Business Case for

Oregon State-Based Marketplace

Oregon Health Authority, Health Policy & Analytics, Oregon Health Insurance Marketplace

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Authorizing Signatures

The person signing this section is attesting to reviewing and approving the business case as proposed.

This table to be completed by the submitting agency Agency Head or Designee	
David Baden	(Date)
Interim OHA Director	
Signature	9/5/2023
Agency Executive Sponsor	
Chiqui Flowers	(Date)
OHIM Director	08/30/2023
Signature	
Agency Chief Information Officer (CIO) or Agency Technology Manager	
Debbie Estabrook	(Date)
ODHS/OHA OIS CIO	
Signature	8/30/2023
Business Analyst or Business Case Author	
Victor Garcia	(Date)
Jeremy Akins	
Signature	

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Executive Summary

Oregonians currently use HealthCare.gov to enroll in individual health insurance plans sold through the Oregon Health Insurance Marketplace. Created by the Affordable Care Act (ACA), these plans are known as qualified health plans (QHPs), and purchasing through a state's marketplace is the only way to qualify for subsidies to increase affordability in the form of advance premium tax credits (APTC) and cost-sharing reductions (CSR).

In 2018, the Health Insurance Marketplace Advisory Committee (HIMAC) asked the Marketplace to begin analyses of rising costs and possible alternatives for Oregon. In the subsequent 2 years, several states have moved forward with plans to replace HealthCare.gov and become state-based marketplace (SBM) states. The advantages of making this change have been illustrated and reinforced with each subsequent state that undertakes it. Becoming an SBM requires that a state acquire and implement its own enrollment technology and accompanying consumer assistance center (CAC) to provide over-the-phone support for enrollees.

After the initial analyses showed a very likely improvement to Marketplace effectiveness, benefit to the services received by Oregonians, and savings of millions of dollars annually, the HIMAC recommended beginning the process to procure a state-based enrollment technology in October of 2019.

Some key reasons (among many others) for Oregon to consider this change:

- Savings of millions of dollars per year in federal technology fees.
- Full access to and control over the enrollment data of Oregonians which will better inform ongoing efforts to provide improved services to underserved populations in Oregon.
- More accurate and real-time demographic data will improve targeted enrollment, outreach, and messaging. This also provides more accurate and comprehensive data to inform Oregon's efforts to contain costs and improve outcomes for all Oregonians, as envisioned by SB 770 (2019).
- Control over the enrollment technology and experience for Oregonians.
- Oregonians would see an immediate improvement in customer service and outcomes on implementation. This would also give Oregon the ability to work with a vendor to add desired functions in the future based on the Governor and Legislature's policy priorities.
- The existence of a competitive market specifically for SBM technology, with vendors that have SBM solutions with a proven track record in other states. The competition serves to contain the cost of the technology.
- Ongoing examples of states that are making, or have already made, this transition.

Overview and Background

Background

In 2010, President Obama signed the Affordable Care Act (ACA) into law. Part of the intent of the ACA was to make individual health insurance more affordable so that more of the then-estimated 44 million uninsured Americans could obtain coverage. Income-based tax credits that eligible consumers could choose to receive in advance (advanced premium tax credits, or APTC) and subsidies to reduce cost-sharing (cost-sharing reductions, or CSRs) – such as co-insurance, co-payments, and deductibles – are the ACA's primary direct mechanisms to make health insurance more affordable for eligible families and individuals who do not receive health coverage through an employer or a government program. APTCs and CSRs are available only to consumers who purchase a qualified health plan (QHP) through an exchange, public or semi-public entities that administer the provisions of the ACA under state authority, including using technology to determine eligibility for APTCs, allowing

consumers to shop for and choose health insurance plans, enrolling consumers in those plans, and storing consumer information. Under the ACA, if a state fails to administer its own exchange, the federal government will step in and do so.

The Oregon Health Insurance Marketplace (Marketplace) is an office of the Health Policy and Analytics (HPA) division of the Oregon Health Authority (OHA), Oregon's public health agency. The Marketplace is Oregon's health insurance exchange, and its mission is to empower Oregonians to improve their lives through local support, education, and access to affordable, high-quality health coverage. The Marketplace administers Oregon's health insurance exchange in this state, through which Oregonians may purchase ACA-compliant individual health insurance plans and receive tax credits and cost-saving reductions to make those plans more affordable.

States, like Oregon, that retain direct authority over their exchanges but that rely on the technology and call center provided by the federal Centers for Medicare and Medicaid Services (CMS), a division of Health and Human Services (HHS), for its APTC, CSR, and plan eligibility, shopping, and enrollment functionalities, are known as state-based marketplaces on the federal platform (SBM-FPs). Thus, because Oregon is an SBM-FP, Oregonians enroll in QHPs through HealthCare.gov, which is owned and managed by CMS. HealthCare.gov, is the front end of the enrollment technology that is known as the federal platform or federally facilitated marketplace (FFM). Tied to the FFM is a telephone consumer assistance center staffed by customer service representatives – federal employees or contractors – who help people with APTC and CSR eligibility, plan enrollment and related support over the phone. Oregon health insurance companies selling plans through the Marketplace pay a fee for use of the federal technology. The fee has fluctuated over the years from zero percent to three percent of total premiums paid by Oregonians who purchase QHPs through the Marketplace.

Problem - Current State

Oregon and other states using the federal platform as SBM-FPs began doing so because a lack of alternative options available to them at the time. When the SBM-FP exchange classification was created, the federal government made the FFM and its call center services available without charge. This is just one of the many disadvantages of using the federal platform, which include the following:

- Inflexibility of the FFM technology
  Because the HealthCare.gov is a one-size-fits-all solution, it is designed for use by many states and cannot be customized according to Oregon's needs, preferences, or requirements. In other words, what works for Oregon must also work for Alabama.

  For example, CMS cannot or will not operationalize the following:
  - Increasing the length of open enrollment to accommodate the specific needs of Oregonians. So, while Oregon has the authority to increase the length of open enrollment (which may be important due to specific conditions in the state, e.g., unusually high COVID-19 infection or hospitalization rates), Oregonians cannot avail themselves of this authority because the FFM cannot operationalize this change.
  - Creating special enrollments to accommodate Oregon-specific circumstances. For example, Oregonians in need could not take advantage of a special enrollment created for victims of wildfires, flooding, or earthquakes unless the FFM deemed it necessary regardless of what the state determines.
  - Providing on-demand and real-time access to current or historical enrollment data and statistics, including race, ethnicity, and language, disability, sexual orientation, and gender identity data (REALD/SOGI).

- Coordinating with OHA's Medicaid program to eliminate gaps in coverage and care resulting from churn or to auto-enroll individuals who are redetermined ineligible for Medicaid after the end of the public health emergency (PHE).
- Establishing a basic health program to use federal funds to provide Medicaid-like coverage for individuals with incomes from 138 percent of the federal poverty level (FPL) to 200 percent FPL, including lawfully present immigrants who do not qualify for Medicaid due to limited in-country residency.
- Innovating and coordinating with other state agencies to, for example, create an easy Marketplace eligibility system for interested Oregonians that allows them to simply check a box on their tax returns authorizing the automatic transfer and analysis of income data to the Marketplace's system to determine APTC and CSR eligibility.

- <u>Lack of control over operations, customer service, and service levels</u>
  Oregonians can face long wait and hold times and when finally able to speak with a customer service representative, there is no guarantee that the information provided will be accurate. The latter is due to the fact that the FFM's Customer Assistance Center (CAC) serves many states, and its representatives are not all well-versed on, or familiar with, Oregon laws and requirements. This has resulted in some Oregonians needing to call the CAC repeatedly over periods extending into weeks or months to resolve complex case issues. While these issues would typically be addressed with the CAC vendor in a service level agreement (SLA) (assuming the state had access to performance metrics), CMS has not entered into an SLA with states for either the enrollment technology or the consumer assistance center, and Oregon does not have the leverage to insist that one be instituted. The agreement for use of the federal platform is presented by CMS to each state for acceptance or rejection, and once accepted, is in place until rescinded by either party for reasons outlined in the agreement or until CMS revises the agreement. There is no negotiation, and all states receive the same terms. For a state to reject the agreement, it must be able to administer its own exchange and provide its own technology platform.
    - The FFM technology's provider search option is frequently out of date. When a consumer desires to select a plan based on its coverage of their doctors, the consumer cannot always trust that the information displayed is correct. Moreover, even though consumers have no choice but to rely on this information, they do so to their detriment because the FFM will not allow a consumer to choose a new plan (outside of open or special enrollment) under these circumstances even though the information provided by the FFM was wrong.
    - Positive customer interactions and quick time to issue resolution are central to the Marketplace's customer service philosophy. Having a customizable system under our more direct control will allow us to address customer issues far more efficiently, saving unknown hundreds or thousands of lost hours for Oregonians and our stakeholders that assist them per year. The amount is unknown because we lack the data to have an accurate reckoning of that lost time – for now, we only have our own customer interactions and anecdotal stakeholder reports from which to estimate.

- <u>Unpredictable and opaque charges</u>
  The fee for using the FFM is paid directly to CMS by Oregon insurance companies and is passed on to consumers in the form of increased insurance premiums. In 2023, a family of five will pay an estimated $42.50 per month in premiums solely for the use of the FFM. The fee is established annually by CMS as part of a set of rules called the Notice of Benefit and Payment Parameters (NBPP). While initially free for SBM-FP states to use, starting in 2017, CMS began charging for use of the federal platform. In 2017, 2018, 2019, 2020, 2021, 2022, and 2023 the fees were 1.5 percent, 2 percent, 3 percent, 2.5 percent, 2.5 percent, 2.25 percent, and 2.25 percent respectively, of total premiums for plans purchased through HealthCare.gov.
    - CMS claims it charges are based on the following "special benefits" provided to insurers that use the FFM: (1) provision of consumer assistance tools; (2) consumer outreach and education; (3)

management of a Navigator program; (4) regulation of agents and brokers; (5) eligibility determinations; (6) enrollment processes; and (7) QHP certification processes. As an SBM-FP state, Oregon performs the majority of these functions yet CMS charges Oregon only half of one percent less than it charges states that rely on the FFM for all of these functions. Although, for the past several years Oregon has inquired about CMS's charging calculous and its underlying rationale and have requested a state-specific break down of services used and charges imposed, CMS has refused to acknowledge Oregon's requests. The state has questioned how a flat percentage fee on premiums could possibly apply across the board. Such a "flat tax" disadvantages smaller states, like Oregon, whose citizens collectively use fewer federal resources - fewer people are using the call center, fewer people are seeking eligibility determinations, fewer people are using the federal platform, fewer people are requesting special enrollments, fewer people are asking shopping-related questions, fewer people are receiving APTC, etc.

- CMS' flat user fee does not give Oregon credit for the expense and success of state-specific programs. As an SBM-FP, Oregon funds its own navigator program and funds a very targeted outreach and education program. For the 2016 plan year, without federal navigator funding, Oregon increased its enrollment by 31 percent over the 2015 plan year, far exceeding any of the FFM states. This increase was second only to New Mexico, another SBM-FP state. For the 2017 plan year, when almost all FFM states lost enrollment, Oregon increased enrollment by 6 percent. In fact, six of the ten top performing states, including Oregon and Nevada, an SBM-FP – at number one, were state-based marketplaces. From the 2015 plan year, when Oregon became an SBM-FP, to the 2017 plan year, Oregon increased enrollment by a total of 39 percent, second only to Utah (at 40 percent), and far outperforming the vast majority of FFM states. The Marketplace also pays for use of a shopping tool that allows Oregonians to compare plans based on medications taken, accurate provider searches, and more. The Marketplace shopping tool, which is made available at great expense, provides a superior shopping experience than HealthCare.gov.
- Although CMS has touted savings and cost-reductions at the federal level, it does not account for those savings when setting the user fee.
- In 2018 alone, CMS collected $1.2 billion in user fees with a two percent user fee and relatively low enrollment. Conservatively, one could estimate that through 2022, CMS will have collected $6 billion in user fees, enough to pay for a state-based technology for a state with twice the enrollment of Oregon more than 400 times. The Marketplace estimates that a customizable, state-based enrollment and eligibility platform and a state-controlled call center would save Oregonians roughly $10 million per year.

- <u>No ownership of data, stifled innovation</u>
  Oregon does not have direct access to the data of any of its residents enrolled through HealthCare.gov. While CMS provides some data periodically, it frequently requires the Marketplace to keep these data confidential. This has proven inadequate for the types of targeted outreach and education the Marketplace must engage in to be most effective. Access to more demographic data would enable the Marketplace to make the most effective and efficient decisions regarding how to engage resources to boost enrollment and education efforts, especially leading up to, and during, an open enrollment period and is necessary for the kind of targeted outreach required to begin to end health inequities in the individual health insurance market.
  - This inability to create and/or share reports at a desired frequency with specific demographic data also limits the Marketplace's ability to provide information regarding health policy initiatives that the governor or the legislature may be considering, such as a public option, increasing subsidies to middle income consumers, or a state premium assistance program to help more marginalized and underserved Oregonians more easily afford health insurance. Since the Marketplace is often the mechanism for

states to enact these initiatives, starting an effort without a functioning, state-specific technology already in place could add years to an implementation timeline for a legislative priority program.

- Barriers to health equity
  Use of the FFM prohibits the state's ability to use input received from its various and diverse communities and partners. Implementing Oregon-centric approaches into the operation and administration of many aspects of the Marketplace to address health-inequities is all but impossible. For example, if certain typically underserved populations in this state speak out to say they would benefit from the use of additional languages (it's currently available in English and Spanish) or even simply alternate verbiage on the enrollment platform, the Marketplace is powerless to act because the FFM does not operationalize single state solutions. Moreover, because the Marketplace does not own or control the data of its enrollees, there is no baseline for Oregon to know the extent of the problem facing priority populations. Simply put, use of the FFM is a barrier to OHA's goal of ending health inequities by 2030.
  - Data collection, particularly on race/ethnicity, is widely recognized as fundamental to understanding enrollment disparities. The FFM's race/ethnicity application data is unreliable because of a low response rate, and the FFM has failed to improve data collection through the application by asking questions differently and does not have the ability to engage insurers in data collection and reporting like the Marketplace.
  - Without additional, more reliable data, the Marketplace is cannot refine its outreach and communication strategies, both overall and in real-time, to reach priority populations.

Opportunity

In May 2018, the Marketplace's governor-appointed Health Insurance Marketplace Advisory Committee (HIMAC) analyzed the increasing costs of the federal platform and asked the Marketplace to review alternatives to using the federal platform. The committee qualified that an alternative to HealthCare.gov must result in all of the following:

1. Improved outcomes and customer service for Oregonians
2. Better alignment with the written statutory purpose of the Marketplace
3. Ownership of and accountability for Oregon Marketplace enrollment and related metrics data
4. Lower overall costs to Oregonians and Marketplace stakeholders

In order to implement any option to become an SBM, the Marketplace must fulfill a set of requirements set by CMS. At a high level, those requirements currently are:

- The state must procure its own eligibility and enrollment technology to replace the federal one.
- The state must have its own consumer assistance center for in-person, over-the-phone support.
- The state governor (or designee) must announce an intention to become an SBM in the form of a letter to CMS.
- CMS must approve the transition plan, along with milestone updates, similar to a stage gate process.

In September 2019, after conducting its own request for information (RFI) and reviewing the experiences of other states that had conducted RFI and requests for proposal (RFP), the HIMAC recommended to the Department of Consumer and Business Services ((DCBS) - the Marketplace authority at that time) director that Oregon move forward with plans to become an SBM.

The opportunity benefits include:

- Increased Flexibility
  Moves away from the HealthCare.gov one-size-fits-all solution. Opportunity to create special enrollments to accommodate Oregon-specific circumstances. For example, Oregon victims of wildfires. Also creates to opportunity to provide on-demand and real-time access to current or historical Oregonian enrollment data and statistics, including race, ethnicity, and language, disability, sexual orientation, and gender identity data (REALD/SOGI) not currently being collected by CMS.

- More Control over operations, customer service, and service levels
  FFM's Customer Assistance Center (CAC) serves many states, and its representatives are not all well-versed on, or familiar with, Oregon laws and requirements. Provider directory list is also frequently out of date.

- Consumer Cost Savings
  The fee for using the FFM is paid directly to CMS by Oregon insurance companies and is passed on to consumers in the form of increased insurance premiums. The Marketplace estimates that a customizable, state-based enrollment and eligibility platform and a state-controlled call center would save Oregonians roughly $10 million per year.

Alignment to Strategic Plans

The project also aims to address the following strategies with the governor's office, state CIO, and ODHS|OIS Programs:

- Cloud Forward Infrastructure Opportunity
  The Cloud Forward Guiding Principles (Page 6, EIS Cloud Forward strategy) of Cloud-First, Agility Counts, and Business Enablement will inform the procurement preferences and considerations. The Proposed SBM intends to procure best in class business solution based on Software as a Service cloud consumption model aligned with these guiding principles in EIS Cloud Forward strategy with emphasis on acquisition of full-service solution developed, deployed, and maintained by an experienced vendor abstracting SMB business unit from ongoing operations and maintenance of underlying infrastructure. An especial preference will be given to a vendor with robust data reporting and analytics capabilities to enable SBM business unit gain great insights with an especially sharp focus on understanding equity and developing programs to address the issues contributing to inequities.

- Data Collection Capacity + DEIA infrastructure and organizational capacity
  'Strategy 5 – Disaggregated Data as a Lever for Change' of the State of Oregon's Diversity, Equity and Inclusion Action Plan highlights the need for using data to invite communities who may have different needs and priorities and efficiently apply resources based on where data shows they are most needed and effective. Having control over the SBM instance will give the advantage of having access to data and metrics that aren't currently being collected. This will enable the Agency to collect, organize and analyze data to understand trends from an equity lens, pinpoint and address inequities, develop targeted campaigns for broader adoption and enrollment, and allocate funds toward overcoming inequities.

  It will also speed up our responses to confront barriers to health equity. Additional and more reliable data will enable the Marketplace to refine its outreach and communication strategies, both overall and in real-time, to reach priority populations.

- Governors Strategic Plan

Strategy number two of the Governor's Modernizing State Information Technology Systems and Oversight Plan (9/24/18) is to Optimize service delivery to the public and internally by modernizing agency-specific and cross-agency systems and creating a statewide cloud strategy. This investment would represent a huge leap for the Marketplace by modernizing with a cross-agency cloud native platform.

- ODHS|OHA OIS Strategic Technology Plan (2021-2023)
  This investment aligns to 'Goal 4: Interoperability and Data' of the ODHS|OHA OIS Strategic Technology Plan by promoting usability, interoperability of enrollment data and data sharing and integration with other systems such as the Medicaid Enterprise System.

Solution

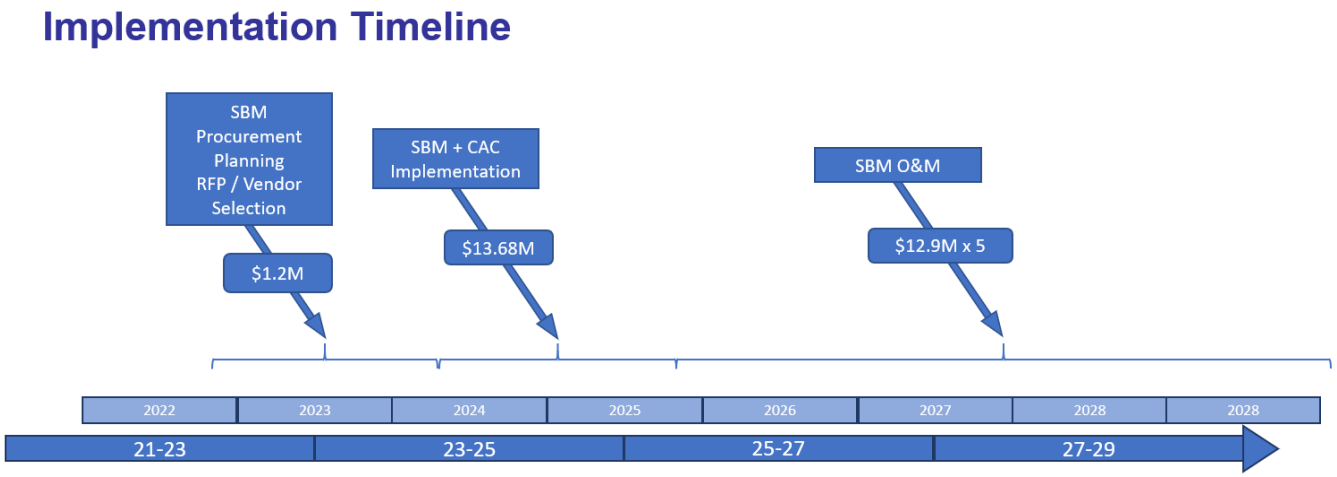
Project Scope and Project Plan Summary

For Oregon to successfully transition to an SBM, the project must resolve the following two primary deliverables:

- Acquisition and implementation of an Oregon-controlled ACA exchange technology platform
- Establishment of an Oregon-controlled consumer assistance center (contracted, state-staffed, or combination)

Timeline

- Procurement: Planning for State Based Marketplace (SBM) Request for Proposal (RFP), vendor selection, contract negotiations and signing. (12 – 18 months)
- SBM implementation including Customer Assistance Center (CAC) (SaaS Vendor). (12 – 18 months)
- SBM M&O + additional enhancements (Vendor) 5 years



These two deliverables form the nexus of the project, and the following high-level sub-deliverables are required for success of the project:

- Partnership with the OHA Office of Information Services (OIS) and OHA Health Systems Division (HSD) for:
    - Prioritization through OHA's IT Governance Process which includes representation of all OHA divisions and DEI Representatives.
    - Collaboration and participation in the appropriate agency Information Service Management Committees (ISMC) for changes, impacts, data governance, and interoperability planning with existing OHA impacts such as the Medicaid Enterprise System.
    - Inclusion of OIS resources such as the Solution Development and Delivery (SDD), Enterprise Architecture, and Business Engagement Services teams.
    - Allocation of an OIS Project Manager familiar with the Project Management Body of Knowledge (PMBOK) for an effort of this size and scope, as well as experience with stage-gate project implementations.
- Establishment of an executive steering committee
- Project planning of sufficient detail, demonstrating sufficient viability for approval by EIS and the legislature
- OHA and Marketplace functional and organizational change management to accommodate the enrollment and eligibility (E&E) technology and CAC responsibilities
- Budget planning, including necessary changes to the Marketplace assessment for funding during and after a transition
- CMS requirements, including letter of intent, blueprint revision, project plan review, and any other federal SBM sign-off requirements
- OHA and ETS collaboration and technology requirements needed to share OHA's existing "Authority to Connect" to the Federal Data Services Hub (FDSH) used for Medicaid (Oregon Health Plan)
- Management of external stakeholders' (OHA and insurance carriers) electronic data interchange (EDI) requirements to connect both to and from the new systems

<u>OHIM Business Process Updates</u>

As outlined above, a substantial expansion of staff and business processes will need to happen within the Marketplace program in order to administer an SBM technology platform and call center, along with other changes to existing processes. These changes include taking on duties and tasks that do not currently belong to Oregon.

By studying and conversing with other states, the Marketplace is aware that it will also need to effectively plan for and manage at least these organizational changes:

- Additional staff will be needed for:
    - Call center and technology contract management
    - Ongoing vendor QA
    - Complex case escalation beyond the contracted call center
    - Enrollment determination appeals
    - Managing vendor change requests
    - Analysis of all related state and federal policies and advising on their practical implications
    - Data analysis
- New business processes will need to be created, including:
    - Call center scripts, structure, guidelines
    - Escalated cases, application appeals

    - Records reconciliation with Medicaid (ONE/ OHP) and insurance carriers
    - Change request submissions
    - Generation of reports from the system
- Additional considerations for OHA outside of the Marketplace
    - Additional OIS staff that may be needed for support
    - Complementary changes to the ONE system needed for EDI links between systems

We anticipate that the project planning period would also encompass this work, with the potential (if necessary) to include a funding request for a project manager or consultant in the 2025 session that could facilitate the organizational change management and the building of business processes around the selected vendor(s) for the technology platform and call center. We also anticipate aligning with OHA strategic initiatives and integrating the values and priorities outlined in the DEI Action Plan as we complete the planning and associated work – these will be especially important when considering how to prioritize additional staffing and when hiring.

Potential Solutions

Examples from other states have followed similar trajectories, patterns, and milestones. Some states required legislation, while others only needed executive action, but the RFP to implementation timelines mirrored each other. In the most relevant examples from Nevada, Pennsylvania, New Jersey, and Maine:

- Each was able to demonstrate a savings over Healthcare.gov beginning with the first year of operations, with savings scaling up according to population
- Each received a number of viable responses to their respective RFPs, indicating a competitive market
- Each completed design, development, and implementation (DD&I) within 14 months of contract execution with Pennsylvania, New Jersey, and Maine tracking closer to 12 months (speed is not necessarily desirable, but shows what is possible)

Of the current 18 SBM states[1]:

- Each was able to open a COVID-19-related special enrollment period (SEP) to allow more residents to seek coverage because of their control over their enrollment technology. (Though able, Idaho did not and chose different strategies related to COVID-19)
- After implementation, each state has been able to take steps to alter its technology to accommodate its specific needs, from extended open enrollment periods to a state premium subsidy program (California).
- Kentucky restored its exchange in 2021 for 2022 open enrollment, which had been taken offline under direction of the former governor. Prior to its decommissioning, the Kynect system was extremely successful and one of the better SBM technology platform examples.

SBM Cost Comparisons

The following table illustrates the differences in overall cost between the SBM-owned systems and Oregon's use of the federal platform in 2020, as well as the cost per member per month (PMPM). The PMPM is the amount each carrier is assessed per plan member on a monthly basis to fund the platform, marketplace staffing and

[1] Virginia passed legislation in 2020 with plans to become an SBM in 2023, leaving only Arkansas and Oregon as SBM-FPs.

administration, and CAC. Nevada, New Jersey, and Pennsylvania have all contracted for SBM technology and CAC services.

Key: M&O = Maintenance & operations; CAC = consumer assistance center;
FP = Federal Platform

State	**Annual M&O** (combined tech & CAC, rounded to nearest 0.1 M)	**Projected 1st year avg. enrollment** (rounded to nearest K)	**Annual M&O as PMPM** (from rounded estimates)
Nevada [1]	$5.2 M	75,000	$5.78
New Jersey [1]	$14.7 M	256,000 - 306,000 [3]	$4.00-$4.79
Pennsylvania [1]	$24.9 M	354,000	$5.86
Oregon 2020 (FP) [2]	$22.4M	118,000	$15.82

1. Based on public contract information and estimates in released RFPs
2. Based on 2020 Marketplace Assessment Memo published Feb. 2019
3. No projections available; NJ RFP asked vendors to estimate cost based on a potential increase over 2019 enrollment of up to 20%, reflected in this range

This simple table demonstrates the cost advantage of becoming an SBM – Oregonians pay two to three times more out of their premiums for the use of Healthcare.gov. In 2020, the estimated costs for Healthcare.gov are nearly the same as Pennsylvania's SBM first plan year technology and CAC costs – Pennsylvania has three times as many enrollees as Oregon.

Analysis of key success factors in other states

In analyzing the three most relevant recent examples of state SBM transitions – Nevada, New Jersey, and Pennsylvania – some patterns emerge as success factors for these states. Key among them are:

- Support from multiple levels of government: The governor, the majority of the legislature, and other involved state agencies
- Narrowed scope: Not simply the ubiquitous "scope creep" tracked as a project risk, but an intentional narrowing of the scope of the SBM technology procurement to no more than, or at most very close to, the replication of Healthcare.gov functionality.
    - This reduces initial costs and time to implementation while reducing project risk.
    - All vendors have contract mechanisms for the development of state-specific features over time. This allows the state to more quickly implement a functioning technology with the features common to all states to immediately reap those benefits, then work with the vendor to create additional desired functionality in subsequent PYs.
- Diligent project planning and early stakeholder engagement.
- Leveraging information from other states' successes and lessons learned.

- Nevada blazed the trail for states now considering this move but learned from existing SBEs and its own 2014 technology failure.
- Pennsylvania and New Jersey then built on Nevada's successes and modified that template to their states' needs.
- This is reflected in the RFIs and RFPs for SBM technology from state to state. There has not been much deviation from Nevada's 2018 RFP example, which has a structure that seeks to have vendors affirm and demonstrate the functionality and ACA compliance required by all states.

The Oregon Health Insurance Marketplace seeks to transition to a fully state-based marketplace (SBM) at a lower cost and at better service levels than are currently being provided by HealthCare.gov. In doing so, the Marketplace furthers its mission "to empower Oregonians to improve their lives through local support, education, and access to affordable, high-quality health coverage." This transition will also allow the Marketplace to have both the data and the ability to take actions that will more closely align with the Marketplace's establishing statute, ORS 741.001[2].

Becoming an SBM will allow Oregon to re-take full control of the operations, customer service, fiscal, and data-related aspects of its individual marketplace in order to fulfill the legislative intent of ORS 741.001. It will also provide a technological foundation through which future health policy initiatives may be implemented.

To accomplish this, the Marketplace must procure an enrollment technology and provide a solution for a consumer assistance center. In terms of information technology (IT) projects, the technology procurement in this case is not a stand-alone proposition. A CAC necessarily interacts with the enrollment technology. The type of technology procured, its contact management features, and how it is implemented will, in part, determine what additional complementary software tools may be needed by the CAC. Technology vendors in this market also offer integrated, or bundled, contracted CAC solutions. The winning bidder may be providing both, depending on how the procurement is conducted. These changes will then require complementary changes to the Marketplace's business processes and organization. Because of the planning required, examples from other states have shown success with conducting a single RFP for both technology and CAC.

Measurable Business Benefits

Oregon transition to SBM ROM estimates:

- <u>Current state:</u>
  - Carriers direct-pay 2.25 percent to CMS, variable annually
  - Carriers pay Marketplace assessment separately, set annually

[2] 741.001 Health insurance exchange; legislative intent. It is the intent of the Legislative Assembly that the health insurance exchange be administered in such a manner as to:
(1) Incorporate the goals of improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of health insurance for all Oregonians and lowering or containing the cost of health insurance so that health insurance is affordable to everyone.
(2) Promote the public interest and for the benefit of the people and businesses that obtain health insurance coverage for themselves, their families and their employees through the exchange.
(3) Empower Oregonians by giving them the information and tools they need to make health insurance choices that meet their needs and values.
(4) Improve health care quality and public health, mitigate health disparities linked to race, ethnicity, primary language and similar factors, control costs and ensure access to affordable, equitable and high-quality health care throughout this state.
(5) Be accountable to the public.

- Estimate for 2020: $21 million from carriers to CMS, by way of Oregon insurance premiums

- <u>Proposed solution:</u>
  - Single carrier assessment to the Marketplace
  - 10 to 12 additional FTE
  - $9 million ongoing annual maintenance
  - Total savings – At least $10 million annually to carriers and, by extension, insurance premiums for Oregonians, with savings increasing over time with current fee model
  - Ongoing costs:
    - Should not exceed 2.5 percent of premium for combined Marketplace operations, technology, and CAC costs
    - This will likely be expressed as PMPM, but the Marketplace and stakeholders should be open to different potential assessment methodologies
  - All associated startup and ongoing costs are achievable with the Marketplace's existing carrier assessment funding mechanism – carriers will stop paying for the federal technology to start paying for Oregon's, with DD&I cost strategies to be determined
  - Vendors are amenable to deferring and amortizing DD&I costs over the life of the contract, having done so with Pennsylvania and marketing the ability to do so in subsequent RFPs for other states.

Cost Breakdown

	Baseline (PEBB OEBB Sample) Build + O&M	Procurement (2022.9-2024.3)	Build (2024.4-2025.8)	O&M + Additional Enhancements (2025.9-2030.9)
Vendor Cost	$17.8M (Implementer) $250K (IQMS)		$9M (Vendor)* $250K (IQMS)	$9M / year *
Licensing			$250K	$250K
Software			$250K	
Consulting	$95K	$50K	$150K	
State	$1M	$1M	$1.5M	$1.5M
Sub Total:		$1M	$11.4	$10.75M
Contingency (20%)		$200K	$2.28M	$2.15M
Grand Total:	$19.15	$1.2M	$13.68M	$12.9

Vendor: Implementer, Information Quality Management System (IQMS)

Licensing: Reporting / Analytics (Tableau, etc.), Identity Management

Software: Custom Data Integration (MuleSoft, Talend)

Consulting: Consulting hours with software support, system architecture and design

State: State and Agency resources to support procurement build and O&M

*** Source: Manatt Memo**

Measurable Benefits

- Access to enrollment data of Oregonians that is currently restricted
- Ability to measure and maintain ongoing metrics regarding customer service levels, complaints, and complex case outcomes

Table n – Example Benefit and Measurement

Benefit	Measurement
Coordinating with Oregon's Medicaid systems to address churn	*Comparison of churn amounts one year after implementation*
Coordinating with other state agency systems to implement innovative, easy eligibility checks to help increase the rate of insurance among Oregonians.	*Comparison of eligibility rates year over year after system launch*
Improving the shopping and customer service experience for Oregonians.	*Customer feedback and satisfaction surveys post-implementation*
Implementing input from Oregon's various and diverse communities into every step of technology and call center implementation.	*Customer feedback, seeking of community input, and satisfaction surveys post-implementation*
Collecting, analyzing, and storing enrollment data, including REALD/SOGI data to: • Recognize trends and Inform policy development and decision-making that affects underserved and marginalized communities • Allow for real-time, micro-focused outreach and education to underserved and marginalized communities • Create a baseline that will inform outreach and education resource allocation to ensure that the Marketplace effectively and efficiently reaches those impacted most by the inequities inherent in current systems	*Business Intelligence reports on enrollment data delivered on a determined reporting schedule*
Customizing open and special enrollments to meet the needs of Oregonians and address the specific circumstances Oregonians are facing in real time.	*Successful implementation of specific-circumstance enrollments*
Embedding health equity principles in every aspect of an SBM, guiding policy decisions, contracting and hiring, consumer support, and community engagement. These decisions can help to enroll disproportionately uninsured groups, including people of color, people with low-incomes, rural residents, and immigrants.	*Customer feedback and satisfaction surveys post-implementation*
Saving Oregonians money.	*Cost Savings analysis vs. previous years*

Assumptions & Constraints

Assumptions and Constraints

Assumptions:

- Multiple vendors will be able to provide solutions of the necessary quality within budget parameters (based on Oregon's RFI and other states' RFPs)
- Experiences from other states accurately portray what Oregon can expect from pursuing the same options
- Solution requirements will not require vendors to develop new product functionality before implementation, unless mandated by authorizing partners (legislature, governor)
- OHA and the Marketplace either have or will procure the appropriate staff to manage the project
- Insurance carriers will accept the fee structure changes necessary for implementation (stop paying the federal technology fee, pay a single fee to the Marketplace for all Marketplace-related operations)
- State partner and oversight agencies (Enterprise Information Services (EIS), Data Center Services (DCS), Cyber Security Services (CSS), Department of Justice (DOJ), Oregon Health Authority (OHA), and Department of Administrative Services (DAS) Procurement) will have sufficient bandwidth and resources to execute within the desired timelines
- Vendors will be able to execute a transition with zero or minimal impact to OHA operations regarding Oregon Health Plan/Integrated Eligibility (ONE) system
- The Oregon Legislature will approve the plan's goals and viability, approve the necessary budget proposal, and grant OHA authority to move forward
- External partners affected by changes to EDI connections (OHA, insurance carriers) will be willing and able to make the necessary complementary changes within the required timelines, with mutual benefit as an incentive

Constraints

- Project and solution are intended to be funded by Other Funds via Marketplace assessment fees. Any excess revenue is designed to be rebated back to Marketplace carriers. Use of the excess revenue for this business case's purposes will need approval from the legislature
- Solution cannot require significant changes that would disrupt OHP processes or ONE system operations
- Solution cannot require or include direct integration with Medicaid/ OHP enrollment and eligibility functions or processes (back-end data reconciliation with exchanged enrollment files is assumed)
- Ongoing combined cost of solution and OHIM operations cannot exceed 5% of the premiums of plans sold through the Marketplace

Alternatives

Alternatives analysis

As stated above, completion of all primary deliverables and sub-deliverables are necessary for the transition to be both possible and successful. Of those, the alternative implementation options for both the technology platform and the consumer assistance center components will need to be assessed, and the sub-deliverables will adapt accordingly.

Technology background, alternatives assessment and methodology

While some alternatives exist for states transitioning to an SBM, the last several years have seen an emergence of a market with solutions that are pre-configured specifically for states transitioning to an SBM model. The solutions have been built, deployed for other states, and have experienced sustainable operations for several years. They are vendor-hosted and cloud-based end-to-end integrations of complex systems with even more complex business rules, at a high level composed in part of:

- A customer relationship management (CRM) database
- A secure document repository linked to CRM entries
- An outward-facing website where external customers can:
    - Fill out and submit an application
    - Securely log in to individual profiles with role-based access controls
    - Experience all of its tools on both regular desktops or laptops and on their mobile devices
- A business rules engine and associated hardware infrastructure, designed in part to:
    - Validate application information against the Federal Data Services Hub (FDSH), which includes federal tax information (FTI) handling and segregation from non-FTI data
    - Use that validated information to pre-determine eligibility for Medicaid, and transfer account information to the Medicaid agency if eligible
    - If not eligible for Medicaid, use that validated information to determine eligibility for applicable tax credits towards the purchase of insurance
    - Use all of that information to pull a subset of insurance plans available to customers in their geographic area
    - Allow customers to select a plan and complete enrollment
    - Transmit enrollment data to insurance carriers in a pre-determined format
    - Support post-enrollment customer relations
    - Provide workflows for customer support ticket resolution, appeals, appeals escalations, IT ticket resolution or handoff to separate ticketing system, plan management, and carrier enrollment reconciliation, among many others
    - Exchange information via EDI with the FDSH, the state's Medicaid entity (OHA), and insurance carriers
- Integrated business intelligence tools for report generation and data analysis

After passage of the ACA in 2010, many states separately engaged systems integrators and developers to create these integrated solutions from scratch with a go-live operations target of October 2013. Some states, including Oregon, tried but failed to produce a viable, sustainable integration. Yet, 13 other states succeeded. Out of those successes, some companies formed an ongoing business model around this specific systems integration.

This market exists because the base requirements for each state are substantially the same, potentially requiring some configuration for each state's unique laws or regulations. This makes other state examples quite relevant in estimating parameters for a related RFP.

In 2018, Nevada's marketplace was the first to attempt this transition, completing a request for proposal (RFP) in late summer. Approximately 14 months after contract execution, the design, development, and implementation (DD&I) was complete, all relevant consumer information had been imported and converted from HealthCare.gov's database, and the system went live one month before open enrollment per the schedule developed the previous year.

Pennsylvania and New Jersey have executed contracts with the same vendor, and Maine with a different one, for even shorter implementation timelines with the same elements and all had successful launches as planned in the last two years.

By necessity, the vendors must already be deeply familiar with our business and with ACA rules and laws in order to be competitive in the market, deploy this technology effectively, and perform the functional maintenance necessary to remain compliant with changes to ACA regulations.

While other IT solution approaches are possible, and diligence dictates that those options are explored for feasibility, not all options will need more than a rough order of magnitude (ROM) estimate to establish feasibility or infeasibility.

The Marketplace has identified the following alternatives and done analysis on the benefits and risks for each option:

Option	Benefits	Risks
State-built solution	Direct control over infrastructure and associated security parameters Direct control over scheduled maintenance and downtime	High up-front development and implementation costs High ongoing overhead/ FTE costs Unpredictable timelines for iterative development Highest risk of over-budget, over-schedule, overall project failure
Licensing existing solution with state infrastructure and hosting (option has been proposed by vendors in RFIs)	Direct control over infrastructure and associated security parameters Direct control over scheduled maintenance and downtime	Only conceptual/ no current direct examples exist High up-front implementation costs High ongoing overhead/ FTE costs in addition to solution/ software costs Not offered by all vendors Vendor support would not extend to issues caused by infrastructure/ state-controlled variables

Procuring fully hosted cloud solution as a service	No new infrastructure investment required Implementation tasks and risks, ongoing maintenance managed by vendor Vendors have previous implementation and data migration experience Multiple vendors in market promotes competitive solution proposals and pricing Vendors must already update platforms according to ACA policy changes, part of business model	Solution dependent on ongoing vendor solvency Data migration to new solution may present issues at end of contract
Use current solution	No changes or additional investment required All associated risks and maintenance managed by healthcare.gov	Cannot become an SBM, no SBM benefits realized. Costs continue to change with no transparency No access to enrollment data

Conclusions

In conclusion, the decision for Oregon to become a fully state-based marketplace is a strategic one which will offer several advantages over the current SBM-FP model the state currently uses. Under current circumstances using Healthcare.gov, Oregon has no control over how its marketplace enrollment platform is deployed, no transparency as to its costs, no access to the data of its enrollees, and no ability to request additional functions that may specifically benefit Oregonians. A transition to a state-controlled SBM platform will alleviate these deficits. In order to carry out this policy decision, Oregon must stop using Healthcare.gov, and consequently have a solution for its own enrollment platform and associated call center.

The Marketplace believes that a hosted, cloud-based enrollment platform solution procured from a vendor as a service will offer the best combination of value and effectiveness for Oregon's transition to an SBM. The last 5 years have seen a steady progression of these solutions into a competitive market, with multiple vendors proposing solutions for states making the same migration with overwhelmingly successful outcomes.

An IT project for an Oregon transition to an SBM would have this procurement and contract execution milestone at its center, along with all of the associated programmatic changes and call center solution around it. Based on the conditions and results in successful states, we project that this transition will lower the associated costs for insurance carriers (and consequently Oregonians by way of premiums), give full access to real-time data, and

allow for collaboration with the vendor to add functionality in the future to enact policy and law innovations and requirements.

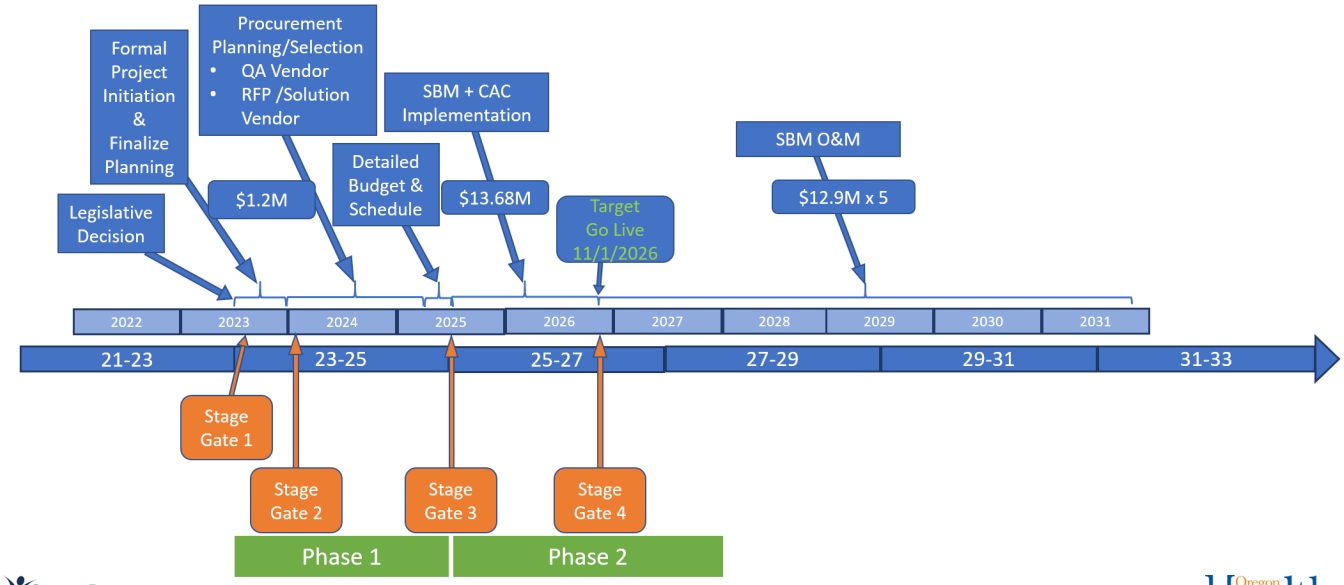
OHA predicts that this will:

- Give full transparency to Marketplace program and platform costs.
- Give OHA additional policy action tools to achieve its strategic goal of eliminating health inequities in Oregon by 2030, enabling the delivery of any Marketplace-related program changes through the platform.
- Use the newly accessible data to identify underserved populations and patterns pointing to systemic inequities that can then be addressed.
- Collaborate with other SBM states to share best practices and benefit from one another's successful outcomes.
- Enable the full spectrum of state Marketplace autonomy to deliver the best possible service and outcomes to Oregon consumers and stakeholders.
- Allow for coordination with the ONE system to accommodate its needs and requested changes, along with ongoing improved data exchange efficiencies that would come out of a true two-way collaboration.

Failure to begin a project timely will result in a continuation of what has already set in with respect to state Marketplace authority: stagnation. The HealthCare.gov solution in place now technically works, but in its current state has no potential for meeting the needs of Oregon's progress towards eliminating health inequities by 2030, adhering to the guideposts set by the DEI Action Plan, or indeed even of delivering the best possible service and outcomes to Oregonians enrolling in Marketplace plans. The solutions available now have been tested, implemented in other states, and are replicable for Oregon at a price point that offers better value than the Healthcare.gov solution now in use, and for these reasons OHA requests that the project be allowed to proceed through the oversight process.

Appendixes and References

Estimated SBM Implementation Timeline 8/9/2022



Oregon Department of Human Services

Office of Information Services
Strategy & Digital Transformation

Oregon Health Authority