HIX 2.0: New Alternatives for State Participation in Health Insurance Exchanges

By examining the pluses and minuses of emerging forms of health insurance exchanges, states can make informed decisions on cost and performance trade-offs and arrive at an optimal HIX model that suits their operational needs and those of their constituents.

Executive Summary

More than 2.5 million people have purchased insurance from state health insurance exchanges (HIX), and another 5.4 million have done so through the federal exchange for plan year 2014. Politics aside, these numbers show that the Affordable Care Act’s health insurance exchanges are here to stay. That said, state health leaders should not necessarily be content with the status quo.

There are many critical questions state leaders must consider when developing future HIX strategies. They include: “What is the most effective HIX model for my state, and what is my implementation strategy and plan?” Fortunately, leaders now have lessons learned and insights derived from HIX rollouts in 2014 to help inform move-forward options and guide procurement and implementation.

A successful exchange model provides a simple and intuitive front-end shopping experience for eligible consumers, a support module to promote broker and navigator usage, and a robust back-end system to integrate with issuers, state and federal agency systems. States must examine the following four important criteria:

- Implementation cost.
- Solution flexibility and interoperability.
- Speed to market.
- Overall implementation effort required.

Such an assessment can help healthcare leaders better understand the strengths and weaknesses associated with various HIX implementation models. This white paper reviews HIX implementation models, examines the next stage in their evolution – HIX 2.0 – and presents a framework to help healthcare leaders evaluate their alternatives.

From the Beginning: HIX 1.0

HIX 1.0 represents the first generation of exchanges for plan year 2014. The mixed results delivered by HIX 1.0 offer many valuable lessons. For plan year 2014, 16 states and the District of Columbia (DC) opted to utilize federal funding to implement independently operated state-based health exchanges (SBE). The remaining states decided to use funds from the Federally Facilitated Exchange (FFE) or enter into a partnership with exchanges operated by other states. By leveraging the FFE or partnership exchange model, these states shifted the burden of facilitating Qualified Health Plan (QHP) and Medicaid

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eligibility determinations and enrollments. Many SBEs and the FFE have struggled with implementation, however. Issues include vendor selection, aggressive deadlines, unrealistic ambitions, lack of technical expertise and unstable federal regulatory requirements. This combination of factors ultimately led to the well-publicized and troubled national roll-out on October 1, 2013.

Residents of Oregon, Hawaii, Maryland, Massachusetts and Minnesota experienced significant issues attempting to enroll in coverage through their states’ exchanges. These failures, in our view, point to a lack of concise and stable regulatory requirements, domain expertise and delivery team discipline.

Even though Maryland was able to enroll consumers in QHPs after extensive manual workarounds and system fixes, consumers endured long wait times and a frustrating process to confirm their coverage. The original vendor reportedly failed to deliver and lacked the expertise to execute a complex implementation program. A troubled exchange launch and critical system defects resulted in Maryland abandoning its solution and licensing technology from Connecticut.2

Even the Massachusetts exchange, once a model for the ACA, has stumbled. A lack of organized execution and an initially incomplete gap analysis caused major roadblocks and system impacts during implementation. Massachusetts now faces the same challenge as other states – how to move forward.3

The Next Chapter: HIX 2.0

The HIX 2.0 marketplace consists of both functioning and nonfunctioning health exchanges. As data is gathered and states execute or rethink their initial strategies, a suite of workable HIX models has emerged. These are depicted in Figure 1.

Each model poses its own set of strengths and weaknesses, and what works for one state may not work for another. Traditional models (as

<table>
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<th>Model</th>
<th>Definition</th>
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<tr>
<td>Traditional</td>
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<tr>
<td>Big Bang</td>
<td>HIX implementation in which all components enter service at the same time.</td>
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<tr>
<td>Phased</td>
<td>HIX implementation in which select components initially enter service. As the platform matures, more and more components will enter service to complete the implementation.</td>
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<tr>
<td>Evolutionary</td>
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<tr>
<td>FFE</td>
<td>Use of the FFE marketplace offered by CMS for QHP. May leverage existing eligibility determination data for expanded Medicaid eligibility determination.</td>
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<tr>
<td>Franchised</td>
<td>Leverage an existing public HIX platform with minimum customization to offer a functioning HIX platform for eligibility determination and QHP enrollments. Franchisee is responsible for upfront implementation costs, subsequent platform maintenance and operations.</td>
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<tr>
<td>Innovative</td>
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<tr>
<td>Outsourced</td>
<td>Leverage an existing state HIX platform with minimum to no customization to process eligibility determination and QHP enrollments. The customer state pays a predetermined subscription cost to the provider state for the services offered.</td>
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<tr>
<td>Multi-state Collaboration</td>
<td>A multi-state version of the FFE with more flexibility for customization and ability to govern and control the entity.</td>
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defined in Figure 1) were widely used during HIX 1.0 implementations and have resulted in both successes and failures. Sourced solutions have been explored since initial HIX 1.0 models were deployed. These solutions offer a quick turnaround that, together with their relative implementation simplicity, may also prove to be an effective entry model into the SBE marketplace or a solution for troubled exchanges.

As defined in Figure 1, innovative solutions are conceptual models that have not been implemented. With stakeholders needing to address both internal and external market conditions, various models must to be evaluated against four important criteria to better understand appropriate fit (see Figure 2).

States currently leveraging FFE funds must decide whether this approach adequately meets their constituents’ needs and how to address shortcomings if it isn’t. Options for these states include:

- Implementing their own SBE (a “big bang” approach).
- Entering into a multi-state partnership with other states to develop a common exchange.
- Implementing a partial solution (phased approach) that best satisfies constituents’ demands (i.e., launch an SBE for individuals and rely on the federally facilitated Small Business Health Options Program, or SHOP).

State leaders must consider several factors when selecting an exchange model and building a strategy, including the political climate, economic makeup (i.e., lower small-business demand vs. individual demand) and the general level of satisfaction with the current solution. Given the number of states that have opted to not build their own exchange, it’s also reasonable for a subset of those states to consider forming partnership exchanges. Because pooling resources can significantly reduce the human capital demands of operating such a solution, this is the most suitable approach for states with similar political atmospheres.

As with Massachusetts, several states face the decision of abandoning their troubled platforms and adopting the FFE in their place. Maryland found itself in the same situation as Massachusetts and opted to franchise the Connecticut solution through a third-party consultant. With most of the law’s final version published, and with the first year of open enrollment complete, it’s unlikely that another state that has invested significant resources into building its own exchange would consider transitioning to the FFE. Those with SBEs that have not met expectations can now assess the features and benefits of HIX 2.0 models and how effectively these will address outstanding issues.

### HIX 2.0 Assessment Criteria

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<tr>
<th>Model</th>
<th>Cost</th>
<th>Solution Flexibility and Interoperability</th>
<th>Speed to Market</th>
<th>Implementation Effort</th>
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Figure 2
HIX 2.0 Model Assessment

This aforementioned assessment will help leaders better understand the strengths and weaknesses associated with various HIX implementation models. From here, states need to evaluate each implementation model based on the assessment criteria outlined in Figure 2.

- **Traditional/Big bang.** Implementing the entire HIX solution is a complex undertaking that requires a significant investment and an extended period for development, integration testing and external stakeholder adoption. Any setback on a component can potentially delay the entire implementation. This model requires significant upfront investment, and delays can create cost overruns.

  States that currently rely on the FFE and wish to transition to their own exchange in the future should look to the state of Washington as an example of how ample lead time and effective planning resulted in a higher quality end product. With that head start, Washington was able to become a close implementation partner with CMS and federal leadership to successfully deliver a fully functional exchange using a big bang approach. Conservative states that are unsatisfied with the FFE should consider this approach while carefully examining associated risks.

- **Traditional/Phased.** States can prioritize implementation of the HIX components that are most suitable for their needs, making smarter investments that can perform and integrate well with existing infrastructure and business processes. States should learn from past implementations and adopt a phased approach to satisfy the segment of the states’ consumers (Medicaid eligible, Premium Tax Credit eligible and SHOP participants) that are creating the greatest demand for exchange services. States with limited resources can devote fewer resources than those required by the big bang approach, significantly interrupting business operations. Enhancements to the system can be added in phases, making this solution very adaptable to changes in requirements and regulations. Utah has an existing SHOP Exchange that predates the ACA. The state decided to take the phased approach and only modify and operate the SHOP module in 2014, leaving the individual exchange components to the FFE.

- **Evolutionary/FFE.** The FFE model offers a common platform solution for a large number of states. Implementation costs shift to the federal government because it maintains the FFE and also relies on it as its own foundation. While this exposes states to minimal financial risk, the solution offers very limited customization, and the state participant will have little to no control over the exchange operations. Given the workload and the volume on the FFE, states will receive very limited attention during implementation, and enhancements will take longer to achieve than on independent SBE models. Most states joined the FFE for plan year 2014. Oregon, after struggling and failing with its SBE, became the first state to subsequently join the FFE. Given Oregon’s experience, the FFE will likely remain the top choice in many states’ contingency plans.

- **Evolutionary/Franchised.** States looking for a quick turnaround to fix an existing troubled HIX and offer uninterrupted service to their constituents should look to a stable working system with a proven track record. States adopting this approach will sacrifice customization to reduce implementation risks. Keep in mind that the system may require additional investment down the road to implement enhancements and upgrades to the franchise solution. Leveraging a working HIX model can quickly restore consumer confidence and promote participation. Connecticut became the first state to franchise its exchange model after a successful implementation in 2014, with Maryland becoming its first franchisee.

- **Innovative/Outsourced.** States with historically similar healthcare policies and strategies can reduce implementation costs and risks by partnering to develop functioning exchange. Costs can be controlled and scaled from implementation to maintenance. Any state opting for this model will need to make sure its development contract covers all aspects of standing up and maintaining an exchange, including performance guarantees, fee schedules and ongoing maintenance costs. At the same time,
this model offers little to no customization, and
the state does not have direct ownership of the
product. This can lead to significant unplanned
expenses resulting from upgrades related to
the rapidly evolving healthcare regulatory and
business environment.

• **Innovative/Multi-state Collaboration.** This
model consolidates infrastructure, pools
resources and creates synergy by combining
the most effective and efficient workforce and
existing business processes from multiple orga-
nizations. The multi-state regional exchange
is an efficient way for states to implement
HIX and underwrite maintenance costs. The
involved states will share both the benefits
and shortfalls of this model. For instance, the
solution offers limited flexibility for change
because it will be designed as a lowest common
denominator to meet the needs of multiple
organizations. The rigid design will also pose
integration challenges when onboarding new
plan issuers into the marketplace because
issuers will need to make internal changes to
accommodate the exchange standards.

**Looking Forward**

HIX 2.0 gives state health leaders more and
better options for offering their constituents
HIX services. When selecting which HIX model is
optimal for their use, leaders must weigh the pros
and cons of the six models against the specific
needs of their particular state. Identifying these
needs also requires examining the state’s techno-
logical capabilities to service an exchange and its
business environment.

From these options, leaders may develop assess-
ment criteria against which they can measure
each model. The “best” model will be the one
that enables the state to smoothly implement
or upgrade an exchange without sacrificing key
state-specific requirements, thus enabling a
simple and intuitive shopping experience for con-
sumers; support for brokers and navigators; and a
robust yet flexible back end to integrate HIX data
with health plans and state and federal agencies.
Selecting a model with these end goals firmly in
mind helps ensure the most value and return on
the state’s HIX investment over the long run.

**Footnotes**

1 “Enrollment in the Health Insurance Marketplace Totals Over 8 Million People,” HHS.gov, May 1, 2014,

http://www.healthcarepayernews.com/content/state-hix-fires-contractor-mulls-damages#.U8gs5vldWO0.

3 Liz Kowalczyk, “Massachusetts Dumping Health Insurance Website Contractor,” Boston.com,
setts-dumping-health-insurance-website-contractor/HzsFo8PvOG48DJfURTFTN4O/blog.html.
About the Authors

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