strategies and performance improvement programs for the healthcare industry. Draws from a large network of senior level consulting executives to tailor make the best possible team for any given engagement – teams with individuals who have the specific expertise and ‘real world’ experience to address the client objectives. Often features an innovative facilitation approach to guide executives and decision makers through rapid resolution of complex issues. Sample engagements include:

- Conducted feasibility analysis for a payer in response to the CMS Medicare Modernization Act, Part D – Identified core competencies, market considerations, revenue potential and investment requirements for becoming a standalone Prescription Drug Plan (PDP).
- Developed an integrated governance approach to involve key stakeholders in addressing the key clinical, technical, financial and performance measurement aspects of Health Information Exchange (HIE) in accordance with CMS and American Recovery and Reinvestment Act (ARRA) requirements
- Led stakeholder groups in the development of pay for performance measures sets for 3 national specialty physician organizations in response to the CMS Physician’s Quality Reporting Initiative (PQRI) program
- Coordinated the UM, CM, DM strategies for a national payer, eliminating gaps and duplication of services, improving the management of chronic conditions
- Developed a value based benefit design for obesity with comorbidities built upon evidence base and leading practices in obesity management.
- Rationalized the pharmacy benefit management and medical management strategies for a large national health insurance company

#### **CAP GEMINI ERNST & YOUNG**

**1994 - 2001**

##### ***Senior Manager, Healthcare Practice***

Managed and directed different consulting engagements for Cap Gemini Ernst & Young’s Healthcare Practice. Facilitated communication between business, clinical and information technology professionals in order to successfully develop strategies, as well as design, develop and implement innovative healthcare solutions. Sample engagements include:

- Led several programs within a 3-year enterprise-wide Transformation for a \$20 billion National Managed Care Organization. The insurance sales transformation program included analysis of their current situation, preparation of a request for proposal, vendor selection and package implementation while standardizing processes.

- Developed several multi-product, multi-state, implementation plans designed to accelerate realization of benefits and minimize disruption to operations while implementing new processes, procedures, systems, and organizational structures
- Directed an integrated program to conduct an enterprise-wide assessment of the indemnity and managed care lines of business of a Blue Cross Blue Shield organization and develop a portfolio of projects critical to the transformation of the organization. Created a network policy, marketing plan and performance management program as well as a 3-year system implementation plan.
- Led the medical management strategy implementation for a statewide HMO with a focus on improving access to specialty healthcare providers. Designed the project with emphasis on building project management skills among client team members.
- Designed system enhancements to support an innovative disease management program for a large regional HMO. Also analyzed medical management procedures and developed interim strategy for immediate medical expense reduction.

**TRAVELERS INSURANCE COMPANY, Hartford, CT**

**1987-1994**

***Director, Managed Care Products***

***1990-1994***

Directed the design and implementation of the first managed care program servicing the Workers' Compensation industry in the US. Flexible design accommodated different states' regulations. Led the redesign of a new utilization management program with an emphasis increasing access to healthcare and facilitating return to work. Developed a customized, national network of specialty physicians focused on work related injuries and workplace health.

***Rehabilitation Coordinator***

***1987-1990***

Coordinated on-site case management activities for individuals with challenging rehabilitation needs following work-related injuries and motor vehicle accidents. Facilitated interaction among individuals, physicians, employers and insurance payers.

**VARIOUS CLINICAL AND MANAGEMENT POSITIONS**

**1980-1987**

**Personal Health Care Services, *Director of Nursing*, Albany, NY**

***1985-1987***

**Staff Builders, *Field Nursing Supervisor*, Stamford, CT**

***1984-1985***

**Immanuel Hospital, *Registered Nurse, Trauma Unit*, Portland, OR**

***1983-1984***

**Beth Israel Hospital, *Registered Nurse, Cardiac ICU*, Boston, MA**

***1980-1983***

***EDUCATION***

MBA, Rensselaer, Hartford, CT

1996

MS Community Health Education, Sage Graduate School, Troy, NY

1990

BS Nursing, Saint Anselm College, Manchester, NH

1980

***AFFILIATIONS***

Mad River Valley Health Center Board of Directors, Waitsfield, VT

2004-2010

## Erica Garfin, M.A.

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***Consultant in health and social services planning*** with 25 years of experience in planning, public policy, government relations, advocacy, non-profit administration, and organizational development. Skilled in research, design, and implementation of planning processes and program development. Areas of expertise include:

- Planning, development, and evaluation of services and programs in health and social services.
- Needs assessment.
- Development of methodology and facilitation of strategic planning processes.
- Focus groups and qualitative research.
- Working with groups with diverse viewpoints to set goals, identify priorities, and reach decisions.
- Creating processes for consumer involvement in planning.
- Project coordination and management.
- Meeting facilitation.
- Clear writing for lay persons, including "easy-to-read" publications.
- Organizational planning.

### PROFESSIONAL EXPERIENCE

**Independent Consultant to State Government and Non-Profit Organizations** 1996-present

*Please see my Client and Project List for a detailed list of consulting clients and projects.*

- AIDS Community Resource Network (ACORN)
- American Hospital Association
- Behavioral Health Network of Vermont
- Green Mountain United Way/Central Vermont Coalition for Health
- Rutland Regional Board for Family Services/Rutland Area Prevention Coalition
- Students FIRST of Chittenden County
- Vermont Cancer Survivor Network
- Vermont Center for Crime Victim Services
- Vermont Children's Forum
- Vermont Commission on Women
- Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)
- Vermont Department of Disabilities, Aging and Independent Living (DAIL)
- Vermont Department of Health
- Vermont HIV/AIDS Care Consortium
- Vermont Information Technology Leaders, Inc.
- Vermont People with AIDS Coalition
- Vermont Program for Quality in Health Care
- Vermont Supreme Court / Chief Justice Paul Reiber
- Waterbury Senior Center

**Sun Yat-Sen University, Guangzhou, China** 2006  
Guest lecturer for Masters and undergraduate students in the Social Work Department.

**Bi-State Primary Care Association, Montpelier, VT** 2000 – 2002  
*Women's Health Coordinator*  
Coordinator of Women's Health Vermont, a diverse, statewide coalition of providers, consumers, and advocates working to increase access and reduce health disparities for underserved women in Vermont. Responsible for all aspects of project, including recruitment, member relations, planning, research, staffing work groups, and meeting facilitation. Prior to moving into this position, served briefly as Community Development Coordinator, focusing on establishing federally qualified health centers in Vermont.

**Vermont AIDS Council, Montpelier, VT** 1990-1995  
*Executive Director*  
Director of non-profit, statewide coalition of community-based AIDS service organizations. Performed systems planning and public policy advocacy with state agencies and other organizations. Lobbied in Vermont legislature. Performed administrative, grant writing, fiscal, fundraising, and board relations functions. Administered grant programs that funded AIDS service organizations, including overseeing creation of quality improvement program. Provided technical assistance to member organizations. Created media presence about AIDS in Vermont.

**Vermont Center for Independent Living, Montpelier, VT** 1984-1990  
*Director, Information and Referral Program*  
Administered telephone-based program that provided intake counseling, assessment, information and referral, and technical assistance on disability-related issues. Hired, supervised, and evaluated staff. Wrote grant proposals, documented activities for major federal grants. Designed and implemented staff training program. Participated in systems planning and advocacy.

**Johnson State College, Johnson, VT** 1983-1987  
*Advisor*  
Advised independent studies and internships on health-related subjects for students in the External Degree Program.

**Community College of Vermont, Barre, VT** 1983-1984  
*Instructor*  
Taught Concepts of Health, an introductory health survey course.

## EDUCATION

**Sarah Lawrence College** 1982  
**M.A., Health Advocacy**  
Clinical training in helping patients to negotiate health care systems, both in (as patient representative) and out of institutions, with emphasis on patients' rights.

**University of California, Berkeley** 1972  
**B.A., South and Southeast Asian Language and Literature**

## **PROFESSIONAL DEVELOPMENT**

*Working in the Groan Zone: Tools for Facilitating Difficult Meetings*—Woodbury College

*Planning and Running Effective Meetings Training*—TAP-VT

*Advanced Low Literacy Communication Skills Training for Health Professionals* --University of New England, Maine AHEC Health Literacy Center

## **PROFESSIONAL AFFILIATIONS AND AWARDS**

Vermont Program for Quality in Health Care, Board of Directors; Chair 2005-08 2003-2008

Recipient of Vermont Dept. of Health/Dept. of Education AIDS Service and Education Award 1993

Vermont HIV/AIDS Care Consortium, Steering Committee 1992-1995

AIDS Professional Training Group, Steering Committee 1990-1995

Vermont Consumers' Campaign for Health, Board of Directors 1989-1996

Vermont Ethics Network, Steering Committee 1989-1990

## **COMMUNITY INVOLVEMENT AND PUBLIC SERVICE**

Vermont Human Rights Commission. Gubernatorial appointment. Chair 1999-2005. 1997-2005

Vermont Public Radio, Community Advisory Board 1996-1999

Health Policy Council. Gubernatorial appointment. Chair, Long Term Care Committee 1988-1991

Volunteer and board member for grassroots community-based organizations.

Activities included crisis intervention, support, counseling, advocacy, and referrals.

Performed grant writing, fundraising, and public relations functions:

- Vermont Refugee Assistance 1986-1989
- Sexual Assault Crisis Team of Washington County 1984-1987
- Chelsea Area Help for Battered Women 1983-1984

## Carry J. Buterbaugh, MS

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### Education

PhD 2010 Muskie School of Public Service, University of Southern Maine  
*Expected Completion Date: December 2010*  
MS 1998 Clemson University  
BS 1996 University of Utrecht

### Employment

Center for Community and Public Health, University of New England	2010-present
Research Associate	
Maine Center for Public Health	2009-2010
Senior Evaluator	
Muskie School of Public Service University of Southern Maine	2002-2008
Project Analyst/ Program Assistant	
Clemson University	1998-2004
Research Associate/Data Specialist	
Cooperative Extension, New York Cornell University	1999-2001
Extension Educator	

### Experience

Carry Buterbaugh, MS, has experience in conducting qualitative and quantitative evaluations for various statewide public health programs. At CPH, Ms. Buterbaugh directs the acquisition, management and analysis of health data sets used in the Center's research studies, including state-level claims, hospital inpatient/outpatient, BRFSS, and special health survey data. She also develops research study project plans and manages research project work plans and provides internal and external consultation on health care evaluations..

### Computer and Language Skills

Windows/Office 95-XP (including Microsoft Word, Excel, Powerpoint, Visio, Publisher and Access),  
Adobe Acrobat, SPSS, Stata, ArcGIS, Basic HTML/Web Site Administration, Mac OS X

English and Dutch – Fluent

French and German – Moderate

## Ronald D Deprez, Ph.D., MPH

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### Education

MPH 1982 Harvard School of Public Health  
Ph.D. 1977 Rutgers University  
MA 1972 Rutgers University  
BA 1967 Franklin and Marshall College

### Employment

Center for Health Policy, Planning and Research, University of New England Executive Director	2006-present
Public Health Resource Group President	1988-2006
Public Health Research Institute President	1991-2006
Edmund S. Muskie Institute of Public Affairs Institute Associate	1993-1995
Medical Care Development Inc. Director, Division of Research and Evaluation	1982-1989
Medical Care Development Inc. Director, Office of Research and Development	1978-1982
Maine State Legislature Director, Legislative Health Policy Analysis Project	1975-1978
State of Maine Executive Department Director of Research: Governor's Task Force on Corrections	1972-1975

### Experience

As President and Founder of PUBLIC HEALTH RESOURCE GROUP (PHRG), INC., and now as Executive Director of the Center for Health Policy, Planning and Research, Dr. Deprez provides research and consultation on the development and application of health assessment and evaluation tools for health services planning, health information and disease surveillance systems, quality assurance and public health preparedness, on a scale encompassing rural health systems, urban American regions, and developing nations. He is the primary developer of the population based health planning tools used by CHPPR (formerly PHRG) including specific planning and assessment tools for chronic disease improvement care including cardiovascular health, diabetes, Chronic Obstructive Lung Disease (respiratory health), and adolescent health and behavioral health services. Dr. Deprez's multi-disciplinary work involves the design and evaluation of health care programs and demonstrations, public health preparedness initiatives and health improvement strategies.

Dr. Deprez is an expert in chronic disease delivery systems—ranging from screening, detection, education, treatment and follow-up care for persons with diabetes, hypertension, heart disease, selected cancers, asthma, and COPD. A focus of the Center is the development and application of health planning and assessment tools to identify and evaluate the health service needs of populations, in particular care management services for persons with chronic medical conditions including behavioral health

conditions. Using these tools the Dr. Deprez and the Center assists health care providers and systems in re-designing patient care to more closely meet the objectives of the Chronic Care Model developed by Dr. Edward Wagner and his associates.

Dr. Deprez and his colleagues at the Center are leaders in the development of population-based healthcare needs assessment and planning technologies. An example is the Center's Community and Institutional Assessment Process (CIAP), a set of research based planning tools for prioritizing and restructuring health services. This system has been used successfully determining a population's bed needs, in reorganization of local and regional health care delivery systems and in the development of practical health and medical education curriculum and training modules for classroom and on-site student and professional education programs.

**Selected peer-reviewed publications (in chronological order).**

- Deprez, RD, Miller, E, & Hart, SK. *A Study of Cardiovascular Risk in Maine*. Medical Care Development, Inc, May 1984. A report to the Maine Department of Human Services and the National Heart, Lung, and Blood Institute (NIH). (Grant #N01-HV92913.)
- Deprez, RD, Oliver, C, & Halteman, W. "Variations in Respiratory Disease Morbidity Among Pulp and Paper Mill Town Residents." *Journal of Occupational Medicine*, July 1986; 28 (7): 486-491.
- Deprez, RD, Pennell, BE, & Spindler, MA. "The Substitutability of Outpatient Primary Care at Rural Community Health Clinics for Inpatient Hospital Care." *Health Services Research*, 22:2 (June 1987). (Grant #18-P-98061.)
- Deprez, RD, LaCasse, J, Peterson, J, & Bowes, C. "Hospital Utilization, Health Status and Rural Health System Delivery Characteristics" September 1991. (Final Report to the Agency for Health Care Policy and Research, PHS. Grant #HCT-1-R01-HS05756-01A1.)
- Deprez, R.D., and Horton, S. "Community Health Status and Service Needs Assessment: An Analytic Tool for the Changing Health Care Delivery Systems." *Journal of Hospital Marketing*: 1996, 10(2).
- Deprez, RD., Agger, M. and McQuinn, L. (aka Niccolai) "Obstetrical Care Use, Access to Physicians, and Adequacy of Prenatal Care for Medicaid Patients in Maine, 1985-89." *Journal of Obstetrics and Gynecology*. Vol. No : Sept., 1996.
- Oliver LC, Deprez RD, Asdigian, NL, Anderson N, Baggott L, and Chilmonczyk B. "Use of an integrated data system in statewide asthma surveillance." *American Journal of Respiratory and Critical Care Medicine*. 1998; 157: A44.
- Deprez RD, Oliver LC, and Asdigian N "Statewide Asthma Surveillance System—a Prototype". *American Journal of Public Health*. 2002; 92:1946-1951.
- Henneberger PK, Deprez RD, Asdigian N, Oliver LC, Derk S, Goe SK. Workplace exacerbation of asthma symptoms: findings from a population-based study in Maine. *Archives of Environmental Health* 2003; 58:781-788
- Deprez RD, Kinner A, Millard P, Mellett J, and Baggott LA. "Improving Care Management for Patients with COPD: Results of a three year Rural Practice Collaborative." *Population Health Management [formerly Disease Management]*. 2009; 12(4): 209-215



## Karen ORourke , MPH

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### Education

MPH 1983 San Jose State University  
BA 1978 University of California, Berkeley

### Employment

Center for Community and Public Health, University of New England	2010-present
Deputy Director of Program Development	
Maine Center for Public Health	1999-2010
Vice President, Operations	
Portland Public Health Division, City of Portland	1994-1999
Portland Public Health Division, City of Portland	
Maine Bureau of Health, ASSIST program	1992-1994
Health Educator	
American Cancer Society, Massachusetts Division	1985-1992
Director of Government Affairs and Special Projects	
American Cancer Society, California Division	1984-1985
Director of School Projects	

### Experience

As the Deputy Director of Program Development, Karen oversees proposal development on behalf of the Center for Community and Public Health, as well as assist with the activities of the Maine-Harvard Prevention Research Center, including support for the implementation and evaluation of programs and policies that help meet the state Physical Activity and Nutrition Program, providing input on state funding applications and develop programs to meet state funding and priorities that support the Healthy Maine Partnerships.

### Computer Skills

Windows/Office 95-XP (including Microsoft Word, Excel, Powerpoint, Visio, Publisher and Access), Adobe Acrobat, SPSS, Stata, ArcGIS, Basic HTML/Web Site Administration, Mac OS X

### Articles and Publications

Joly B, O'Rourke K, Tilson H, Leonard J. Use of National Public Health Performance Standards to Assess Maine's Diabetes System, *J Public Health Management Practice*, 13(1), 69-72, 2007.

Polacek M, O'Rourke K, Root A. Take Time! School Physical Activity Project. Poster Session, APHA Annual Meeting & Exposition, November 4-8, 2006, Boston, MA.

O'Rourke K. Maine's Approach to Reduce Junk-food Marketing in Schools. Selected for Oral presentation during the 136th APHA Annual Meeting & Exposition October 25-29, 2008 in San Diego, CA.

## HANK STABLER, MPH

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### Education

MPH 2009 University of Michigan School of Public Health, Ann Arbor, Michigan  
BA 2004 Carleton College, Northfield, Minnesota

### Employment

The Center for Health Policy Planning and Research The University of New England <i>Research Associate/Development</i>	11/09-Present
Karlsberger Healthcare Consulting, Ann Arbor, MI <i>Intern</i>	5/08-6/09
Medical Care Development International (MCDI), Silver Spring, Maryland <i>Finance Officer</i>	8/04-08/07

### Experience

Prior to joining CCPH, Mr. Stabler worked as the Finance Officer at Medical Care Development International, where he worked for 3 years. In addition to his responsibilities assisting with the financial management and financial reporting for MCDI's portfolio of international public health projects, Mr. Stabler also assisted the Sr. Health Economist with logistics of an annual household survey conducted in Equatorial Guinea.

Mr. Stabler also participated in a number of informal evaluations while at the University of Michigan, including an evaluation of Detroit's Village Health Worker Partnership Program, as well as a cost-effectiveness study of MCDI's malaria control project in Equatorial Guinea that compared different delivery models for conducting indoor-residual spraying.

### Previous Account (Past 5 Years) -

#### PREVIOUS EMPLOYER

5/08-5/09 *Karlsberger Healthcare Consulting, Ann Arbor, MI*

- Assisted in strategic and operational planning, implementing lean design, and best practice programming for U.S.-based hospital planning and design.
- Responsible for quantitative and qualitative analysis for large hospital systems in San Francisco, Dallas, and San Antonio.

8/04-08/07 *Medical Care Development International (MCDI), Silver Spring, Maryland - Finance Officer*

- Responsible for assisting with the financial management and financial reporting for MCDI's \$20 million portfolio of international public health projects.
- Required close association with MCDI Director and Country Project Managers.
- Extensive familiarity with spreadsheets and other financial software (Quicken, MUNIS) as well as financial regulations and procedures for both private (Marathon Oil) and public donor agencies (US AID, World Bank, African Development Bank)

## Appendix B: Comparison of Massachusetts and Utah Exchanges



## **Drawing Lessons: Different Results from State Health Insurance Exchanges**

by Amy Lischko

### **Foreword**

In Massachusetts and across the country, the Commonwealth's health care reform has taken on an exaggerated "persona"; for some, it embodies all that is evil about government intrusion into health care markets; for others, it exhibits all the virtues of government action.

The simple fact is that the reform is an experiment. It is likely to succeed on some fronts and fail on others. Given the early stage of our 2006 reform, we are now only starting to gain access to data on outcomes, and the series of years covered is often inadequate to making judgments.

State-level experimentation is needed to test and ultimately to drive the national debate on health care reform. As occurred with welfare reform in the eighties and nineties, robust experimentation allowed federal officials to draw important lessons from the successes and failures of a number of states as they sought a thoughtful national welfare reform bill.

It is undeniably premature to enact a reasoned national-level solution based on Massachusetts' or other state experiments. They have yet to be evaluated. In a field as complicated as health care, where government involvement is already considerable and where states have historically played a defining role, we need a sensible debate based on facts.

That's where *Drawing Lessons* and the upcoming *Interim Report Card* series of reports come in. *Drawing Lessons* compares and contrasts features of the Massachusetts' health insurance "Connector" to Utah's experience with a differently structured exchange. Pioneer's *Interim Report Card* series will be the first comprehensive assessment of the Massachusetts Health Care Reform Act, analyzing its impact on access, financing and affordability, administration, and cost-effective quality of care.

Pioneer has not yet taken a position on the reform act. We seek first to understand and measure its performance empirically. Only after publication of the Report Card series will we begin suggesting fixes and formulating a comprehensive position. The tone and substance of current federal proposals does not remotely resemble the quality of dialogue we need.

*James Stergios*

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**Amy Lischko** has over fifteen years of experience working for the Commonwealth of Massachusetts, most recently as Director of Health Care Policy and Commissioner of the Division of Health Care Finance and Policy under Governor Romney. Amy holds a doctorate degree in health services research from Boston University and was one of the key authors of the administration's health care reform proposal.

## **Introduction**

Policymakers are considering several options for national health reform, each of which includes some form of “insurance exchange.” These exchanges allow the uninsured, and employees of small to medium-sized businesses, to compare qualified health plans, purchase insurance and, if eligible, receive subsidies toward the cost of their plans. Two states, Massachusetts and Utah, have already established their own, independent insurance exchanges. Their experiences offer many valuable lessons for other states.

Massachusetts’ Commonwealth Health Insurance Connector Authority (Connector) was created by Chapter 58 of the Acts of 2006 as an independent quasi-governmental agency to implement key elements of the Massachusetts health reform law. The Connector serves many integral functions including management of both a state-subsidized insurance program called “Commonwealth Care” and an unsubsidized insurance program called “Commonwealth Choice.” The Connector was designed to assist both individuals and businesses in acquiring health care coverage through these programs, but also assumed numerous policy, administrative, and educational roles to facilitate effective implementation and execution of the overall health reform law.

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Massachusetts and Utah have already established their independent insurance exchanges. Their experiences offer many valuable lessons for other states.

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The Utah Health Insurance Exchange was established in March 2009 by HB 133 and HB 188. The laws directed the Office of Consumer Health Services to develop an internet-based information portal to connect consumers to information they need to make informed choices about health insurance. The overall goal of Utah’s exchange is “to serve as the technology backbone to enable the implementation of consumer-

based health system reforms.”<sup>1</sup> Small employers may offer “defined contribution” benefit plans through the exchange--reducing their administrative burden and making their annual cost for providing insurance more predictable. On the consumer side, three core functions were identified for the exchange: 1) provide consumers with helpful information about their health care and health care financing; 2) provide a mechanism for consumers to compare and choose a health insurance policy that meets their families’ needs; and 3) provide a standardized electronic application and enrollment system.

The following lessons from these two experiments point to opportunities and challenges that lie ahead regarding future exchanges. They suggest that allowing states flexibility in their execution of this new model will allow best practices to emerge.

***Lesson #1: Where the exchange is housed, and under whose direct authority, will play a large role in shaping the culture, practice and effectiveness of the organization.***

Utah and Massachusetts offer two distinctly different models for the governance, location of the exchange functions, and primary target populations. The Utah Health Insurance Exchange (UHIE) operates with just two employees within the Governor’s Office of Economic Development. Its location, under gubernatorial control and within an office that has a mission to promote the growth of Utah’s business community, small business in particular, has informed a good deal of the operational choices it has made. The eligibility standards for the Utah exchange initially include the phasing in of small businesses (2-50) and their employees over the first two years, with all businesses eligible to use the exchange by Fall 2011.

The size of the Utah staff dictated that much of the operational work of the exchange be done by private entities. Contracts for the system’s administrative and financial operation were negotiated quickly, with one-year renewal options to allow for flexibility and

modification in vendors and services. Utah's approach in developing its portal is to build on existing technology and work with the existing entities in the health care system to improve the technological interface with consumers.

Utah has developed a cooperative relationship with the business community and relied on significant, unpaid marketing and policy guidance from the private sector. The exchange does not have a board of directors. It does convene business leaders, primarily through the Salt Lake Chamber of Commerce, to solicit input and advice on its operations. In the way of outreach and education, the entire marketing budget for the exchange is \$10,000. The exchange has relied on brokers and business organizations to promote its use. Despite its meager budget and the lack of an individual or employer mandate in the market, demand for participation in the exchange's launch was enough to quickly fill the 100 employer slots allotted for its pilot phase and establish a waiting list of more than 150 for its next round of expansion.

The Massachusetts Health Insurance Connector Authority was established as an independent, quasi-governmental entity that is self-governing and a separate legal entity from state government. The Connector contracts with other state agencies and private businesses in fulfilling its responsibilities. The Connector is governed by a 10-member Board consisting of private and public representatives appointed by the Governor or Attorney General and chaired by the Commonwealth's Secretary for Administration and Finance. The Board approves most policy, regulatory and programmatic decisions at the discretion of the executive director, and generally meets on a monthly basis in a public forum. Massachusetts legislators invested significant decision-making authority in the Connector - which has largely performed both the regulatory and implementation duties for health reform in the Commonwealth.

But creating an entirely new organization to operate an exchange comes at a cost. The Connector's budget for FY09 was \$30 million. It employs about 45 people and pays an average salary of \$100,000.

There has been some criticism over the number of managerial positions created and the salaries paid to top leadership. Overall, the relatively "hands off" approach of the state's legislative and executive branch during the implementation of health care reform has empowered the Connector to act quickly and decisively. Although, it has concentrated major, system-altering decisions in the hands of a few individuals.

One of the fundamental decisions in establishing an exchange is whether it will be under the authority or influence of the state's health care or insurance agency. In Massachusetts, because of the visibility of the Connector as the entity championing health reform, the state's Division of Insurance ceded responsibility for many policy decisions to the new entity. The Connector is led by a former executive at one of the state's largest health insurance plans, but many of its staff are former employees of the state's Executive Office of Health and Human Services. The program is tethered closely to the MassHealth Medicaid program. MassHealth provides eligibility determination services for the Commonwealth Care program, which is similar in design to Medicaid, and until recently relied exclusively on the Medicaid Managed Care Organizations (MMCOs) that served MassHealth to provide benefits for Commonwealth Care enrollees as well (see below for more details).

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A fundamental decision in establishing an exchange is whether it will be under the authority or influence of the state's health care or insurance agency.

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This has led to what many perceive as a bias toward the subsidized Commonwealth Care program. Although the Connector serves both individuals and small businesses, the focus has been, by far, on low-income individuals without access to employer-sponsored health insurance who are eligible to enroll in subsidized plans offered through Commonwealth Care. Over 90% of the revenue generated for Connector operations comes from the administrative fee earned by the Connector for administering the

Commonwealth Care population. The Connector board and staff have spent a majority of their time discussing and debating the decisions around affordability and benefit levels for the subsidized population. In comparison, little effort has been spent thinking about how to motivate the carriers to establish Commonwealth Choice plans that add more value for non-subsidized individuals or for small employers.

***Lesson #2: The decision to place a subsidized population into a separate market at startup may be more politically acceptable; however, it may also prevent the population from transitioning to the competitive, private insurance market and cause unnecessary risk-segmentation.***

Massachusetts offers one model for how to facilitate subsidies and the purchase of insurance for lower-income individuals through an exchange. The primary focus of the Connector has been on the subsidized population, which is its own risk pool and exists entirely within the Connector. When health care reform was passed in Massachusetts, leading policy makers in the Commonwealth and Washington wanted the subsidized plans to look more like the private market and less like Medicaid. Therefore, the role of purchaser and insurance distributor for the subsidized product, Commonwealth Care, was located within the Connector rather than the state's Medicaid program. However, that's where the private market influence ended.

During negotiation of the health reform bill, the safety net hospitals that served a majority of those receiving "free care" in the Commonwealth expressed a strong concern that they would lose the foundation of their revenue stream under a new insurance-based model—particularly since it was proposed that much of the state's Disproportionate Share Hospital (DSH) funding would be redirected to pay for Commonwealth Care subsidies. To address this concern, the final legislation granted the state's existing four Medicaid managed care organizations (MMCO's) (two of which were also safety net providers) the exclusive

right to serve this population for three years. A fifth carrier, Centene Corporation, was approved to offer Commonwealth Care coverage beginning July 2009. Centene was the only new insurer to formally pursue the opportunity when bidding was opened.

The lack of interest by the state's dominant not-for-profit insurers (e.g. Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan) and by national for-profit insurers in serving the subsidized population in Massachusetts is an indication that true competition and market forces have yet to take hold in this segment of the market. Premium increases for Commonwealth Care plans have been kept well below the average increases for private insurance coverage over the last decade. This is primarily a result of the captive nature of the relationship—specifically the dependence of the predominant Commonwealth Care carriers on various forms of state funding. Many believe that significant cost-shifting is still occurring among the various public programs and from public to private plans. Coupled with the strong political pushback on rate increases by the Connector board and the Governor, one can see why most of the state's mainstream insurers and national for-profit insurers have thus far taken a pass.

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This situation could create problems for Commonwealth Care recipients should they transition from subsidized care into private coverage. They will not only face the loss of the subsidy, but many will need to move to another carrier and face the relatively higher cost of the private insurance market, which is pooled separately and is not under the same rate negotiations as the Commonwealth Care program. States considering using exchanges for their subsidized populations will need to carefully

consider whether those receiving subsidies should be part of the larger risk pool and have access to mainstream insurance products.

***Lesson #3: System capabilities including IT compatibility and connectivity can limit advances in administrative simplicity and bog down potential innovation.***

One of an exchange's primary goals is to transform the purchase of insurance from a confusing web of paperwork to a transaction akin to purchasing an airline ticket online. In order to achieve this, all transactions need to be fully integrated and automated to reduce paperwork, improve system and supply chain efficiency, and increase customer satisfaction. That means that brokers, consumers and employers should be able to compare price and quality information across plans and providers, get quotes, conduct cost-benefit analysis across plan types, combine payments from different payers, pay premium, and enroll in a plan, all via an electronic interface.

In Utah, three of the largest insurers in the state are currently participating in the new defined contribution market through the exchange. Other carriers expressed interest in participating in the launch but were unable to because of internal technology challenges. On the web portal side, the exchange has taken a relatively open approach to the addition of services and functions to its site, which has allowed for an expansion of offerings--even in the short period of time for which the site has been operating.

Massachusetts faced significant technological challenges in both its Commonwealth Care and Commonwealth Choice programs. In fact, the two programs remain operationally separated with distinct vendors responsible for enrollment, customer service, quality assurance, and billing.

In order to get systems up and running quickly, the Connector initially made the decision to purchase services for Commonwealth Care from existing

Medicaid vendors. Immediately there arose a number of billing system challenges, stemming from the fact that Commonwealth Care had a variety of benefit and co-payment structures, which were hard to align with Medicaid's much more standardized billing process. The challenges included the vendor's inability to process accurate monthly premium bills for Commonwealth Care consumers who frequently churn through the system and the renewal process for individuals, which was to many cumbersome and confusing. In addition, the close linkage with the Medicaid program (particularly around eligibility) made it difficult to provide accurate, understandable correspondence to members regarding eligibility and benefits.

Challenges in the Commonwealth Choice program included shortcomings in the initial billing system, which did not allow for e-payment of premiums (an electronic pay system was subsequently set up in Spring 2009). In addition, no technology currently exists for accepting premium payments from multiple sources, such as two spouses or from contributions from multiple employers. The small group employer contributory plan pilot had a very rocky launch due to problems with the program's website and the provision of information to brokers.

Finally, the Connector has thus far failed to provide detailed information relevant to not only health care financing choices, but also quality and transparency of the health care provider system. In Massachusetts, transparency of provider cost and quality information under the state's health reform law was delegated to an organization outside the Connector--the newly established Health Care Quality and Cost Council. As a result, consumers do not have access to fully integrated cost and quality information for insurance plans and providers through the Connector. Information on provider networks and participating primary care providers has just become available on the Connector's website at the end of its third year in operation.

Technology challenges exist for states interested in facilitating a model which transforms the purchase of health insurance from the employer to the individual.



How and with whom the state contracts for these services can make a big difference in the launch and ongoing capabilities of an exchange.

***Lesson #4: Small businesses are seeking “added value” through the use of an exchange, including assumption of HR functions, a predictable cost structure (defined-contribution program) and the ability to remove themselves as the middle man in insurance plan selection.***

An exchange can operate as a distribution channel for small businesses seeking insurance for their workforce and introduce greater portability, affordability and choice in the small employer insurance marketplace. It can be established as an optional or exclusive distribution channel and Massachusetts and Utah offer two models for discussion.

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Technology challenges exist for states interested in facilitating a model which transforms the purchase of health insurance from the employer to the individual.

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The need for increased affordability in the small group market in Massachusetts was acknowledged as an important goal for health reform. Choice and portability were also values that the bill’s original architects thought were important. While the Connector began offering a voluntary (non-contributory) insurance program for employees without access to employer sponsored insurance (ESI) in September 2007, its small employer program did not launch until December 2008, and only on a pilot basis.

The Contributory Plan, as it is called, allows small employers with 50 or fewer full-time employees to subsidize their employees’ purchase of health insurance through the Choice program. During the pilot phase, the plan is only available through certain

pilot brokers. An employer selects a level of plan for their employees (Gold, Silver or Bronze), agrees to pay at least 50% towards the employee premium (and meet employer participation rules), and a base employer contributory amount is set based on the employer’s selection of a plan within a coverage tier. Employees can then take that base employer contribution and select any carrier’s plan within the tier of coverage selected by the employer, but they may not buy a product outside the tier selected by their employer.

As of now, the small group contributory plans do not provide for greater predictability for employers as Massachusetts chose not to include a defined contribution method. Moreover, plan offerings are quite limited and similar to those available in the marketplace prior to reform. Because employers must choose a tier of coverage, their employees are not provided with as much choice as they may desire. These factors, plus consistent, double-digit increases in annual premiums, have combined to make this aspect of the Connector’s mission its least successful to date.

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An exchange can operate as a distribution channel for small businesses seeking insurance for their workforce and introduce greater portability, affordability and choice in the small employer insurance marketplace.

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Although more than 20,000 individuals have signed up for coverage through Commonwealth Choice program, 90 percent of these enrollees have entered the market as individuals. In other words, three years into the state’s reform effort, fewer than 150 employees of small businesses are receiving coverage through the Connector. This can be explained, in part, by the fact that early emphasis was placed on enrolling lower-income individuals. Still, the results are disappointing and reflect an overall inability to attract employers to the Connector’s model.

Meanwhile, rates for businesses under 50 employees have increased by double digits in each of the last two years, enough so that Massachusetts Governor Deval Patrick has announced he will file legislation to expand the state Division of Insurance's authority over health insurance premiums, allowing it to review insurance rates for small businesses before they go into effect and adjusting them if they are deemed "excessive" or "unreasonable." Currently, the Division of Insurance (DOI) does not have the authority to review health insurance rates before they go into effect. The DOI is also evaluating options that could possibly allow small businesses to join together to increase their purchasing power to buy health insurance. It is clear that health care reform and the Connector's model for small employers has not addressed the central issues of affordability and predictability for small employers.

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An exchange can be established as an optional or exclusive distribution channel and Massachusetts and Utah offer two models for discussion.

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In contrast, the Utah Exchange's biggest drawing card is that it is the only outlet through which employers can establish and fund a defined contribution plan for their employees. Although any individual is able to use the exchange to compare plans, the system was primarily designed for small employers, allowing for comparison, enrollment, premium determination, billing and collection. Employers determine how much they will contribute toward employees' premiums and then establish accounts for them with the exchange. After collecting limited health histories from all employees, the exchange creates a risk premium for the employer and applies it in determining the individual's final premium. Once this is completed, the employee can choose from among the 66 plans offered through the portal. It is too early to tell whether Utah's model will be successful at constraining health care costs for small employers and provide greater choice and portability for employees. However, their decision to extend two

of the most important factors in creating a sustainable exchange - exclusivity and predictability of cost - is promising.

***Lesson #5: An exchange with limited product choice for individuals that exists side by side alternative distribution channels should, at a minimum, develop robust consumer information and administrative support in the area of customer service.***

An important question for policymakers is how to position an exchange within the existing distribution channels in a state. Will it be an alternative to, work closely with, or subsume the current channels?

The Connector has been most successful in enrolling people in products where the statute deemed it to be the exclusive distributor, that is, in the subsidized Commonwealth Care program and the "young adult marketplace," where carriers may offer plans with more limited benefits to individuals aged 18 to 26. For small employers and non-subsidized adults over 26, it has not made significant progress. Many eligible individuals continue to purchase their insurance outside the Connector.

Since reform began, fewer than half of the 46,000 new enrollees in the un-subsidized, non-group market, have purchased their coverage through the Connector. In some cases this is because they require more assistance in purchasing insurance than the Connector's web-based tool allows. Although the Connector has an established customer service center, they primarily rely on a web-based model for shopping and enrolling in coverage. Consumers who need more guidance for their insurance purchase typically call the carriers directly to obtain individualized support and then enroll from there.

In addition, there is a wider choice of products for individuals outside the Connector. Some carriers offer products that either have not been approved or renewed by the Connector. For example, the authority has developed its own "seal of approval" process through which plans offered through the exchange

must meet higher standards in terms of benefit levels than those already in place for the state's overall insurance market. The Connector conducted focus groups with consumers purchasing in the non-group market and found that consumers generally wanted fewer, more meaningful product choices. That, in combination with the Board members' overall belief that standardization is important, has prompted the Connector to further reduce the number of options available to consumers through the Connector. However, if consumers continue to purchase products offered outside the Connector with greater frequency than inside, the Connector may need to evaluate whether this is a sustainable model.

States considering using an exchange as a distribution channel for individuals can learn from Massachusetts. Experienced staff who have the necessary IT expertise and understand the commercial health insurance market are essential for developing decision tools that present choices to consumers in a way that is easily understood. Licensed health insurance agents are required to provide excellent real-time customer service to individuals requiring additional support for the entire transaction.

***Lesson #6: Broker, provider and carrier support for reform is essential to success, both in passing exchange legislation and implementing a functional exchange.***

One of the lessons learned from earlier versions of small business purchasing cooperatives was the importance of harnessing broker, provider and carrier support.<sup>2 3 4</sup> Other states are advised not to underestimate these key stakeholders' influence in maintaining the status quo. Massachusetts and Utah again offer two approaches to consider.

An important barrier to the Connector's success has been resistance from brokers and carriers. An inability to tap the broker and payer networks more effectively in Massachusetts has resulted in continuing difficulties for the Connector, particularly in the small group market. Brokers make more money from a carrier if they bring an employer to a single

carrier versus sharing the administrative fee with the Connector. Brokers also tend to concentrate volume with particular carriers because their commissions go up with volume and there are significant retention incentives.

Although one could argue that it is less work for the broker to bring the employer to the Connector, as the Connector assumes some of the administrative responsibilities, thus far that has not been a persuasive argument. In fact, brokers have remarked that it is more work explaining to employers how this new model operates. Before passage of the reform law, brokers had saturated the Massachusetts small employer market with long standing, trusted relationships. Brokers are often responsible for the multitude of administrative tasks involved with purchasing insurance coverage, including explaining any changes in state or federal law that apply to employers, processing paperwork, and providing human resources support. It seems likely that the Connector needs to offer improvements in broker connectivity and other incentives in order to become a major player in the distribution of insurance to small employers.

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Experienced staff with necessary IT expertise and knowledge of the commercial health insurance market are essential to presenting choices in a consumer-friendly way.

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Massachusetts carriers also remain skeptical of the Connector and continue to provide and promote direct service to employer groups for administrative and risk selection reasons. The carriers with more market share have the most to lose if the Connector becomes a significant distribution channel for the small employer market. Not only will those dominant carriers give up margin and market share, they will disrupt broker relationships. Moreover, carriers are understandably risk averse and are afraid that if given choices, employer groups will segment themselves in a way that will result in adverse selection. Carriers have not, for the most part, delivered on developing

narrow network plans which would be more affordable and more attractive to small employers in an exchange model. Carriers greatly influenced the Connector to begin with a pilot program for its Contributory Plan for small employers, and to allow employee choice only within a tier of coverage.

Without the individual mandate or subsidies provided for in Massachusetts, policymakers in Utah realized that support for the initiative from the state's insurance brokers was a key element to their future success. Exchange staff developed strong relationships with brokers in designing and implementing their reform plan. Early feedback indicates that consistent, ongoing communication with and guidance from brokers, insurers and the business community has contributed to the enthusiastic reception the Exchange has received.

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One of the lessons learned from earlier versions of small business purchasing cooperatives was the importance of harnessing broker, provider and carrier support.

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The Utah Exchange has addressed the risk concerns of carriers head-on by developing a risk-adjustment methodology and implementing the program in a pilot fashion. This has occurred in what is arguably a more complex environment as Utah allows for rate adjustment for the health of an employer group in Utah while Massachusetts does not. However, only three of the nine carriers operating in the State are offering products in the Exchange during this pilot phase. It will be interesting to watch whether offering a defined contribution model with employee choice will be enough to attract a large number of employers to this new distribution channel.

Many opportunities exist to streamline the way insurance is designed, purchased, and used. An exchange typically touches all of these aspects. Part of what makes an exchange appealing is that it offers hope that the way health care is delivered can be changed. Being mindful of these important lessons

moving forward, states should be allowed flexibility in implementing exchanges so that policymakers can learn what does and doesn't work.

## **Endnotes**

1. From online brochure, accessed 11/09: <http://exchange.utah.gov/brochure.html>
2. Wicks, E.K. et al. March 2000. "Barriers to Small-Group Purchasing Cooperatives" *Economic and Social Research Institute*: accessed November 2005: <http://www.esresearch.org/Documents/HPC.pdf>
3. Curtis, Richard et al. 2001. "Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?" *Health Affairs* 20(1): 164-168.
4. Wicks, E.K. 2002. "Health Insurance Purchasing Cooperatives" *The Commonwealth Fund*: accessed November 2005: [http://www.cmwf.org/usr\\_doc/wicks\\_coops.pdf](http://www.cmwf.org/usr_doc/wicks_coops.pdf)



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## Appendix C: Certificate of Compliance

RFP/PROJECT: DVHA Planning for Vermont's Benefit Exchange DATE: 10/22/10

CERTIFICATE OF COMPLIANCE

This form must be completed in its entirety and submitted as part of the response for the proposal to be considered valid.

TAXES: Pursuant to 32 V.S.A. § 3113, bidder hereby certifies, under the pains and penalties of perjury, that the company/individual is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due to the State of Vermont as of the date this statement is made.

INSURANCE: Bidder certifies that the company/individual is in compliance with, or is prepared to comply with, the insurance requirements as detailed in Section 7 of Attachment C: Standard State Contract Provisions.

CONTRACT TERMS: The undersigned hereby acknowledges and agrees to Attachment C: Standard State Contract Provisions.

TERMS OF SALE: The undersigned agrees to furnish the products or services listed at the prices quoted. The Terms of Sales are Net 30 days from receipt of service or invoice, whichever is later.

FORM OF PAYMENT: Would you accept the Visa Purchasing Card as a form of payment? Yes \_\_\_ No [X]

Insurance Certificate(s): Attached \_\_\_ Will provide upon notification of award [X]

Delivery Offered: N/A days after notice of award Terms of Sale: N/A

Quotation Valid for: 60 days Date: 10-22-10 (If Discount)

Name of Company: Bailit Health Purchasing LLC Contact Name: Michael Bailit

Address: 56 Pickering Street Needham, MA Fax Number: 781 453 1167

E-mail: mbailit@bailit-health.com 07492

By: [Signature] Name: Michael H. Bailit Signature (Bid Not Valid Unless Signed) (Type or Print)

All returned quotes and related documents must be identified with our request for quote number.