State Health Reform Assistance Network
Charting the Road to Coverage

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Report from the States: Early Observations about Five State Marketplaces

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Introduction

On October 1, 2013, sixteen (16) states and the District of Columbia launched health insurance marketplaces.[1] While the federal marketplace has faltered in its first months of operation, it has been widely reported that many state marketplaces are off to a better start and have steadily improved their functionality and client services since launch. The culmination of three years of intensive design and development, many of these 17 state marketplaces show promise of realizing the Affordable Care Act's (ACA) vision for "American Health Benefit Marketplaces:" virtual insurance marketplaces through which Americans can determine their eligibility for financial assistance and easily shop for and purchase affordable health insurance.

The ACA required that each state establish its own marketplace by January 1, 2014 and authorized full federal funding for states to design, implement, and run their marketplaces through the first year of operations. The law stipulated that in the event that a state had not taken action or was unable to implement its marketplace, the Secretary of Health and Human Services (HHS) would establish and operate a federal marketplace.[2] In the months and years following the passage of the ACA, political hurdles, uncertainty regarding the law's future, and implementation concerns prompted 34 states to rely on a federal marketplace—requiring the federal government to take a far bigger role in operating marketplaces than originally anticipated. Indeed some observers speculate that the system problems plaguing the federal marketplace are due, at least in part, to the scale and complexity of supporting so many diverse states.[3]

While state marketplaces are still evolving, and some are experiencing their own implementation challenges, they are largely working. According to the latest report from the HHS Office of the Assistant Secretary for Planning and Evaluation, state marketplaces have processed 675,365 applications for health insurance, determining

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[1] California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington.

[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(b)(1) and § 1321(c) (2010).

[3] Pearson, Michael. "Obamacare glitches are to be expected, health experts say." CNN. October 2013. http://www.cnn.com/2013/10/02/politics/obamacare-exchange-problems/.

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eligibility for a total of 1,315,978 unique individuals included in those applications. More than 225,000 of those individuals have already selected a marketplace plan, while more than 534,000 were determined or assess eligible for Medicaid or CHIP coverage by the marketplaces (Also see chart below, "*Five State Marketplaces by the Numbers*").[4] By the end of the open enrollment period on March 31, 2014, state marketplaces are expected to exceed 1.7 million in total enrollment.[5] For the most part, state marketplaces are functioning, with few of the problems that have dogged the federal model.

This report explores the early implementation experience of five state marketplaces: Kynect (Kentucky), New York State of Health (New York), MNsure (Minnesota), HealthSource RI (Rhode Island), and the Washington Healthplanfinder (Washington State).[6] The information in this report was gleaned from interviews with state leadership responsible for developing and implementing these marketplaces and a review of publicly available documents and media reports.

Five State Marketplaces: Early Lessons

Integrated Eligibility and Enrollment Systems

All five states have fully integrated eligibility and enrollment systems across all insurance affordability programs (IAPs; i.e., Medicaid, CHIP, APTC/CSRs) and commercial Qualified Health Plans (QHPs). All rank the decision to integrate eligibility systems (rather than relying on account transfers between systems) as among the most significant factors in their early implementation success.

A Kynect leader commented that "the marketplace doesn't have to talk to a separate Medicaid system; I can't imagine how those dynamics would work. We have a single streamlined process." These states credit integration with supporting a better consumer experience and enabling more efficient, streamlined marketplace systems and operations. MNsure's goal from the outset was to have a single marketplace system that covered all IAPs through one portal, running one set of software with no handoffs between the marketplace and Medicaid. One Minnesota official noted: "All of our operations are as integrated as they can be. We aren't stepping over each other or having to transmit information from one agency to another."

Integrated eligibility and enrollment systems fulfill a major goal of the ACA—a single, streamlined process through which any consumer can apply, receive a determination for, and enroll in the health insurance coverage for which they are eligible. These states embraced the requirements of the law with respect to streamlining, building integrated "rules engines" to determine eligibility for Medicaid, CHIP, APTCs/CSRs, and QHPs, interfacing to the federal data services hub and state data sources needed to verify application information, and generating real-time eligibility determinations. States interviewed cite remarkably similar estimates regarding the duration of their online application processes; from roughly 10 minutes for a single applicant to a maximum of 45 minutes for a complex family application.

The benefits of integration were evident with the launch of marketplaces on October 1. Integration has allowed these states to avoid the system complexity and pitfalls required to "transfer" application accounts for Medicaid/CHIP-eligible individuals to/from the marketplace to Medicaid/CHIP eligibility systems. In stark contrast, the federal marketplace is required to transfer application accounts to 34 state Medicaid or CHIP agencies—and this transfer is still not fully functional nearly three months after the federal marketplace started taking applications.

While not required by the ACA, these states are extending integration beyond Modified Adjusted Gross Income (MAGI) eligibility determinations for health insurance. All states interviewed for this report plan to extend their integrated eligibility functionality to other Medicaid programs and social service programs including the Supplemental Nutrition Assistance Program (SNAP). States are also expanding integration to plan selection and enrollment, permitting families with Medicaid and CHIP-eligible members to shop for and enroll in health plans on their marketplace websites just as QHP-eligible individuals do. Kentucky, New York, and Rhode Island already support Medicaid/CHIP plan shopping and enrollment functionality; Minnesota and Washington State are slated to add it in future system upgrades.

[4] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. "Health Insurance Marketplace: December Enrollment Report." December 11, 2013. http://aspe.hhs.gov/health/reports/2013/MarketPlaceEnrollment/Dec2013/ib_2013dec_enrollment.pdf.

[5] Anticipated QHP enrollment reflects state estimates, when available, or Urban Institute analysis of individual exchange enrollment (http://www.urban.org/UploadedPDF/412310-Health-Reform-Across-the-States.pdf).

[6] Minnesota, New York, and Rhode Island are participants in the Robert Wood Johnson Foundation's *State Health Reform Assistance Network* (SHRAN).

Being "Nimble"

Critically important was the ability of these states to be nimble, responding quickly and decisively to day-to-day questions and "curve balls."

In the months leading up to October 1, these states convened internal teams and external vendors with increasing frequency (in most cases daily by the summer of 2013) in order to make fast decisions that would keep pace with their implementation requirements. This process was essential not only because of the tight timeframes for going live, but also because the federal government made several eleventh hour policy decisions and changes. Most notably, the administration announced in June that state marketplace websites would not be permitted to show consumers their income data accessed through the federal data services hub (specifically tax data from the Internal Revenue Service and income data from the Social Security Administration).[7] Many states designed their websites to present these data to applicants and had to quickly decide how to modify the website designs and defer other functionality to a later system upgrade to "make room" for the new system work.

States' ability to be nimble has been equally important in the early months of marketplace operations. New York State of Health was deliberate in building fail safes that would allow the marketplace to be responsive to problems and issues that might emerge at launch. The State was "always contingency planning"—for instance, building a backup plan for its call center to step in and take phone applications if the online system failed. HealthSource RI noted that its project schedule built in capacity for new and unanticipated systems upgrades and fixes so that unexpected problems would not automatically knock them off schedule.

States all discussed the fact that they have been prioritizing and "fixing" issues identified during launch and initial operations. Some of these issues are caused by system glitches. For example, most states (Kentucky, New York, Rhode Island, and Washington) reported experiencing higher than anticipated application volume in the first days of October, which created server capacity and other system problems; all of these states implemented rapid, effective solutions such that their websites were operating the way they wanted within the first few days of implementation.

These states also continue to make system fixes to improve consumer experience. As marketplaces learn where "the consumer isn't responding to questions exactly as we anticipated," or "our application isn't clear enough about what the consumer is supposed to do," they are addressing it quickly either through system changes or educating their call centers and consumer assisters, or both. For example, Kynect learned soon after its launch that consumers with health insurance coverage ending before January 1, 2014, were being denied APTC eligibility because the application did not provide clear enough instructions for consumers to enter their current coverage "end date." The marketplace alerted all of its Kynectors (assisters), implemented an application fix, and re-determined eligibility for the roughly 500 consumers who were affected.

Some of the states that are using the federal hub's remote identity proofing (RIDP) service (through which applicants have their identities validated so that they and the marketplace can access tax and other private records) experienced large numbers of applicants erroneously failing RIDP in the early days of implementation. HealthSource RI deployed its call center to help applicants get through this step in the process and proactively reached out to others who left the marketplace after failing RIDP to "bring them back." Rhode Island also learned that address changes are a root cause of some RIDP failures, and is modifying its system to capture both current and most recent addresses. Similarly, New York State of Health immediately implemented workarounds to RIDP problems including advising customers to use first and last names, but not middle names, initials, or suffixes.

Prioritizing Critical Functionality and Deferring Enhanced Functionality

With a three-year timeline to procure contracts, design, develop, and implement the complex information technology necessary to support their marketplaces, states realized early on that prioritization was essential to early functionality. Washington State described setting goals and expectations early, taking a disciplined approach to scoping their marketplace and consistently focusing on what had to be done for day one rather than "adding a bunch of nice-to-haves." MNsure purposefully made a decision early on to "stay simple, stay modest, and focus on key functionality." Each state recognized that the more bells and whistles they attempted to build, the more opportunity for systems to go awry. As a result, all are "phasing in" their full, functional marketplace systems.

Several states, including Minnesota, New York, and Rhode Island, noted that they deferred day one provider and formulary search functionality that allows consumers to identify QHPs that cover their prescription drugs and include their providers (New

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[7]   June 2013 Release of Information: Centers for Medicare & Medicaid Services. "Guidance Regarding Identity Proofing for the Marketplace, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Data Services Hub." June 11, 2013. 78 FR 49367.

York of State Health has since implemented a "provider finder"). As noted above, all states that were interviewed plan to fully integrate eligibility and enrollment for other Medicaid and social service programs in their marketplaces; states are phasing in these plans after ensuring successful implementation of APTC/CSR/QHP and MAGI[8] Medicaid and CHIP eligibility ("must have" functionality for day one).

MNsure discussed giving up for the short-term functionality related to provider quality information and health plan selection and enrollment through the marketplace for Medicaid-eligible individuals. New York likewise deferred Medicaid health plan selection and enrollment through the marketplace, and implemented such functionality in December.

Delaying some functions to later upgrades was in some cases straightforward. For example, neither administrative renewal nor special enrollment period (SEP) functionality is required until after March 2014. But, other decisions were more challenging, and states didn't always get it right. New York State of Health made a decision to forego anonymous shopping (allowing a consumer to see what plans are available on the marketplace before they enter information for account set up or identity proofing) for initial launch, and the inability to "window shop" has been a top consumer complaint since October 1. The marketplace responded quickly, however, providing "back end" shopping screens to allow the call center to assist any consumer who calls to understand their potential options, and is re-evaluating the timing to upgrade its website to allow anonymous shopping.

Cohesive Teams with Clear Lines of Authority

States uniformly cited the importance of leveraging state leadership, infrastructure, and staff for their marketplace builds. By doing so, these states were able to expedite project start up and development, and establish clear lines of authority and decision-making from the earliest stages of project planning.

Kynect stated that "a lot of the folks on the team either came from Medicaid or from the Department of Insurance, or they had IT experience within our Cabinet for Health and Family Services." While State officials praised Kynect's primary vendor, Deloitte, for its key role in project management and system design and implementation, they said that "we didn't have 'outside people' who were the main players in the development." Vendor selection also played an important role in the cohesiveness of New York's team; the State selected CSC, its longtime Medicaid claims processing contractor, as its end-to-end system integrator and marketplace vendor. CSC's ability to leverage the claims processing architecture and knowledge of New York was seen as helpful to the State's work, and the use of one systems integrator, with clear accountability, contributed to assuring delivery. MNsure credits its progress in part to relying on state infrastructure (including servers, hardware, etc.) and "knowledgeable staff that has worked with that infrastructure for a long time." As a result, marketplace leadership noted, they have a granular understanding of their IT systems and don't have to rely on vendors to know "what's working and what's not working. We know the systems side."

States benefitted by pulling their teams together from existing state agencies; these agencies and in many cases, individuals, had prior working relationships and understood how best to navigate the state bureaucracy. By building cohesive and collaborative teams, states were able to stick to the vision and work plan for marketplace implementation and, most notably, drive timely and effective decision-making.

Central to state marketplace teams are agency experts in Medicaid and CHIP eligibility. These state experts, who "know eligibility in their bones" as one stakeholder put it, were deployed to help develop the business requirements, rules, and use cases for states' integrated eligibility systems—arguably the most complex aspect of marketplace system design. These experts are now playing a key role in quality assurance (QA). In New York State of Health, designated staff has been doing QA on applications since launch to "make sure the results are right." Twenty staff are co-located with the State's system vendor, CSC, reviewing notices, eligibility results, and plan selections to ensure accuracy. The most senior members of the project team also have spent time reviewing application results, to ensure they have a sense for how the process is working for consumers. Based on this QA process, New York reports that its eligibility system is producing accurate results.

Finally, committed leadership, empowered to make hard decisions in a timely way, matters. States described the need to make major policy decisions, like timing for integration of other social service programs, where various team members persuasively argued "both sides" (for example, whether to integrate SNAP eligibility early or later). A Kentucky state official noted that at the end of the day

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[8] The ACA provides a new simplified method for calculating income eligibility for Medicaid, CHIP, and APTC/CSR through the marketplace. The method calculates eligibility on MAGI and will replace the current process for calculating Medicaid eligibility, which uses income deductions. The new MAGI rules apply to most people eligible for Medicaid and CHIP, but not the elderly or those who qualify based on a disability.

"you need leadership to vet both sides, make a decision, and move on. Leadership can consider the whole project, timeline, and ramifications."

Connections to Stakeholders on the Ground

A final, common theme among states interviewed for this report is their close connection to "on the ground" stakeholders, including consumers, Navigators/consumer assisters, agents/brokers, call centers, and health plans. States have leveraged these resources in pre-launch testing, and issue identification and resolution since marketplace launch.

Kynect staff noted the benefits of using local consumer groups to test the online application and, since October 1, relying on Kynectors and insurance agents/brokers to provide daily feedback on consumers' experiences and needed system changes. For example, Kynectors and agents/brokers were the first to alert Kynect to the problem of applicants not realizing they had to enter a current coverage end date in order to be determined eligible for APTC/CSRs. Kentucky credits these front-line resources as a key source of information about what's working well and not-so-well for consumers using the Kynect website.

New York State of Health held daily "escalation calls" with QHP issuers during the first week of implementation and continues to hold separate weekly operations and technical calls with issuers. The State also holds regular calls with Navigators. These calls have yielded rapid identification and resolution of issues related to applications, plan presentment, and enrollment effectuation, and have been essential for New York State of Health and its stakeholders in terms of near real-time communication about marketplace implementation.

Marketplace call centers have also been critical in issue identification and resolution during the early months of marketplace operations. States have established formal call center reporting to track indicators like call volume spikes and complaints, but are also using call centers and social media as qualitative feedback loops. A New York State official described staff and leadership walking around the call center and listening to calls in order to learn what consumers are asking and their experiences with the marketplace website. The State is also reviewing and responding to questions posted to New York State of Health's Facebook page, and uses this information as a source of feedback on consumers' experiences. Similarly, HealthSource RI and MNsure point to their call centers as important quality assurance mechanisms.

Challenges and Future Priorities for State Marketplaces

When asked about challenges and priorities for functional improvements to marketplace websites and operations, certain common themes emerged in state responses.

Federal Data Services Hub

While the federal hub is working well for state marketplaces when it is "up," states report that frequent hub downtime during the first two months of open enrollment has impeded operations. Hub downtime is particularly problematic for states that built their applications to "ping" the data hub in real-time as the applicant is entering information, rather than verifying against the hub at the end of the process after the applicant has entered all of his or her information. When the hub is down, marketplace web applications with this design are also effectively down. An announcement on the website advises consumers to come back at a later time to apply.

In July 2013, HHS issued guidance that marketplaces are required to hold applications for one day in instances when the federal hub is down, making a second attempt at electronic verification through the hub instead of requesting paper documentation.[9] Some states report that this guidance was issued too late, and they had already locked in system designs that default immediately to paper documentation when the federal hub is down. These states plan upgrades to bring their systems into compliance with federal regulations and relieve consumers of the burden of providing paper documents when the federal hub is down.

Finally, while some states built and rely on their own APTC calculator, others rely on the federal calculator available through the hub. Hub downtime has caused these states to reconsider building their own APTC calculators in future system enhancements.

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[9] 78 FR 42251 (45 CFR §155.315(f)).

Consumer Decision Support in Plan Selection

States highlight the plan selection processes as a high priority for improvement and development in future upgrades. One state noted that "we knew going in that our plan selection functionality does not have the best consumer experience. We're not sure we even know what the best experience is yet, and we don't think any state has really figured it out." In addition to robust provider and formulary search capacity, states acknowledge that consumers want functionality "like the airlines have" where they enter a few key pieces of information and they get a short list of plans that meet their criteria. Another state is looking to build more robust capacity to show consumers the impact of CSRs so that they have a better understanding of the differences between bronze and silver plans.

Small Business Health Options Program (SHOP)

Several states noted that one focus of their upcoming system improvements will be the SHOP marketplaces, which are functional, but basic, in most states. One state points to agent and broker feedback that many insurance plan websites have better functionality for small businesses and that the marketplace will need more "bells and whistles" to attract small businesses.

Conclusion

Health care is local. State insurance commissioners regulate the health insurance sold within the state; Medicaid and CHIP commissioners manage their programs; elected officials including Governors and state legislators set policy goals and objectives for states' health care systems overall. Recognizing this history of local control and the knowledge base that comes with it, Congress sought to implement the ACA's coverage expansions through state-based marketplaces. As the experience of these five states makes clear, implementation of the new coverage paradigm is an incredibly complex undertaking; but, early results are promising.

Five State Marketplaces by the Numbers

	Kentucky	Minnesota	New York	Rhode Island	Washington
IT Vendors	Deloitte Consulting LLP (main) CGI Federal (sub)	Maximus, EngagePoint, Curam Software/IBM, and Connecture	CSC (System Integrator and Program Management) Maximus (Interfaces) Cognosante (IV&V and QA)	Deloitte (Systems Integrator, Developer, and QA) Public Consulting Group (PMO for Medicaid and Human Services) Wakely/KPMG (PMO/TA for marketplace)	Deloitte (System Integrator) Bluecrain (QA) PCG Technology Consulting (IV&V) Cambria, TSG (Sub Contractors)
Call Center	146,323	35,055	195,000	22,756	131,235
Completed Applications	87,640	32,209		13,082	127,456
Total Individuals in Completed Applications	151,255	68,927	297,331	18,815	246,967
Total Eligible for QHP Enrollment	75,008	46,153	224,542	6,145	59,839
Eligible for QHP Financial Assistance	27,003	15,493	80,834	4,130	30,452
Individuals Selected QHP	13,145	4,478	45,513	2,669	17,770
Medicaid Eligible	53,046	20,108	52,888	6,627	154,060

Sources: National Academy for State Health Policy StateRefor(u)m.“Exchange and Medicaid IT System Contracts.”
https://www.statereforum.org/medicaid-exchange-it-contracts.

Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. “Health Insurance Marketplace: December Enrollment Report.” December 11, 2013.
http://aspe.hhs.gov/health/reports/2013/MarketPlaceEnrollment/Dec2013/ib_2013dec_enrollment.pdf.