

# State Health Reform Assistance Network

## Charting the Road to Coverage

ISSUE BRIEF

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## Assessing a New Option: The Feasibility of Contracting With a Single Firm to Build and Operate a State's Marketplace

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As we approach the third open enrollment under the Affordable Care Act (ACA) and the end of federal grants to support exchange development, states that have developed their own marketplaces are confronting new budget challenges and looking to streamline operations. Additionally, some of the 34 partnership and federally-facilitated marketplace (FFM) states may decide over the next several years to develop their own state-based marketplaces (SBMs). For states that cannot sustain their original approach, as well as states newly planning their own SBMs, a novel approach is now available and merits consideration. In this brief, we assess the feasibility of a state delegating the development and operation of its SBM to the fullest extent possible to a private exchange operator. If feasible, this approach offers several potential advantages:

- Substantially reduce the cost of developing the SBM;
- Offload much of the financial risk for operating an SBM;
- Access state-of-the-art exchange technology, even as that technology evolves over time; and
- Maintain an integrated eligibility determination customer experience, under the state's control, for Medicaid/the Children's Health Insurance Program (CHIP) and premium tax credits.

Under a project supported by the Robert Wood Johnson Foundation's *State Health Reform Assistance Network*, Wakely Consulting Group has assessed the feasibility, and some of the potential advantages of this approach. This appears to be a realistic option for states that, at least in theory, offers some real advantages over the approach that most states have taken. The assessment is summarized below.

### A new model for SBMs?

Over the last decade, the information technologies, as well as the number and capabilities of commercial firms offering or supporting health insurance exchanges, have progressed considerably. This field includes private exchanges that primarily serve large employers; web-based brokers enrolling millions of individual households; and pure technology firms providing private-labeled websites and back-office functions to health plans. A few of these new "players" have also supported certain functions of SBMs.

#### ABOUT STATE NETWORK

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit [www.statenetwork.org](http://www.statenetwork.org).

#### ABOUT WAKELY CONSULTING GROUP

Wakely Consulting Group is an actuarial and healthcare consulting firm specializing in government healthcare programs including state and federal reform, Medicaid and Medicare Advantage. For more information, visit [www.wakely.com](http://www.wakely.com).

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As a result, a new model of vendor contracting and management is available to states, for instance to select one primary contractor to stand-up and operate much of an SBM on that vendor's own technology platform. Under such arrangements, an SBM no longer needs to contract with a systems integrator (SI) to coordinate other vendors in developing new software and/or adapting and integrating off-the-shelf software. Nor does the SBM need to staff the exchange with its own employees and/or separate contractors for plan management, customer service, outreach and enrollment, financial management, etc. Rather, at least four experienced firms have each expressed an interest in assessing and considering a state contract to perform much of the daily operations of an SBM for a percentage of revenues over a minimum course of three to five years.

Being able to outsource much of the information technology (IT) development and operational management of an SBM to a prime contractor that also operates its own commercial exchange and/or other public or private exchanges may enable greater speed to market, and could actually increase vendor accountability. With this approach, only one vendor is accountable rather than several, and a revenue model based on user fees would put the primary vendor at financial risk for growing enrollment and retaining members. If the vendor's expertise and resources are robust, this model could simplify vendor management, and align the incentives between a client SBM and the primary vendor.

Under this model, a state might contract with a firm to install and customize its marketplace for a "set-up" fee, and to conduct many of the SBM's functions for a percentage of revenues—much as public agencies contract for a transit system or an in-house cafeteria with private firms that specialize in handling the full range of relevant functions. Moreover, as technology and decision-support tools continue to evolve in the highly-competitive commercial exchange sector, states that depend upon these same firms to operate their SBMs should be able to access routine, annual upgrades, without paying separately for them or relying on a difficult and expensive change request process.

This model goes beyond outsourcing the development and maintenance of the IT systems, to contracting with the same vendor to operate the SBM on a day-to-day basis. Operating the SBM under this model would entail such functions as certifying Qualified Health Plans (QHPs), managing and reconciling enrollment and premium collections, operating the SBM's call center, overseeing or running its marketing, sales, and renewal campaign(s), certifying and managing relationships with navigators and brokers, handling appeals, and so forth. No firm has yet done all of this for an SBM, but several firms have performed many or most of these tasks for some combination of their own, as well as some state-based marketplaces.

That said, an SBM is still a public (or semi-public) agency that must, under federal regulation, retain certain functions. The Affordable Care Act (ACA) prohibits SBMs from contracting with a for-profit entity to operate its entire marketplace, but it does not define the boundary between that restriction and, for example, contracting with one firm to run much of the daily functioning. Under this model, the SBM would presumably retain eligibility determination, define certification criteria for QHPs, brokers, and navigators, oversee appeals adjudication, approve the annual budget and multi-year goals, and oversee financial management. Eligibility determination, including the amount of tax credits and cost-sharing reductions, is primary among those functions to be retained by the state, typically as a shared function between the exchange and the state Medicaid agency (responsibility for final determination of premium tax credits is also shared with the Internal Revenue Service).

The state also must retain overall governance (see Appendix A for a possible allocation of responsibilities between a state agency and its contracted administrator). In addition, the SBM should retain, at a minimum, oversight of the marketplace and vendor, control of public policy (such as criteria for certifying QHPs), issuing regulations, and ultimate overall accountability, even if it delegates the execution of operational functions to a single vendor.

The Centers for Medicare & Medicaid Services' (CMS) policy has evolved since 2012 from requiring a so-called "no wrong door" to requiring "one front door" for eligibility determination. There are considerable efficiencies and customer service advantages to locating eligibility determination for Medicaid, CHIP, and marketplace subsidies (Advance Premium Tax Credits [APTCs] and Cost-Sharing Reductions [CSRs])—not to mention Temporary Assistance for Needy Families (TANF) and other means-tested, state-administered benefits—in one agency and information system, at the state level. One of the biggest challenges (and set-up expenses) to the kind of outsourcing described in this policy brief is effectively integrating the commercial "exchange-in-a-box" functions with a state's eligibility determination system. When considering this model and any contractor, states should pay special attention to the cost and time required for integration, as well as the vendor's understanding of how to do so. The vendor's prior experience integrating into a state Medicaid/APTC/CSR eligibility determination system should merit careful scrutiny.

## The field of exchange-related firms

In order to assess the feasibility of this new model, Wakely Consulting surveyed 15 firms that have a dedicated focus on health insurance exchanges. The preliminary scan included a web-based information search for such firms, plus interviews with their CEOs or other senior managers. This effort was not intended to be exhaustive, but to discover the most obvious candidates for being able to supply an "exchange-in-a-box." (This term was actually coined by Access Health CT, which has suggested that it can

supply similar services to other states; CMS is also “supporting” SBMs in New Mexico, Oregon and Nevada, but this review does not extend to either possible arrangement.) Wakely succeeded in talking with 13 of the firms, each of which is profiled briefly in Appendix B.

However, not all of them fit the model described above. Four firms appear to be sufficiently experienced and interested in long-term relationships with SBMs. And though all four expressed strong interest—strong enough to host our site visit team for a half-day each—in-depth interviews with four senior management teams revealed varying levels of experience with SBMs. Each of these options offers its IT solution as a service, in the cloud, so that changes and refinements made for any one client can readily be made available to other clients licensing its software.

It is important not to overstate the readiness of the private sector to support the model described above. One firm seems very eager, has a major role with three or four marketplaces, and claims to fully operate a Small Business Health Options Program (SHOP) marketplace. A second firm currently operates its own private exchange for employers and some of their employees who qualify for individual (not group) coverage, but has no experience in the public sector. A third candidate is actually a partnership between two complementary firms that have experience working together to support an SBM and have recently submitted joint bids in response to Requests for Proposal (RFPs) from SBMs to develop and operate some, but not all functions. The fourth firm offers an end-to-end technology solution specifically for public marketplaces, but does not claim prior experience in actually operating a marketplace; in fact, no firm has run a marketplace, but several have experience running private exchanges and/or large chunks of the SHOP marketplace for an SBM.

On the other hand, it is also reasonably likely that if several states indicated that they are actually going to pursue this model, these four vendors would be very interested, and other credible vendors might emerge. We summarize our review of the four most promising vendors below.

**Option 1** is a web-based brokerage with nearly a decade of experience selling a wide range of health plans (and other insurance lines) to individual households across the country. It also provides a range of private-labeled services, to other large, national brokerage and human resources consulting firms. It has experience supporting and/or operating both SHOP and individual marketplaces in multiple states, which vary considerably in terms of size and geographic location. It has experience handling the premium billing for SHOP in some of these states and for individual households in its own private exchange. In total, it currently supports well over 1 million exchange enrollees. Senior management believes that it can handle all of the transactional functions of a public marketplace, other than eligibility determination. It has handled many of these functions in its support of public exchanges, its own exchange, and for other private exchanges.

It also has experience integrating with the eligibility determination engine of a state. Having done so for a small state, this firm estimates that its set-up costs for doing so in a medium-size state—for example, a state with between 3 million and 8 million residents—might run in the range of \$5 to \$12 million, which could be compensated either as a one-time set-up fee, or built into a per member per month (PMPM) fee and amortized over the length of a contract (five years or longer). Some of the integration costs might also be covered by Medicaid matching funds.

This is a technology firm that has developed all of its software (as a service) on its own. Its database was built by Oracle, hosting is done by Rackspace, and it has two call centers. It routinely exchanges enrollment and billing information with approximately 250 carriers across the country, representing a broad range of IT capabilities. It has myriad decision-support tools, such as anonymous shopping, an APTC estimator, a total consumer cost calculator, a central provider directory and look-up, an algorithm-driven tool for ranking QHPs by best fit with a consumer’s personal preferences, customer service chat, and online educational videos. It also has experience providing back-office and marketing support to some of its private-labeled clients. The firm generally releases several updates a year to its exchange capabilities, all of which are available for low or no cost as a matter of course for all of its clients, and many of which are driven by the particular demand of one or more clients for improved capabilities.

In addition, the firm in Option 1 markets its own exchange to individual households searching for coverage, and works with independent brokers, so it has firsthand experience and understanding of the peculiar marketing and sales challenges that public and private health insurance exchanges face.

**Option 2** is an IT firm offering a national, multi-carrier exchange for large, medium, and small employers. This company is owned by several health plans. Its client employers range in size from 10 to 2,200 employees, and the firm handles all functions related to shopping and enrollment for its client employers, employees, and retirees, including individual enrollment of those who are not eligible for group benefits. It serves about 300 employers covering 150,000 enrollees across 22 states. It also sells other types of coverage (dental, vision, life insurance). The firm is especially proud of its consumer profiling techniques, which rank available health plans (on total expected costs) according to their suitability for the consumer’s health status, risk aversion profiles, and financial means.

The firm does not have experience working with public exchanges or with Medicaid programs, but this private employer exchange is interested in building volume and believes that it has most of the functionality in-house to operate a public marketplace. It has developed its own exchange IT platform in-house, but it also partners with another IT firm to use some licensed software. It does not generally work with brokers and navigators or other in-person assisters, so it has not trained them, and it does not have broker compensation and broker/navigator management tools or experience. Nor does this firm perform retail marketing and sales, since its target enrollees are all employees of client firms. Perhaps the firm's biggest deficit from a state perspective is its lack of experience in contracting with states, especially around integration with a state's eligibility determination system. The state would probably have to take the lead in planning the integration process.

This firm is very willing to consider a governance and business model that delegates the full build-out and operation of a marketplace to a single entity. It has its own call center, but also partners with several other firms, including IT and call centers staffed by licensed brokers, to provide supplementary bandwidth in order to accommodate large new clients, such as an SBM. The firm's core business model is to develop private exchanges for any client—employer, insurer, or provider. Its preferred revenue model is a flat fee per employee per month (PEPM), but management is open to other arrangements and appears eager to consider such engagements.

**Option 3** is a partnership of two firms that have teamed in two bids to support SBMs. One firm (A) is an intermediary or private exchange for small employers and individuals, which originated many years ago as a small employer membership organization, and has been acquired and capitalized by a national financial services firm. The other firm (B) is technology focused, and has developed websites, consumer decision-support tools, broker business support tools, and related functionality for multiple carriers, including many of the largest in the country.

Firm A operates its own multi-carrier private exchange for small employers and individuals in three states. Additionally, firm A serves multiple carriers with self-service shopping portal solutions. Firm A also serves several SBMs with its Financial Management solution that includes premium billing, collections, enrollment, accounting, premium aggregation, reconciliation, call center, and other related back-office functions. In total, firm A serves more than 210,000 members, 32,000 employers, 2,000 producers, and several hundred Chambers of Commerce and other business trade associations. This firm also functions as a third-party administrator for a health plan on the FFM. It has three call centers, including brokers licensed in several states, and over 40 years of experience marketing and selling health insurance to small employers (down to the size of one employee). It is a versatile, relatively small firm (100 employees) with deep experience in health insurance, operating exchanges, and working closely with the broker community.

Firm B is a technology firm that has provided websites, decision-support tools, and enrollment functions for some of the largest national carriers and many smaller health plans in support of single-carrier exchanges, as well as multi-carrier exchanges used by broker agencies. As the technology and customer-facing partner in this arrangement, Firm B is accustomed to customizing and private-labeling its modular functionality for its many large clients. It has experience supporting and/or operating both SHOP and individual marketplaces in multiple states. Firm B can handle many of the functions required to build and operate a marketplace, including integration with a public eligibility determination system and plan management, but not necessarily marketing and sales, appeals adjudication, or navigator training and management. Firm B has some experience providing web-based decision-support and enrollment services to SBMs and Medicare, and is actively planning expansion into the Medicaid managed care space.

For many of these functions, Firm A represents a complementary partner, providing the back-office staff and expertise that Firm B lacks. Their technologies have been developed precisely for this market, having worked with small businesses and individuals on a multi-carrier marketplace for many decades. Together, the firms appear to have most of the capability and experience required to operate a public marketplace, other than eligibility determination by household income.

The two firms recently submitted joint proposals to SBMs, and they have some history of working together on one public marketplace (as independent contractors). They decided to bid jointly in part because they thought that eliminating the systems integrator as a middle man would actually enhance efficiency and reduce costs. They are willing to evaluate and consider a governance and business model that delegates a full build-out and operation of a marketplace through a single contract, but the two firms have not actually done this to date. Rather, each firm has worked with multiple vendors to support marketplaces. They expressed flexibility on the financial model, but prefer a set-up fee, plus a fixed annual fee with volume incentives, or a set-up fee plus PMPM payments.

**Option 4** is the youngest of these firms, dating back to 2009, but has grown rapidly with its dedicated focus on the expanding market of health insurance exchanges. It is an IT start-up, with approximately 750 employees, with 60 percent of its work geared towards public marketplaces, including the FFM SHOP and several larger SBMs. It is also building the entire SHOP

systems platform for one state, including the IT support for its service center, to be effective October 2015, and it has also developed eligibility determination software for another individual marketplace. This company's product is used in four SBM's eligibility systems, and it now advertises an end-to-end fully integrated systems solution, including integration with the federal identification system, shop and compare, handling 834s and 820s, premium billing and collections, plan management, portals for the key users and partners, and extensive reporting. Most of the component elements are internally built, other than banking, hosting, print, and an off-the-shelf customer relationship management (CRM) system. The other 40 percent of its work is for health insurance carriers, especially in building the capability to receive and manage 834s and 820s.

This firm is unique among the four options in having built a state eligibility determination system for APTCs, CSRs, SHOP, Medicaid, and CHIP. It is the only company with a product that has a single front door for exchange and Medicaid Modified Adjusted Gross Income (MAGI) eligibility. It also has experience integrating with other eligibility determination engines in other states. It appears to be relatively strong on financial management. For example, the system shows pending payments, can roll-over outstanding payments, and generates delinquency notes. In setting up the system for SHOP, it will support and train customer service representatives to see into both comparison shopping and enrollment on the one hand, and billing and collections on the other.

It offers standard shopping and plan comparison tools. For example, its calculator to help a consumer project his or her likely out-of-pocket spending plus premium contribution, or to rank QHPs based on other factors, is fairly standard. It does not offer an Rx calculator that allows shoppers to compare their out-of-pocket spending on prescription drugs for various QHPs.

By contrast with the other three options, this firm has not operated a private exchange end-to-end. It does bring considerable experience in every facet of both its private and public exchange offerings. It is primarily an IT firm, albeit one that appears to provide strong support to users. So, for example, as part of set-up, it will train brokers on how to use its system, but it has not provided broader certification of brokers for a marketplace, let alone managed a broker distribution channel. On the other hand, it has hired brokers on staff and has been growing capacity and expertise with the broker community. It has a training function for CSRs, but it does not run its own call center—although it will do so for 2016 open enrollment, and has significant experience coordinating with exchange call centers. The firm has no current service experience (i.e., business revenue) in selling health insurance, managing brokers, answering customer calls, and so forth. It would likely utilize its new service center, launching October 2015, for these functions if an SBM asked it to administer the entire operation.

The firm indicates that it would be interested in doing so, most comfortably for a set-up and annual fee, and is typically priced well below the SI solutions. It is also developing a PMPM financial package for its end-to-end IT solution.

## Conclusion

While much of the discussion about marketplace financial and operational sustainability has centered around the dichotomy of having a marketplace built and run by a state versus the federal government, or a hybrid of the two, this brief explores a third option. While perhaps not completely ready to take on the full range of requirements yet, there are several firms that are poised to build and operate a state's marketplace. States can now begin to consider the additional option of contracting out both the development and maintenance of the IT systems that an SBM needs, as well as many of the operational aspects of running an SBM on a day-to-day basis.



## Appendix A

# List of Health Benefit Exchange Functions & Feasibility of Delegating Them to a Third-Party Administrator

Outsourcing enables an exchange to tap into a depth of expertise that is often not available internally. It allows the exchange to leverage its vendor's experience administering similar programs, as well as Medicare and Medicaid, to meet the unique needs of exchange consumers. It will usually make sense for an exchange to outsource largely nondiscretionary, mechanical functions competitively available in the private sector. Those functions could include premium billing, collection, and reconciliation systems; enrollment and account management services; data processing; and customer relations management. Such services are readily available and efficiently provided in the private sector.

The table below reflects at a high-level what functions could potentially be outsourced, and what functions the exchange should continue to own. (The IT that was developed to support a function is not the focus of this table.) More detail is found further in the report. In some cases, statutory requirements mandate that the state retain a certain function such as producer licensing. Under this scenario, the state would continue to license producers, while management of the licensed brokers could be handed over to an outsourced partner/vendor.

| Function                                 | Exchange Core Function | Available for Purchase in Private Market | Exchange Core Function Some of Which May be Outsourced |
|--|------------------------|--|--|
| Governance & Oversight                   | X                      |  |  |
| Financial Management                     |                        |  | X  |
| Eligibility Determination & Verification | X                      |  |  |
| Website & Decision Support               |                        | X  |  |
| Enrollment                               |                        | X  |  |
| Premium Billing                          |                        | X  |  |
| SHOP                                     |                        | X  |  |
| Customer Service                         |                        | X  |  |
| Plan Management                          |                        |  | X  |
| Appeals Management                       |                        |  | X  |
| Broker Support                           |                        | X  |  |
| Navigator Program Management             |                        | X  |  |
| Marketing and Outreach                   |                        |  | X  |

## Exchange core functions

### GOVERNANCE, OVERSIGHT, AND INTERNAL ADMINISTRATION

The exchange must retain the requisite administrative infrastructure to carry out the requirements outlined in the ACA or, alternately, to oversee and ensure their execution by the private entity contracted to operate the exchange. While it is theoretically possible to outsource all management functions, doing so runs the risk of disempowering the Board. The Board should retain a legal and administrative infrastructure necessary to obtain/maintain grant funding, hire/maintain staff, and oversee the implementation and ongoing operation of the systems and business processes needed to support enrollment. This includes, at a minimum, staffing the Exchange Board of Directors, as well as the development of the internal administrative and financial infrastructure necessary to hire and support a core staff and provide for the ability to acquire and manage contracts with outside vendors.

Critical functions to be retained by the state:

- Hiring and management of a core staff
- Oversight of employee benefits, policies, and procedures for core staff
- Maintenance of a physical space (temporary or permanent) and equipment (computers, software, email capability, data storage) for core staff
- Substantive and administrative support for the Exchange Board

- Procurement strategy and ongoing oversight and management of the prime vendor in coordination with state partners
- Development and review of key policy decisions and design specifications for the exchange
- Oversight and evaluation of exchange projects, performance metrics, and required reporting
- Oversight and organization of interagency meetings and/or representation of exchange in existing interagency meetings
- Compliance activities related to federal grant funding
- Oversight of internal financial management
- Regulatory compliance

## ELIGIBILITY DETERMINATION AND VERIFICATION

The exchange must assess eligibility for individuals seeking premium and cost-sharing subsidies, as well as eligibility for those not seeking subsidies to enroll in QHPs. The eligibility system must capture and verify required information to determine eligibility, support the ability to track changes in individual income, circumstances, and employment status, and interface with the required tax credit, enrollment, billing, and account management functions operated by or on behalf of the exchange. While there are vendors that market eligibility services and systems, the state must retain ultimate decision-making authority. Development and operation of IT systems aside, eligibility determination is a core function of a public agency.

Determining whether to outsource elements of this function should be done in partnership with the agency that oversees Medicaid eligibility. Critical functions include:

- Develop/revise eligibility rules
- Control the timing and processes for redetermination
- Eligibility screening
- Eligibility determination—QHP, APTC, and CSR
- Processing of applications via web, phone, in-person, and paper
- Referral of potentially eligible individuals to Medicaid and CHIP for additional screening
- Processing of individual exemption applications
- Interface with federal and state data sources for verification
- Verification of information required for certificates of exemption
- Qualification of individuals for an enrollment period
- Processing of customer account changes (e.g., address, income, dependents)
- Review and verification of any paper documentation
- Send required eligibility notices to applicants
- Management of eligibility business rule
- Oversee or conduct appeals management
- Development and documentation of reporting requirements

## Functions available for purchase in private market

### WEBSITE AND DECISION-SUPPORT TOOLS

The website must support online, real-time eligibility determination, and support enrollment for small and nongroup customers. Vendors are already in the marketplace with customizable solutions to support this functionality.

Critical functions to outsource:

- General education and shopping for coverage
- Anonymous browsing of QHPs
- Online comparison of QHPs
- Online application and selection of QHPs
- Premium tax credit and cost-sharing subsidy calculator

- Plan rating
- Other decision-support tools
- Integration with eligibility system(s)
- Account management
- Help text or ability for consumers to request assistance
- Online feedback functionality
- Provider directory
- Ability to host images and videos
- Mobile device capability and features

## **ENROLLMENT**

The exchange must send eligibility and enrollment information to carriers on a timely basis and develop a process by which carriers can verify and acknowledge the receipt of this information. Enrollment information must be reconciled with QHP issuers no less than monthly. The exchange must maintain records of all enrollments in QHPs through the exchange and submit enrollment information to the Department of Health and Human Services (HHS) on a monthly basis.

Critical functions to outsource:

- Provide customized plan information to individuals based on eligibility and QHP data
- Rating engine with real-time rate calculations for instant online quotes
- Calculation of multiple premium adjustments
- Processing of consumer plan selections
- Enrollment transactions to QHP issuers via automated daily 834 transaction
- Receive acknowledgements of enrollment transactions from QHP issuers
- Resolve errors on the daily 834 with QHP issuers
- Reconcile enrollment information with QHP issuers on a monthly basis
- Compile enrollment data for HHS
- Integrate with call center solution and premium billing functionality (invoice generation, interface with lockbox, payment receipt process, refunds; member support through e-pay and online account view, noticing; reporting)
- Support special enrollment periods
- Process requests for disenrollment, change in household composition, or renewals
- Process plan enrollment availability and changes
- Record keeping and reporting

## **PREMIUM BILLING**

- Initial and monthly invoicing
- 834/820 electronic data interchange (EDI)
- Premium aggregation
- Payment options
- Payment processing/collections
- Online account management
- Notices
- Subsidies and reporting to CMS
- Reconciliation
- Customer billing support



## SHOP-SPECIFIC FUNCTIONS

In addition to verifying eligibility and facilitating enrollment, SHOP functionality will need to address online premium quote generation, employer account set up, plan selection options, contribution levels, the employee cost calculator, employer invoicing and payment, aggregated payments, customer service protocols, broker training and sales tools, broker compensation, and broker reporting. Since there are many vendors with a long history of supporting this population, and eligibility does not entail a subsidy through the exchange, there may be considerable benefit to largely outsourcing this function.

Critical functions to outsource:

- Verification of employers and employees through the Federal Data Hub
- Determination of eligibility to participate in SHOP marketplaces
- Provisions for qualified employers to search, compare, and select from health plan products for employees
- Allowing qualified employers to upload and maintain employee rosters
- Provisions for qualified small employers to apply for tax credits
- Calculations, collections, and payments of employee contributions
- Provisions for employees to purchase plans selected by employers
- Facilitation and tracking of payments by employers and employees to the QHPs
- Processing any broker fees and/or navigator payments
- Premium aggregation

## CUSTOMER SERVICE OPERATIONS (CALL CENTER)

When call center functionality is outsourced, the exchange can benefit from a vendor's focus and experience in running a call center, but the state should establish concrete performance objectives and conduct regular reviews. There are vendors who specialize in all of the incumbent responsibilities of a health insurance call center, including projecting call volumes, managing the right mix of metrics, hiring and managing staff, training and knowledge management, and integrating the call center technology with the system(s) technologies of the client enterprise. The seasonal work fluctuations (and staffing requirements) that will regularly challenge exchanges are then the responsibility of the vendor to oversee and manage.

Critical functions to outsource:

- Assistance with eligibility determinations and navigation through the online (and paper) application process for individuals
- Enrollment (and re-enrollment) support
- Health Plan Issuer questions, inquiries on the status of enrollment or identification cards, general health plan inquiries, and provider network inquiries
- Billing questions
- Account updates
- Assistance with self-service web portal
- SHOP support
- Broker and navigator support
- Hiring and retaining customer service representatives, frontline supervisors, support staff, and management team
- Track all customer encounters in a Customer Relationship Management (CRM) solution
- Provide in-person support to consumers
- Process incoming mail
- Interactive Voice Response (IVR) system to facilitate automatic selection of the core contact center services
- Provide language services to support customers fluent in languages/cultures other than English through non-English speaking service members or a language line service
- Fulfill client requests for mailed or electronically delivered correspondence or documentation
- Perform all necessary post-call processing; research, callbacks, inquiries to billing vendor or other agencies in order to fully resolve customer issues to 100 percent satisfaction

## BROKER SUPPORT AND RELATIONSHIP MANAGEMENT

Federal guidance only requires the exchange to display information about brokers on its website or in other public materials, but experience has shown that a robust broker program can greatly impact the success of the exchange. Many vendors have experience working with and supporting brokers, especially those with a long history of serving health plans. Supporting brokers can be outsourced, just as national carriers routinely outsource this function to local general agents, but as a key distribution channel, the direction for broker management should be reviewed and approved by core staff at the exchange.

Critical functions to be outsourced:

- Training (online and in-person)
- Compliance
- Management of monthly targets and sales objectives
- Management of compensation
- Testing of incentive returns
- Broker evaluation
- Production of monthly paper/e-statements
- Administration of self-service portal with account management functions including statement generation, data interchanges with carriers, and billing
- Management of disputes
- Broker inquires and questions
- Management of a broker-advisory group for feedback on exchange processes

## NAVIGATOR PROGRAM

Some states have decided to outsource management of the navigator program to an outside entity. It may be politically appealing, easier, and less costly to engage an outreach organization embedded in the community to manage the program. Some vendors may have more history of involvement and cooperation with community groups, so that should be something to consider when evaluating potential partners to work with to outsource. The exchange should continue to pay close attention to the type and distribution of navigator entities to ensure proper access to assistance across the state.

Critical functions to outsource:

- Training (online and in-person)
- Certification
- Compliance
- Management of compensation and controls
- Development of web tools to support the navigator program and track individuals using navigator assistance

## Potential to outsource in part, if not entirely

### FINANCIAL MANAGEMENT

The exchange's core management and Board must continue to meet the administrative and financial needs of the entity itself (i.e., ensuring the exchange has sufficient resources to pay staff, rent, and vendors), as well as ensure the appropriate controls and reporting capabilities are in place to manage state and federal funds. It is critical that the exchange retain sufficient analytical and reporting capabilities to track and report on the funds under its control.

The alignment of financial interests between the state and its third-party administrator (TPA) will depend on the exchange's revenue model and how the TPA is compensated. For example, if the revenue model were a user fee, e.g., the 3.5 percent of premiums "charged" by the FFM, and the TPA were compensated by retaining most of that user fee, e.g., 100 percent less the annual budget for the Board and core staff, then the incentives would be well-aligned, and more of the financial management could be delegated.

Critical functions to be retained by the state:

- Annual administrative budgeting and financial planning
- Oversight and review of financial statements
- Federal and state audit responsibilities
- Liaison for federal audits

Depending on the desired staffing load and alignment of interests with the TPA, the state could outsource these functions to the TPA:

- Cash management and cash flow planning
- Internal controls
- Fraud, waste, and abuse monitoring
- Federal financial reporting

### **QHP PLAN MANAGEMENT**

Certifying, offering, managing, and reporting on the performance of QHPs is a core business process of the exchange (or in some states of its division of insurance [DoI]). The Board and core staff must ensure that the operational capacity to manage ongoing carrier relationships is in place, including certification and monitoring plan performance, receipt and use of quality information to support the plan comparison functions, and procedures to monitor compliance with federal and exchange requirements. While a vendor can operationalize enrollment between the exchange and issuers, as well as many of the plan reporting and oversight functions, the agency (exchange and/or DoI) should retain the authority to make policy, oversee plan offerings, and structure key contractual relationships with the issuers.

Critical functions to be retained by the state:

- Management of the certification, decertification, and recertification of QHPs
- The QHP submission process, including acquiring rates and the formation of agreements with QHP issuers
- Management and reporting of QHP and QHP issuer information
- Oversight of QHP plan ratings
- Ongoing maintenance of plan offerings, including monitoring changes in plan availability and plan compliance
- Oversight of operations and communications plan with QHP issuers

### **APPEALS MANAGEMENT**

The exchange must establish and maintain an appeals process for findings and determinations related to individual eligibility for premium tax credits and cost-sharing subsidies; determination of employer eligibility to purchase coverage through the SHOP exchange; determination of eligibility for exemption from individual responsibility requirements; employer responsibility determination for employees determined eligible for premium tax credits; and QHP decertification. While the administration of appeals can be outsourced, at the very least the exchange will want the authority to set policy and to review appeals decisions.

Critical functions to outsource:

- Acceptance and processing of appeal requests from individuals, employees, and employers
- Implementation of adjusted eligibility or enrollment determination resulting from appeal
- Tracking of appeal requests
- Administrative support of appeal adjudication
- Reporting on the types and outcomes of appeals

## **MARKETING AND OUTREACH**

Marketing and outreach is another core business process to build public awareness of available plans, programs, or services, and to drive enrollment. While the exchange may want to work with an advertising company, experienced outsourcing partners can provide specialized services in this area as well, including implementing strategies designed to maximize investment, such as analytics-driven marketing, retention, and cross-selling programs. The exchange will want ultimate oversight over messaging and brand, as well as control over communication with the press and public officials.

Critical functions to outsource:

- Market research
- Drafting marketing/outreach plan
- Identification of target population segments
- Sales/marketing/outreach materials
- Fielding a sales/marketing team
- Establish performance metrics (including return on investment) and evaluate success against these metrics
- Management of marketing/advertising budget
- Management of relationships/alliances with marketing partners

## Appendix B

### Potential Third-Party Administrators for a Public Exchange

This is a list of potential vendors for operating a state-based marketplace, other than the eligibility determination function, which would remain the responsibility of the state. In developing this list, Wakely also assumes that the state exchange would retain an executive director and key staff, such as an outreach and sales team, a general counsel, an analytics team, a director of finance, and director of plan management, to oversee or conduct key functions that can be separated from day-to-day operations. This is a preliminary list of such vendors, based on an internet search and brief company interviews conducted in fall 2014. Further research may unearth additional candidates.

The list of potential vendors is organized into three categories:

1. Private exchanges run by IT entrepreneurs or large brokerage agencies and marketed primarily to individuals
2. Private exchanges run by HR benefits consultants and marketed primarily to employers
3. Business processing, IT development, and professional services firms serving health plans, employers, and public exchanges

The field is rapidly evolving and we have eliminated from consideration many firms that focus on only one part of the public exchange space. In particular, there are a number of firms that have developed IT systems for public exchanges (such as Oracle, CGI, and Curam) or call centers (such as Maximus) that we considered, but eliminated as insufficiently diverse in their management expertise to oversee the full outsourcing of operations. Wakely has excluded these firms, even though they might respond as part of a team of vendors to an RFP for complete outsourcing, because none is considered capable of supplying most of the services required.

Instead, the list focuses on those firms which already provide a sufficiently broad set of exchange-related services that each might be able to provide the majority of services required to operate a public exchange for both subsidy-eligible individuals and employers, and knows enough about running a state-based marketplace to oversee subcontracts for key operational components. Examples of key operational components which the prime vendor might subcontract out are processing appeals or even operating a contact center.

#### Preliminary assessments of potential vendors

Wakely interviewed senior executives at 11 potential vendors to ascertain their firms' ability and experience in providing the following functions for a mid-sized SBM:

1. Outreach and sales (including enrollment)
2. Health plan presentation and shopping (including website)
3. Premium billing for SHOP
4. Contact center
5. Broker and assister management
6. QHP management
7. Data analytics and reporting
8. Financial management
9. Integrating with the state's eligibility determination platform

Six of the vendors indicated reasonably strong interest in responding to an RFP from an SBM to operate its exchange, and made the case that their organizations have the experience, resources, and capacity to execute. Further investigation of the six narrowed the final list to four vendors (see policy brief). Here we describe briefly all the vendors initially considered for this assessment.

**Aon Hewitt:** Like other large private exchanges, Aon Hewitt has some of the functional capability, and has purchased an individual, direct sales exchange (Senior Educators) in the Medicare space. However, there is a "land rush" on for group and Medicare enrollees between Mercer, Aon Hewitt, Towers Watson, and other HR consulting firms, for which operating an SBM could be a big distraction.



**Bloom:** Bloom currently serves small and mid-sized employers, and appears to be interested in exploring the possibility of serving as the TPA for an SBM. Unlike some private exchanges, Bloom has no experience working in the public sector, nor any insights into the challenges of integrating with a state's eligibility determination platform.

For IT and customer service, Bloom uses a combination of proprietary and partner resources. For example, Bloom has its own brokers at its call center, but also uses the broker/call center at Novo-One. Bloom has its own IT, but also partnered with Empyrean to develop a joint Bloom-Empyrean platform, and uses Empyrean to do the back-office functions for larger, more complex groups.

Bloom is owned by three large Blues plans: Anthem, Michigan Blue Cross Blue Shield, and Health Care Service Corporation. It is open to other carriers, including private-labeling for plans that compete with the Blues.

**Choice Administrators:** Choice Administrators runs several health insurance exchanges in California, including one that serves nearly 200,000 enrollees from over 10,000 small employers. It offers four major issuers and dozens of health plans. Choice Administrators teamed with a couple of other vendors in 2011, in an effort capture business from SBMs. Although it is not currently pursuing such business, the principals in the company expressed some interest in potentially responding to the type of business opportunity presented.

Choice Administrators does not have experience working with state IT platforms. Its largest client to date is Kaiser Foundation Health Plans, for whom it private-labeled an exchange serving some 30,000 enrollees. Its origins are in the brokerage business, as a private venture of Ward & Brown, a large multi-line general agency in California. It uses Consumer Checkbook for a provider directory, and claims to be developing with another party a tool that helps enrollees find the best plans for their particular health status.

Choice Administrators claims to have a full back-office suite of services, including its own collection agency. In the words of its CEO, Ron Goldstein, it is broker-driven, and really understands sales, customer service, and carrier support. It has been in this business and successful for 18 years. The preferred revenue model is a percentage of premium, plus an initial set-up fee to cover their costs.

**Connecture:** Connecture is an information technology company that originated at the turn of the century providing quoting and plan comparison tools to brokers. It has since developed a platform for additional sectors, including carriers and state government. It is one of the largest private-label suppliers to health plans of consumer-facing information technology. Connecture's platform provides consumer shopping, enrollment, retention, and back-office capabilities to some of the largest health plans around the country, and multi-carrier private exchanges for brokerage agencies—all supporting individual and small group with medical and a complete range of ancillary plans. Connecture has developed a consumer-centric, personalized health insurance shopping experience that recommends the best fit insurance plan based on an individual's preferences, health status, preferred providers, medications, and expected out-of-pocket costs. Connecture works with two SBMs currently, under the systems integrator in both cases, and has experience working with managed Medicaid programs. Connecture's platform handles more than 20 million annual shoppers.

**Deloitte:** Deloitte has done the principal IT build for Rhode Island, Connecticut, Kentucky, and Washington, and added the Maryland exchange during 2014. It also has substantial history serving Medicaid and other state programs, including running call centers for states. In Maryland, Deloitte has played a broader role for the exchange than just developing IT and being the systems integrator. Deloitte's head of exchange development for states indicated that Deloitte would want to do most of the work itself, if it would be accountable for operating the SBM.

Nevertheless, the division within Deloitte with exchange experience is principally an IT shop and staffing outsourcer for government agencies. It probably understands the challenges in integrating with a state eligibility platform as well as anyone—the eligibility platforms in Connecticut and Maryland are not Deloitte's own—but we do not believe that this division of Deloitte has experience in outreach, insurance customer service, broker, or plan management (nor has Wakely explored Deloitte's ability/interest to bring in expertise from other parts of the company). Deloitte lacks the experience operating in the individual and small group insurance markets that some of the other potential vendors have. On the other hand, it is a far larger and more government-oriented vendor than some of the interested TPAs reviewed above.

Therefore, Deloitte would need to bring on a dedicated operating team, including outreach, broker management, insurance sales, carrier management, operations staff, and business analysts in order to evolve from IT development and management into a full TPA. Despite the expression of interest, and Deloitte's evolution in its recent work for Maryland in this direction, doing so would require a commitment from the company to alter its business model. Deloitte's focus seems to be on large IT projects, with "bottom-up" budgets, rather than, for example, operating the entire SBM for a PMPM fee.

**eHealth:** In 2011, eHealth was interested in operating public exchanges, and won the contract to operate HealthCare.Gov before it could offer plans for sale. However, eHealth has since expanded its private business, both in direct sales and operating private exchange portals for Aon Hewitt, Willis, Walmart, and others. Today, eHealth does not appear to be interested in operating SBMs, although a company executive interviewed for this project indicated that eHealth might still take a look at such an RFP.

**GetInsured/bSwift:** Both are relatively young companies with a heavy technology orientation that have been focused on the exchange space for years, and have considerable experience already working for public exchanges and operating private exchanges. Both companies are interested in working with SBMs, and have already partnered to do so. Specifically, the two companies have built and are operating one SBM. In addition, GetInsured plays major roles in supporting several other exchanges, and bSwift plays a major role in supporting one state's SHOP exchange.

Together, the two entities claim to have the capacity and experience to operate all nine functions listed above. Integration with a state's eligibility platform is one of the biggest challenges for any TPA, and GetInsured also has experience doing this integration with Idaho.

GetInsured private-labels its services for various large HR consulting firms and for tax firms, assisting their customers to enroll with APTCs. For Covered California, with approximately 1.4 million enrollees, GetInsured provides several of the nine operating functions enumerated above (policymaking related to these functions is retained by Covered California, as is the operation of its own call center).

GetInsured is venture-backed (Bessemer). bSwift was venture-backed, and has been purchased by Aetna. It apparently intends to continue its alliance with GetInsured, and will operate as a separate division of Aetna.

**GoHealth:** The company provides its core platform to approximately 20,000 brokers around the country, sells directly to individuals, provides website and technology to health plans, and provides the contact center with licensed brokers to Coventry. However, the executives interviewed did not think that operating an SBM was a good fit with the company's business plans and functional capabilities.

**hCentive:** Headquartered in Reston, Virginia, hCentive was founded in 2009 to respond to the changing health insurance marketplace and the operational demands these changes required. hCentive specializes in configurable, scalable solutions for health plans. hCentive's products currently connect to multiple SBMs, as well as the FFM. Their WebInsure Platform offers a suite of modular technology pieces to support a health plan or exchange. Features include simple eligibility determination, enrollment, a quoting engine, 834/820 EDI support, a recommendation engine, a broker portal, premium billing, defined contributions, analytical reporting, and a customer service platform. Kentucky and New York's health benefit exchanges used hCentive for their SHOP marketplaces and Kentucky used hCentive for individual shopping as well.

hCentive recently launched WebInsure Benefits, a multi-carrier, multi-product platform that is designed to provide a comprehensive private exchange solution to large brokers and employers. hCentive also works with public exchanges and recently announced its offering of a cloud-based IT platform for an entire state-based marketplace.

**Mercer Marketplace:** Mercer uses GetInsured to operate its exchange offering, and the executive interviewed there thought that it was extremely unlikely that Mercer would consider the kind of business opportunity under review in this report. Its main interaction with public exchanges would be through GetInsured to access COBRA and subsidized individual coverage for part-time employees.

**NFP Health:** NFP Health operates as a division of NFP, a privately held corporation (owned by Madison-Dearborn out of Chicago) with over \$1 billion in gross annual revenues and offices (brokerage, wealth management, and others) across the country. NFP Health originated as an intermediary for health and other benefits in the small end of the group market. It has grown substantially over the past several years, and its business now includes serving as the private label behind various exchanges, both private and public, as well growing its own branded private exchanges. Senior executives expressed interest in serving as the TPA for an SBM.

NFP Health operates its own private exchanges for small employers, serving thousands of employers and over 150,000 enrollees, connecting them to about a dozen carriers and hundreds of health plans. NFP Health works with independent brokers and has its own brokers in-house. It has a robust marketing, sales, and service orientation, including broker management, social media, decision-support tools, live chat, and sophisticated sales cost management and trends analysis. It also does the financial management, including billing, collections, setting up the exchanges' accounting systems, and exporting data to their general ledgers for two SBMs. NFP Health also provides full integration and support of carriers participating on the FFM for enrollment, billing, all financial management, call center, EDI, and reporting.

**Towers Watson:** A worldwide HR benefits consulting and risk management firm, Towers Watson was a fast follower of Aon Hewitt in 2013, using two major purchases to jump-start its presence in the private exchange space. It acquired Liazon, a 6-year-old venture-backed effort to automate and better serve health plan enrollment for small and mid-sized employers. At the time Towers Watson acquired Liazon, it was active in approximately 23 states. About the same time, Towers Watson also acquired Extend Health, which specializes in retirees' health benefits. Towers projects to serve nearly 420,000 active employees and about 800,000 retirees in 2015.

Operating under the name "OneExchange," Towers Watson is actively pursuing clients among its many large employers. It has not yet bid for or actively pursued SBM work.

**Xerox and Buck:** Buck is a wholly-owned subsidiary of Xerox, and together they sought to operate SBMs, but their experience trying to stand-up the Silver State Exchange for Nevada seems to have soured them on this market. Xerox and Buck are currently re-evaluating whether and how they intend to serve SBMs and participate in exchanges in the future. Xerox and Buck had partnered with Choice Administrators to run Nevada, but then took those functions in-house. Buck does operate its own private exchange, and Xerox operates KYnect's call center.