



Health Reform Update – Week of September 29, 2014

CONGRESS

Second federal court says ACA subsidies are not authorized for federal Marketplace

Oklahoma Attorney General Scott Pruitt (R) prevailed this week in his lower court challenge to the premium tax credits offered under the Affordable Care Act (ACA) for consumers in federally-facilitated Marketplaces (FFMs).

The ruling by U.S. District Court Judge Ronald White for the Eastern District of Oklahoma closely followed the earlier decision from a three-judge panel for the U.S. District of Columbia Court of Appeals. That ruling invalidated the premium tax credits based on their claim that the ACA provision in question refers only to health insurance Marketplaces created by states (see Update for Week of July 21st).

The U.S. Fourth Circuit Court of Appeals in Richmond ruled to the contrary, concluding that when the specific provision was not pulled out of context, the surrounding provisions of the ACA clearly intended the tax credits to be offered to consumers in both state-based and federally-facilitated Marketplaces (see Update for Week of July 21st).

Judge White, appointed by President George W. Bush, stayed his ruling pending the Obama Administration's promised appeal to the U.S. 10th Circuit Court of Appeals, meaning the tax credits remain available to FFM consumers in Oklahoma. A related challenge has yet to be heard by the lower federal court in Indiana (see Update for Week of August 11th).

To date, all of the decisions have followed partisan divisions, with Republican-appointed judges united in opposition and Democratic-appointed judges unanimous in their support. The full District of Columbia Court of Appeals, controlled by Democratic appointees, has already agreed to rehear the adverse panel decision in December (see Update for Weeks of August 25th and September 1st). The 10th Circuit is narrowly controlled by Republican appointees.

House Oversight and Government Reform Committee chairman Darrell Issa (R-CA) specifically referenced the D.C. appeal in subpoenaing the Internal Revenue Service and Department of Treasury this week for documents that he believes will show that Administration officials internally doubted the validity of FFM subsidies.

The U.S. Supreme Court is expected to intervene only if a split in decisions remains at the appellate level once all pending cases are resolved.

GAO says most large insurers participated in Marketplaces, though plan options varied widely

The Government Accountability Office (GAO) released a new report this week showing that most of the nation's largest health insurers participated this year in the health insurance Marketplaces created pursuant to the Affordable Care Act (ACA).

GAO specifically found that for two-thirds of states, the insurer with the largest share of their 2012 individual or small group market participated in that respective Marketplace during 2014. An average of six insurers participated in the Marketplace for individuals and families, while an average of four participated in the small group Marketplace (representing 57 and 56 percent of the respective share of these markets in 2012).



Two states (New Hampshire and West Virginia) had only one participating insurer in their individual Marketplaces, though both will have increased competition in 2015 (see Update for Week of September 22nd). (Five states had only one participant in the small group Marketplace). The largest number of participants was 17 for the individual Marketplace in New York and 13 for the small group Marketplace in Maryland.

In 30 states, individual Marketplaces had more participating insurers than their small group counterpart. Just over 54 percent of individual Marketplace insurers also participated in the small group Marketplace for that state.

For both Marketplace versions, about 40 percent of participating insurers were non-profits, a dramatic increase from the outside markets where only nine percent of insurers were non-profits as recently as 2012. The ACA's creation of 22 non-profit insurance cooperatives (CO-OPs) was a major reason for this increase, as they made up 20 percent of all non-profit insurers participating in the Marketplaces (even though they were offered in only one-third of rating areas)(see Update for Week of June 23rd). In fact, CO-OPs were the only non-profit competing in nine individual Marketplaces and nine small group Marketplaces.

All but 12 percent of participating insurers offered more than the minimum-required number of plan offerings (at least one silver and gold plan). However, even though each individual Marketplace insurer offered an average of ten plans in each rating area (12 for small group Marketplaces), they varied widely in terms of the actual number of plans (ranging from seven to 178 in a given rating area).

Insurers in the most populous states tended to offer the most plan options for both Marketplace models. For example, consumers in Alabama, Connecticut, Delaware, New Hampshire, Vermont, West Virginia, and Wyoming had the fewest number of individual Marketplace options (only 11-25) while consumers in larger states led by Florida, New York, Ohio, Pennsylvania, and Texas had 101-280 plans from which to choose (California had only 51-100).

In addition, although 58 percent of rating areas had plans available at all metal levels, the most comprehensive platinum-level plans were unavailable to consumers in 42 percent of rating areas.

The Obama Administration reported last week that more than 80 percent of Marketplace consumers lived in a region served by at least three insurance carriers in 2014, and 96 percent of consumers could choose between at least two carriers. Their report found that each region averaged five carriers offering an average of 47 plan options (see Update for Week of September 22nd).

FEDERAL AGENCIES

CMS launches Open Payments website despite physician concerns about inaccuracies

The Centers for Medicare and Medicaid Services (CMS) officially launched the Open Payments website on September 30th, providing the public with a first glimpse into newly-collected data on payments that physicians receive from drug and device manufacturers.

The “physician payment sunshine” provisions of the Affordable Care Act (ACA) mandated the disclosure, which had been repeatedly delayed due to complaints by physician groups that much of the data reported earlier this year was erroneous or misleading (see Update for Week of August 18th).

CMS did agree to redact nearly one-third of records that it found to contain inaccuracies and extend the period of time for physicians to review the data and seek corrections. In addition, it withheld some data on research grants that could mislead the public into believing that physicians receive the entire amount even though portions were designated for other entities. However, the agency refused to



accede to industry demands to delay the public launch for six months (see Update for Weeks of August 25th and September 1st).

The final data released this week details roughly \$3.5 billion in manufacturer payments made to nearly 550,000 physicians and 1,360 teaching hospitals from August-December 2013. However, several provider and consumer groups immediately complained of technical glitches, error messages, and long delays, as well as the lack of an online search tool to see results for a given physician. (CMS relied on the same contractor responsible for many of the flaws in the ACA Marketplace portal last fall). In addition, there were many complaints that manufacturers made their payments difficult to analyze by reporting them under multiple subsidiaries instead of a single parent company, or by using different names to refer to the same product.

The agency stripped identifying details from 40 percent of the 4.4 million transactions released this week because they were not sure the data could be connected to a single physician or teaching hospital. Furthermore, provider names were redacted for about 64 percent of total payments, a figure that rose to 90 percent for research payments. (CMS has pledged to include the names of all recipients in its June 2015 release.)

Nearly 69 percent of all general payments went to physicians while teaching hospitals received about 25 percent. Roughly 31 percent of general payments were in the form of royalty or licensing fees paid to physician or hospital investors, while promotional speaking fees and consulting fees represented another 21 and 16 percent respectively.

Approximately \$130 billion of the payments came from Genentech, Inc., which was more than 3.5 times the second-largest amount attributed to the DePuy subsidiary of Johnson and Johnson. Pfizer came in third at \$20 billion.

OIG blames lack of federal oversight for disparate access under Medicaid managed care

A new report released this week by the Health and Human Services (HHS) Inspector General warned that federal and state officials are not ensuring Medicaid beneficiaries enrolled in private managed care plans have access to care.

There are currently 33 states with full-risk Medicaid managed care for more than 50 million enrollees. Federal regulations require Medicaid managed care organizations (MCOs) to offer "adequate access to all services covered." However, OIG noted that these regulations leave the definition of "adequate" up to individual states, resulting in widely disparate standards.

For example, some states only require one primary care provider per 100 enrollees while others require one per 2,500 enrollees. The distance that a physician must be within reach of all enrollees also varies from only five miles in Arizona to 100 miles in Delaware while the time an enrollee can wait for an appointment ranges from ten days in California and Pennsylvania to 60 days in Massachusetts.

The report notes that while some states specifically enforce these distance and waiting time standards for MCOs, others simply require a minimum number of providers in plan networks. However, only a handful of states actually verify the accuracy of the data provided by MCOs and most have failed to cite a single MCO for violations within the past five years.

The Office of Inspector General (OIG) points out that the lack of federal oversight of MCOs has gained critical importance as eight million new enrollees have been added to Medicaid this year under the Affordable Care Act (ACA) expansion (see Update for Week of September 22nd).

The Centers for Medicare and Medicaid Services (CMS) Administration concurred with most of OIG's recommendations for greater oversight, as well as the development of standards for urban versus



rural areas and primary care versus specialist care. She pledged to offer “additional guidance to states” in the future and the agency did issue a guidance document later in the week to improve MCO payments and ensure they are “actuarially sound” (meaning they cover all medical and administrative costs, as well as plan taxes and fees).

According to CMS, more than 70 percent of Medicaid enrollees nationwide are now in some form of managed care plan.

Survey shows that few Marketplace enrollees plan to change coverage for 2015

Roughly 29 percent of current Marketplace enrollees are considering changing to a different plan during the 2015 open enrollment period, according to a September poll conduct by Morning Consult.

According to final rules from the Centers for Medicare and Medicaid Services (CMS), the agency will automatically re-enroll Marketplace consumers in the same of similar plan if they fail to take any action by December 15th, one month after the new open enrollment period commences (see Update for Week of August 25th and September 1st).

Morning Consult’s survey of 116 consumers that purchased 2014 Marketplace coverage revealed that 43 percent do not plan to take any action and are likely to face this automatic renewal, while another 25 percent are undecided. Meanwhile, among all 1,673 registered voters surveyed, nearly half (47 percent) are “not at all likely” to purchase Marketplace coverage, up significantly from 28 percent in 2013.

STATES

Survey shows more than 50,000 ACA-deficient plans may be cancelled in coming weeks

Survey results released this week by Morning Consult show that at least 50,000 individual health plan consumers in more than ten states will start seeing plan cancellation notices prior to the November 15th start of open enrollment.

The cancellations are occurring even in states like Kentucky and Tennessee that allowed insurers to extend individual plans that failed to comply with all of the consumer protections in the Affordable Care Act (ACA) until 2017 (see Update for Week of March 3rd). According to Consumer Watchdog and other advocacy groups, the voluntary cancellations are an indication that insurers increasingly believe they can make more money selling ACA-compliant plans in or out of the new Marketplaces created by the law.

America’s Health Insurance Plans (AHIP) insists that the total number of plan cancellations will be but a fraction of the five million canceled plans that became a political lightning rod before last year’s open enrollment period (see Update for Week of November 11th). A similar backlash this fall could impact already close electoral races will decide control of the U.S. Senate for the next two years. For example, more than 14,000 Kentucky subscribers had ACA-deficient plans canceled by Humana or UnitedHealth Group starting October 1st, where Senate Minority Leader Mitch McConnell (R) is locked in a competitive re-election battle. Likewise, one of only two Marketplace insurers in Alaska (Moda Health) already announced they would cancel the transitional plans for more than 800 non-Marketplace subscribers (see Update for Week of September 15th)—a move that could shift that state’s tight Senate race.

The insurance departments in Colorado, Maine, New Mexico, North Carolina, Oklahoma, Tennessee, and Texas also have confirmed that significant numbers of ACA-deficient plans will no longer be offered. However, unlike last year, all subscribers must be notified of other insurance options including Marketplace coverage under the Obama Administration’s transitional policy that gave states the discretion to extend ACA-deficient plans (see Update for Week of March 3rd).



Insurance departments in states such as California and Washington (as well as the District of Columbia) elected not to exercise the discretion and required ACA-complaint plans starting in 2014. However, more than two dozen have allowed ACA-deficient plans to be extended through 2016, while others like Maryland and Virginia permitted the transitional policy to run only through 2014.

As a result, Kaiser Permanente and CareFirst Blue Cross Blue Shield (BCBS) are cancelling more than 3,500 ACA-deficient policies in Maryland and Virginia, while Anthem BCBS is doing likewise to an undisclosed number of subscribers in those two states as well as Connecticut, Indiana, and Nevada.

California

Despite lawsuits, Covered California will continue relying on narrow provider networks for 2015

Despite consumer complaints, lawsuits, and new federal standards, Covered California plans will still rely on narrow physician networks to control costs for 2015, according to a new analysis published this week in the *Los Angeles Times*.

The restricted networks were the primary cause of consumer complaints during the inaugural open enrollment period, with more than 300 levied against the two largest insurers (Anthem Blue Cross and Blue Shield of California). The Consumer Watchdog advocacy group has also filed several class action lawsuits alleging that Covered California insurers willfully misled consumers about the severely limited scope of these networks and delayed correcting erroneous provider directories until it was too late for consumers to switch plans (see Update for Week of September 22nd).

The insurers had pledged to broaden their 2015 provider networks in response to these complaints, as well as new federal and state standards. However, the *Los Angeles Times* analysis of 2015 rate filings showed that while 75 percent of licensed physicians in the state and more than 80,000 other providers have contracted with the ten insurers participating in Covered California, most are only available to treat consumers in 1-2 qualified health plan offerings.

In several cases, the researchers found that provider networks are actually more narrow than 2014. For example, HealthNet intends to eliminate its preferred provider organization (PPO) network and switch to a nine-percent more costly network with 54 percent fewer physicians and no coverage for out-of-network care. Blue Shield of California's proposed physician network will have up to four percent fewer providers in certain areas (even though its Marketplace networks already have less than two-thirds of the providers in their non-Marketplace offerings), while Anthem Blue Cross (which already added 7,000 physicians since January) will simply extend its existing network from 2014.

Amplifying the problem is the acknowledgement this week that Covered California insurers are still not posting a comprehensive directory of physicians available in each network. Even though inaccurate or incomplete directories plagued the Marketplace in year one (see Update for Week of October 21st), state officials conceded that maintaining correct directories has remained a "low priority" for participating insurers. In the interim, Covered California officials are advising consumers to contact insurers directly for provider network data prior to selecting a plan.

An investigation by state regulators has already verified that in several cases only 33 percent of area physicians were accurately listed within provider networks for 2014 (see Update for Weeks of June 30th and July 7th).

Governor Jerry Brown (D) did sign legislation last week (S.B. 964) that will expand state monitoring and enforcement of existing rules for network adequacy (see Update for Week of September 22nd) and new federal rules generally require Marketplace plans to contract at least 30 percent of "essential community providers" in their service area (up from 20 percent in 2014) and provide an advance list of all in-network providers and facilities when seeking certification. However, consumer



groups have largely panned these measures as “nowhere near adequate” (see Update for Weeks of March 17th and 24th).

Covered California officials acknowledge that limited provider networks are a major reason that average premium increases are limited next year to only 4.2 percent (see Update for Week of July 28th).

Governor signs bill improving comparison shopping for prescription drug coverage

Governor Jerry Brown (D) signed S.B. 1052 last week, which will allow consumers to better compare prescription drug coverage when selecting a health insurance plan.

The new law proposed by Senator Norma Torres (D) requires the Department of Managed Health Care and the Department of Insurance to develop a uniform template by 2017 for insurers that share drug formularies and update it monthly. In addition, the Covered California board must create an online search tool for consumers to compare the cost and coverage of prescription drugs under Marketplace plans and provide web links to the drug formularies for each plan.

Idaho

U.S. Supreme Court to hear Idaho Medicaid’s appeal to keep rates at 2006 levels

The U.S. Supreme Court agreed this week to decide whether private sector health care providers have a legal right to force Medicaid reimbursement rates to keep pace with rising medical costs.

Idaho Medicaid had petitioned the high court to overturn a Ninth Circuit U.S. Court of Appeals and lower court decision requiring the state to update their rates from 2006 levels. The appeal stems from a 2009 lawsuit filed by five providers.

The Idaho Attorney General insists that neither the state nor federal constitutions give private parties to enforce federal Medicaid funding laws against states. The U.S. Supreme Court recently remanded a similar appeal from California health providers back to the Ninth Circuit, which held that states should have “wide discretion” to set Medicaid payments and refused to block a ten percent rate cut (see Update for Week of January 6th).

Minnesota

Minnesota will again have nation’s lowest average Marketplace premiums

The Minnesota health insurance Marketplace created pursuant to the Affordable Care Act (ACA) will have the lowest average premiums in the nation for the second consecutive year, according to rate data released this week by the Department of Commerce.

The 4.5 percent average premium increase for MNSure is comparable to the 4.2 percent hike also expected for Covered California (see Update for Week of July 28th). The projected spike in premiums after the recent defection of Preferred One (see Update for Week of September 15th), the insurer with the lowest rates for 2014, failed to materialize largely because Blue Plus will be added to the Marketplace for 2015. The four participating insurers from 2014 (Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, and UCare) will all return.

The Department of Commerce noted that some insurers will actually drop their premiums by an average of ten percent, with others will climb up to 17 percent. However, the agency refused to identify the premiums that specific insurers will charge for 2015. Instead, it announced that the lowest monthly premium in the Minneapolis-St. Paul region will be \$110 for a 25-year-old on the least generous bronze-level plan—roughly a \$20 increase from 2014.



State officials insisted that MNSure would not be plagued with the severe software failures and glitches that greatly impeded enrollment for much of the inaugural open enrollment period. MNSure's ability to overcome those issues and maintain affordable premiums has been a major topic of debate in the re-election campaign of Governor Mark Dayton (D).

The MNSure board has already authorized more than \$8 million in web portal repairs (see Update for Week of July 28th) and eliminated more than a dozen enrollment subcontractors after concluding that the \$4.7 million outreach effort lacked proper oversight and underperformed (reaching just 45 percent of the goal of 51,600 enrollments).

Mississippi

Marketplace will have competition in all counties after UnitedHealthcare agrees to participate

Consumers in every Mississippi county finally have a choice of Marketplace plans after insurance giant UnitedHealthcare announced this week that they will participate for 2015.

During the inaugural open enrollment period, Humana was the lone insurer offering plans in 36 of the state's 82 counties. The limited competition resulted in Mississippi having the second-highest average premiums for 2014.

The two participating insurers from last year (Humana and Magnolia Health Plan) had already agreed to expand to 68 counties for 2015 (see Update for Week of September 15th). However, UnitedHealthcare's entrance means that all of the remaining counties will have at least two competitors, while all three insurers will now offer plans in 14 counties.

Magnolia Health Plan had previously announced that it will reduce Marketplace premiums by 25 percent next year, although Humana plans a six percent average rate hike (see Update for Week of August 4th). It is not yet clear what additional impact UnitedHealthcare's presence will have on premiums, since the federal Centers for Medicare and Medicaid Services (CMS) still needs to issue final approval for Mississippi's federally-facilitated Marketplace. However, several studies have shown that premiums are likely to fall when the number of competing insurers increases (see Update for Weeks of August 25th and September 1st).

UnitedHealth Care elected to opt-out of most Marketplaces in 2014 but has already decided to participate in nearly half of the Marketplaces for 2015, including Connecticut, Florida, Georgia, Maryland, Massachusetts, Missouri, New Jersey, and New York (see Update for Weeks of August 25th and September 1st). However, it will continue to avoid the largest Marketplace in California (see Update for Week of July 14th).

Missouri

Former CCIIO chief sues Obama Administration for lack of rate transparency

The former head of the Center for Consumer Information and Insurance Oversight (CCIIO) with the U.S. Department of Health and Human Services (HHS) filed a federal lawsuit this week on behalf of a Missouri-based consumer group seeking to force the release of final 2015 premiums for Missouri's federally-facilitated Marketplace (FFM).

CCIIO is required to issue final approval for FFM rates but refusing to release them until shortly before the November 15th start of open enrollment (likely after qualified health plans are certified on November 3rd). However, the Consumers Council of Missouri (CCM) and their attorney Jay Angoff (who formerly headed both CCIIO and the Missouri Department of Insurance) insisted that consumers need to have ample opportunity to review and challenge any increases in FFM premiums from 2014, since Missouri insurance regulators currently lack that authority.



CCM has been frustrated in their efforts to get information on rates or even participating insurers via Freedom of Information Act (FOIA) requests and filed the lawsuit in the U.S. District Court for the Eastern District of Missouri. The complaint alleged that HHS failed to comply with its own rules and the ACA in not ensuring “the public disclosure of information on [unreasonable] increases and justifications for all health insurance issuers” nor publishing the actuarial data that insurers must provide to justify any presumed “unreasonable” increase of at least ten percent (see Update for Week of August 29th 2011). However, CCM and Angoff acknowledge there is no advance timeframe by which HHS must publish the final rates and stated that the lawsuit was meant to send CCIIO officials a “message” that they need to be “more transparent” about 2015 premiums.

Republican critics have claimed that HHS is withholding premium data until after the November 4th midterm elections (the same reason they claim the open enrollment period was moved back to November 15th). However, Angoff indicated that HHS reluctance to release the premiums may have more to do with insurer concerns about competitiveness. Nevertheless, Angoff insisted that nothing in the ACA authorizes HHS to withhold premium data, especially when the applicable insurers have not attempted to claim any protection under existing laws governing trade secrets.

Although UnitedHealth Care and CIGNA have publicly announced that they will join 2014 holdovers Anthem Blue Cross Blue Shield of Missouri and Coventry Healthcare, consumers do not yet know how many insurer will be participating in their county nor what type of plans will be offered. Missouri’s FFM enrolled more than 152,000 consumers during the inaugural open enrollment period, with 57 percent of those paying less than \$50 in monthly premiums after accounting for ACA tax credits.

Premium increases nationwide are averaging about six percent, according to data from preliminary rate filings in 38 states and the District of Columbia that were analyzed by PricewaterhouseCoopers. However, premiums are increasing by only an average of 2.5 percent for the seven states with finalized rates (including Colorado, Maryland, New York, and Ohio).

New Hampshire

Medicaid expansion enrolls one-third of eligible applicants in first three months

The New Hampshire Department of Health and Human Services (HHS) announced this week that more than 18,500 residents have enrolled in the Health Protection Program since it started on July 1st.

The agency predicts that roughly 50,000 residents will eventually enroll in the alternative to the Medicaid expansion under the Affordable Care Act (ACA) that was federally-approved earlier this year (see Update for Week of June 23rd). Instead of a traditional expansion, the program uses ACA matching funds to cover applicants in either Medicaid managed care plans or (when cost effective) in private plans offered by the state partnership Marketplace

The rate of enrollment has slowed slightly since the first month, when about 8,500 were enrolled (see Update for Week of August 11th). However, HHS officials still expect to meet their 50,000 target.

The Health Protection Program will automatically terminate after 2016 if not reauthorized by the legislature or if the federal matching rate drops below the 100 percent rate set by the ACA for 2014-2016.

New Jersey

Marketplace adds additional competitor

Oscar Health Insurance announced this week that it will enter the federally-facilitated Marketplace (FFM) operated in New Jersey pursuant to the Affordable Care Act (ACA).



The New York-based company becomes the second new insurer to the Marketplace in 2015, joining insurance giant UnitedHealthcare. Horizon Blue Cross Blue Shield of New Jersey, AmeriHealth NJ, and Health Republic Insurance of New Jersey are all returning from 2014.

New Jersey's Marketplace for individuals and families did enroll more than 160,000 consumers during the inaugural open enrollment period. Combined with the state's Medicaid expansion, this reduced the rate of uninsured among non-elderly adults from 21.2 to 10.5 percent from September 2013-June 2014, according to the Robert Wood Johnson Foundation. However, the presence of only three insurers caused Marketplace premiums to rank far above the national average (\$465 per month before subsidies compared to \$346 nationwide).

It is not yet clear what impact the two new competitors will have on premiums, as the federal Centers for Medicare and Medicaid Services (CMS) has yet to approve final premiums for 2015.

CMS announced last week that FFM participation will increase by 25 percent for 2015, prior to Mississippi (see above) and New Jersey adding competitors (see Update for Week of September 22nd).

Vermont

BCBS to launch small group Marketplace portal in place of delayed state-based model

The state's largest private health insurer, Blue Cross and Blue Shield (BCBS) of Vermont, announced this week that it will launch an improved web portal on October 15th that will allow small business consumers to renew Vermont Health Connect coverage and change their information online.

The portal will go live on October 15th, the earliest allowed by the federal Centers for Medicare and Medicaid Services (CMS) as open enrollment for all Marketplaces does not start until November 15th.

Vermont was the only state to mandate that small employers with 50 or fewer workers purchase coverage through the Small Business Health Options Program (SHOP) created by the Affordable Care Act (ACA). However, the SHOP Marketplace remains non-functional for 2015 as Vermont focuses on repairing its glitch-plagued counterpart for individuals and families, which was recently shut down due to concerns about security breaches (see Update for Week of September 15th).

Vermont Health Connect officials insist that they are working to open the SHOP portal at some point in early 2015, even though federally-facilitated SHOP Marketplaces will start on November 15th (see Update for Weeks of August 25th and September 1st). In the interim, BCBS will directly offer small business workers the full range of their Marketplace plan options they offer in for small groups, if their employer decides to make all of them available to employees.

BCBS currently has 3,500 small group clients purchasing Marketplace products for 32,441 employees, representing 49 percent of overall Marketplace plans sold. BCBS can circumvent the Vermont Health Connect web portal because small employees are not eligible for ACA premium tax credits, negating the need for BCBS to connect to the federal data hub. The transfer of data between Vermont Health Connect and the federal data hub remains the primary cause of technological glitches.