

On the Fence: IT Implications of the Health Benefit Exchanges





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Acknowledgements:

NASCIO would like to express its thanks and gratitude to the members of the **2011 Health Care Working Group and its Co-Chairs, Lisa Feldner, CIO, State of North Dakota and Edward Driesse, CIO, State of Louisiana**, for lending their time and expertise to help guide this product's development.

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NASCIO would also like to thank Chad Grant, NASCIO Policy Analyst, for his work as lead NASCIO staff on this project as well as Doug Robinson, NASCIO Executive Director and Sam Hearn, AMR Graphic Designer, for their guidance and creative services regarding this publication.

Finally, NASCIO extends a special thanks to those state CIOs and their staff who contributed in the development and revision of this product.

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“In deploying health information technology (HIT)...we also are at the cusp that is faced by every pioneering enterprise” –Dr. David Blumenthal, Former National Coordinator for Health Information Technology

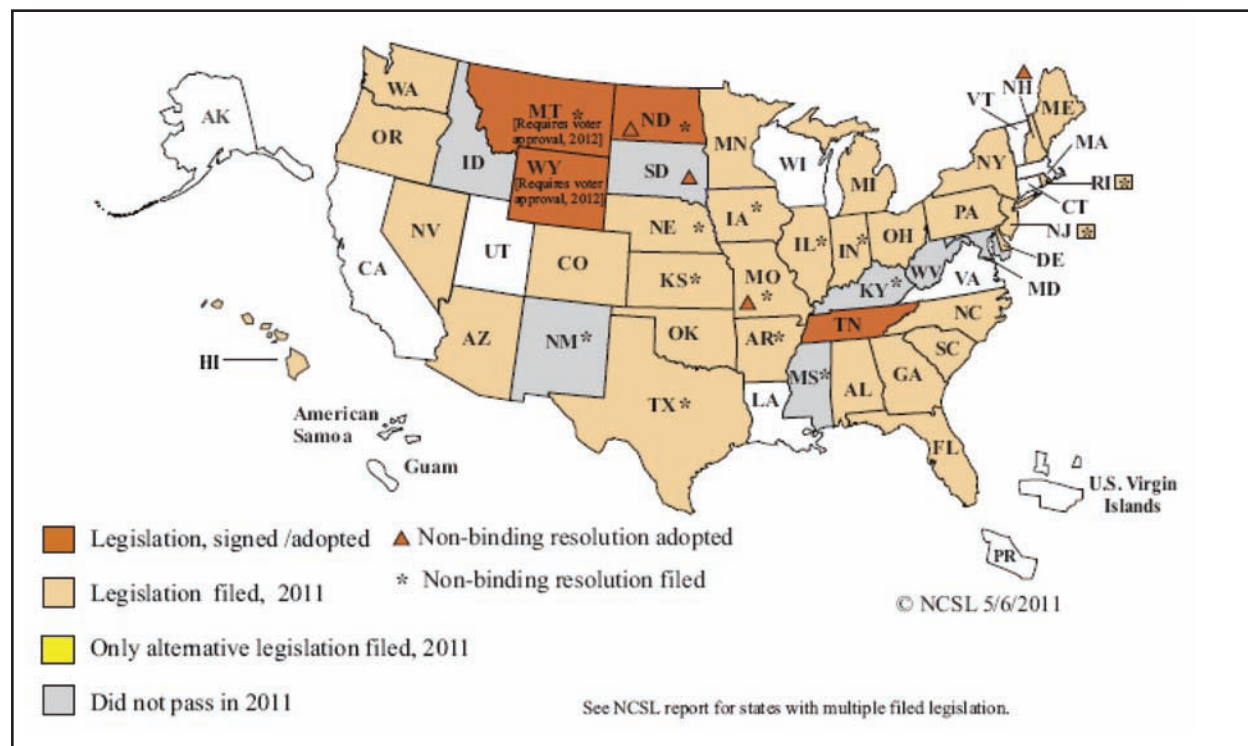
Despite the contentious debate over national health care reform there seems to be one trend that has gained some degree of consensus at the state level – planning for implementation of state health benefit exchanges. As of September 2010, forty-eight states and the District of Columbia have received planning grants and efforts continue in the development of roadmaps by which the states can tailor their exchanges to meet the needs of constituents.

State officials from both sides of the aisle seem to have varying interest in the concept of a benefits exchange. The goal will be to increase state insurance coverage by simplifying the enrollment process through a user friendly online sys-

tem. The intent is to create more market competition and hopefully drive down increasingly high premiums. The Patient Protection and Affordable Care Act (PPACA) has already provided \$2.8 billion in funding to states to build benefit exchanges, expand Medicaid eligibility and continue prevention efforts. In addition to the substantial amount of funding states have already received, they will receive billions more during 2011 and beyond.¹

The Affordable Care Act provides states with the unique opportunity to either develop and run their own exchange or default to the federal government to establish and operate the exchange. As shown in Figure 1, a total of 41 states have already filled measures opposing at least some part of health care reform or proposing alternative policies. Only six states have enacted health insurance exchanges as of May 2011, and two of these (Massachusetts and Utah) predated passage of the health care law.²

Figure 1: NCSL 2011 State Legislation Opposing Elements of Federal Health Reform³





If a state finds it in their best interest to set up their own exchange they will be required to serve individuals receiving tax credits as well as those who are purchasing insurance on their own. The law further requires states to establish a Small Business Health Option Program (SHOP) for employers with up to 100 employees. States can operate these systems separately or combine them into a single exchange. To date, nearly \$296 million worth of grants have been made available to states and territories to start planning for the creation of health benefit exchanges. This funding includes the “Early Innovator” grants that have been awarded to six states and a consortium of states in developing an array of models for exchanges’ information technology systems.⁴ Details of the early innovator states can be found in Appendix I.

There is a great deal of variation that can exist when defining the purpose of an exchange – it can serve as market organizer much like Utah’s Health Exchange or it can be used as a tool that drives market reform like the Massachusetts Connector. Regardless of how a state chooses to approach cost containment, they have the flexibility of joining regional exchanges that may share the same standards for quality and price of coverage.

The PPACA builds upon the efforts of the American Recovery and Reinvestment Act (ARRA) by promoting the use and implementation of health information technology. This analysis is exclusive to the state health benefit exchanges mandated by PPACA, but please reference NASCIO’s [Profiles of Progress 4: State Health IT Initiatives](#) , [HITECH in the States: Action List for State CIOs](#) and [The MITA Touch: State CIOs and Medicaid IT Transformation](#) as a resource for federal directives that have also had major health IT implications for the states.

While guidance from the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) are minimal and still forthcoming, states should be prepared to start planning and implementing in their state.⁵ State CIOs will play varying roles in health care reform, but irrespective of their responsibilities it will be imperative to provide sound leadership and provide feedback to governors on any IT gaps that may exist during this momentous time.

What Is An Exchange?

An exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits a simple comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, exchanges create more efficient and competitive markets for individuals and small employers.

Historically, the individual and small group health insurance markets have suffered from adverse selection and high administrative costs, resulting in low value for consumers. Exchanges will allow individuals and small businesses to benefit from the pooling of risk, market leverage, and economies of scale that large businesses currently enjoy.

Beginning with an open enrollment period in 2013, exchanges will help individuals and small employers shop for, select, and enroll in high-quality, affordable private health plans that fit their needs at competitive prices. Exchanges will assist eligible individuals to receive premium tax credits or coverage through other Federal or State health care programs. By providing one-stop shopping, exchanges will make purchasing health insurance easier and more understandable.



Functions an Exchange Must Meet⁷

The PPACA mandates core functions that an exchange must meet in order to qualify. The main requirements would be:

- Maintenance of a web portal for providing information on plans to current and prospective enrollees
- Operation of a toll-free hotline
- Assignment of a price and quality rating to plans
- Certification, recertification and decertification of plans
- Presentation of plan benefit options in a standardized format
- Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs
- Provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions
- Certification of individuals exempt from the individual responsibility requirement
- Establishment of a navigator program that provides grants to entities assisting consumers
- Additional exchange functions include:
 - Presentation of enrollee satisfaction survey results
 - Provision for open enrollment periods
 - Consultation with stakeholders, including tribes
 - Publication of data on the exchange's administrative costs

I. The Affordable Care Act: Implementing a State Exchange

As states start to contemplate the long check list of things that need to be accomplished prior to implementing an exchange, there is one vital question that needs to be answered by the executive branch – does the state want to have control of the governance and architecture or would the state like to delegate this responsibility to the federal government. A simple question, but still a highly contentious issue that will need to be determined prior to rationalizing what governance options would be best for your state.

Exchange Design Options

Specific to state exchange planning efforts, there will inevitably be varying opinions from state to state on how they would like to structure the governance model. During the 2011 legislative session, states may debate legislation creating health insurance exchanges or they may defer this option to later years, depending on existing authority to carry out implementation or to block implementation. If a state chooses to move forward there are several options that exist:

- An exchange could be established as a clearing house for all plans offered by all issuers
- An exchange could be designated as a purchaser that selectively contracts with insurance plans
- An exchange could be a clearing house, purchaser and/or a market organizer⁸

Exchanges are also required to be operated by a governmental agency or non-profit entity established by the state. States have the flexibility to contract with eligible entities to carry out one or more duties of the exchange. Despite the numerous requirements, states have the flexibility to choose if they would like to



establish one exchange, subsidiary exchanges that serve geographically distinct areas within the state, or join a regional exchange serving multiple states.⁹ In addition, the number of exchanges that exist is left up to the state to decide. They may want to combine the employer and individual exchanges or leave them as separate entities. Regardless of the governance model a state chooses it will be held accountable for being self-sustaining by January 1, 2015.

exchange legislation under PPACA, plans to structure its governance model under the state Senate and House bills that were passed and signed into law by Governor Schwarzenegger.¹⁰ In addition to the California example, states may also want to consult the model exchange statutes that were developed by the National Association of Insurance Commissioners.¹¹ Other states that have passed legislation and received the Governor's approval for moving forward on a health benefits exchange are West Virginia and Maryland.

In Figure 2 you will find an example of how the State of California, the first state to pass

Figure 2: California Governance Model¹²

California: Governance of the State Exchange

- Independent, five member exchange governing board within state government; members must have significant demonstrated expertise in various exchange-related health care areas, such as the individual and small group markets
- Appointed by Governor and legislature
- Significant conflict of interest provisions that generally bar anyone working as insurers, agents or brokers, health care facilities, and health care providers
- One year revolving door provision
- Board members are unpaid

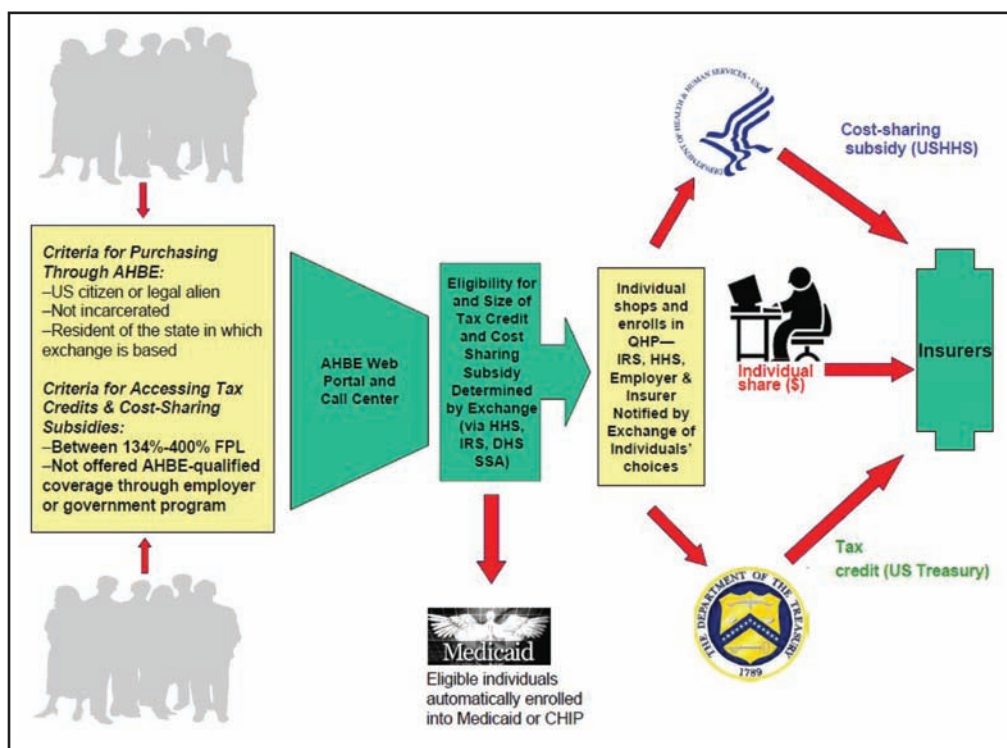
Building a First-Class Citizen Experience through the use of Business Architecture

If you were to ask citizens what they would like to experience when navigating enrollment in the exchange, Medicaid or CHIP – it would most likely be a seamless system that generates health coverage options and enrollment in real-time. Fortunately, this is also a requirement of the Centers for Consumer Information and Insurance Oversight (CCIIO) who are overseeing the federal funding for the exchange. Over the past decade consumer services have evolved by leading businesses in the United States and this has put more demand on states to accommodate and replicate this high level customer experience.

Eligibility evaluation will be done, for most citizens seeking enrollment, through a predetermined set of rules established for the exchanges, Medicaid and CHIP. State CIOs can use common systems and integration of systems to avoid duplication of costs, processes

and effort on the part of either the state or the beneficiary.¹³ HHS guidance has suggested that states will not be obligated to independently establish their own interfaces and connections for verification and this will be done through federal agencies such as the Internal Revenue Services (IRS), the Department of Homeland Security (DHS), the Social Security Administration, and DHHS. In addition, CMS will be implementing a data service that exchanges can use for one source of verification for all of the federal programs listed above. It is expected that IT systems have the capability to generate transparent data on program evaluation and performance management.¹⁴ General business practices should be a top priority for State CIOs, but the design of IT systems for states should ultimately meet the statutory requirements mandated by the Affordable Care Act. Figure 3 provides a map of the criteria and organizations that will determine eligibility requirements.

Figure 3: Criteria for Determining Eligibility¹⁵





What Are The Fiscal Implications for States?

In addition to the legislative and technical challenges states face with implementation, it is imperative that state CIOs consider the possible budgetary impact the Affordable Care Act could have on states. An enormous variation already exists across states in terms of health insurance coverage rates, generosity of coverage under state-administered public programs, generosity of state-financed programs to purchase private coverage, health insurance regulation, and other factors that affect state responsibilities and budgets.¹⁶ The health benefit exchange establishment grants, which will later be discussed in further detail, should be used to establish an initial revenue structure and budget that will be fiscally sustainable by the 2015 deadline.

One of the few existing exchanges, the Massachusetts “Connector,” can be used as an example to calculate what the cost may be for states that project high levels of membership. The

costs to maintain and run the “Connector” are approximately 4% of average premiums with enrollment at approximately 187,000 citizens, but this may vary by state. Because the exchanges must be self-supporting by 2015, it is important that states create a strategy to pay for the cost associated with¹⁷:

- Staff salaries and benefits
- Appeals
- Marketing
- Advertising and communication
- Customer service and premium billing
- Enrollment and eligibility services
- Website development and maintenance
- Professional services and consulting
- Information technology
- Facilities and related expenses

An example of recent legislation, which was signed into law by West Virginia Governor Earl Ray Tomblin on April 4, 2011, demonstrates how states plan to fund the exchanges through assessing fees. Figure 4 is an example from the text of West Virginia Senate Bill 408.

Figure 4: West Virginia Funding Structure¹⁸

§33-16G-6. Funding; publication of costs.

(a) On and after July 1, 2011, the board is authorized to assess fees on health carriers selling qualified dental plans or health benefit plans in this state, including health benefit plans sold outside the exchange, and shall establish the amount of such fees and the manner of the remittance and collection of such fees in legislative rules. Fees shall be based on premium volume of the qualified dental plans or health benefit plans sold in this state and shall be for the purpose of operation of the exchange.

(b) The exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the exchange, and the administrative costs of the exchange, on an Internet website to educate consumers on such costs. This information shall include information on moneys lost to waste, fraud and abuse.



Strategize for Sustainability

It is an unprecedented time for the states with the federal government providing the initial funding to develop and implement exchanges. The main caveat is that as of January 1, 2015 the state exchanges will need to be fully functioning and also self-sustaining. The Affordable Care Act did take into account the need for revenue to maintain operations and gave the leeway to charge user fees or assessments to fulfill operational needs. Because the user

fees will be the basis for operating revenue, it will be essential that enrollment is achieved quickly to gain as many enrollees as possible. States that project lower citizen enrollment may want to consider the benefits of collaborating with other states on a regional exchange that may be a more viable option for maintaining a sustainable exchange. Figure 5 provides a summary of the initial funding opportunities for states to plan, design and implement exchange operations.

Figure 5: Initial Funding Opportunities for Infrastructure¹⁹

Funding Opportunities	Amount	Dates	Description	Planning and Development	Operations
Planning Grant	\$49 million in grants to 49 States	Awarded on 9/30/10	Exchange research and planning	✓	
Innovator Grant	\$241 million awarded to 12 states	Awarded on 2/16/11	Development of cutting-edge technologies and models for insurance eligibility and enrollment	✓	
Establishment Grant	Will vary according to States' needs and progress	Level 1 due by 12/30/11 Level 2 due by 6/29/12	Development and implementation of Exchange operations	✓	✓
FMAP for Eligibility and Enrollment Development	90% Federal Financial Participation (FFP)	Through the end of 2015	Design, development and installation or enhancement of eligibility determination systems.	✓	
FMAP for Eligibility and Enrollment Maintenance	75% FFP	After 2015 (available prior to 12/31/15 for systems in compliance with new rules)	Maintain and operate eligibility determination systems that comply with federal standards for integrated eligibility systems		✓
Medicaid Administration	50% FFP	Available continuously	Build, maintain and operate eligibility systems that do not meet standards necessary for enhanced matching funds	✓	✓



Maximizing the Benefits of State Health Insurance Establishment Grants

On January 20, 2011 DHHS announced exchange establishment grants for states that are making progress towards establishing exchanges. While states are doing this at different paces, there are two options for funding requests:

1. States with a rapid pace for establishing exchanges can apply for multi-year funding.
2. States that plan to establish an exchange through a step-by-step process may find it beneficial to request funding for each project year.

The grants being awarded are based on current progress and states have the option to apply for either a level one or level two establishment grants. (See Figure 6) As deadlines near, the flexible grant process will give the states the opportunity to work at their own rate and establish their own timeline for building an exchange. The funding to the states is intended to be flexible and can be used for numerous purposes, but states should consider using the funds to conduct background research, consult with stakeholders, govern the exchange, conduct financial management, ensure program stability and most importantly for state CIOs, building out the information technology systems.

Figure 6: Establishment Grants – Level One and Level Two²⁰

Level One Establishment Grants: These grants provide up to one year of funding to states that have made some progress under their exchange planning grant. States may plan to reapply for a second year of funding under the level one establishment grants if necessary to meet the criteria to apply for level two establishment grants.

Level Two Establishment Grants: This category of grants is designed to provide funding through December 31, 2014 to applicants that are further along in the establishment of an exchange. In applying for level two establishment grants, states must meet specific eligibility criteria, including that the state has:

- Legal authority to establish and operate an exchange that complies with federal requirements available at the time of the application;
- A governance structure for the exchange;
- A budget and initial plan for financial sustainability by 2015;
- A plan outlining steps to prevent fraud, waste, and abuse; and
- A plan describing how consumer assistance capacity in the state will be created, continued, and/or expanded, including provision for a call center.



II. The State CIOs Role in Health Care Reform

Changing the landscape of the health care industry may begin with decisions at the executive level, but where the rubber meets the road is the level at which citizens will interact. Through the use of interoperable IT systems, greater customer service levels can be achieved and a higher level of efficiency and satisfaction can be gained through consolidated and streamlined efforts.

Coordinate and Streamline Eligibility Systems

Accommodating the approximately 36 million citizens entering the health insurance market in the United States will require a massive simplification of eligibility and enrollment systems. Most states currently depend upon a county-based eligibility platform designed around the cumbersome and intrusive processes of welfare eligibility systems.²¹ State CIOs will need to assess the capabilities of existing legacy systems that may be very expensive to replace and may require a great deal of time to update. States like Oregon currently depend on statewide eligibility platforms, but must automate medical eligibility determination to make the state exchange functional and usable.

The Affordable Care Act is going to require states to rethink the way they have designed eligibility systems in the past. The new portals must assure that they are able to serve as a seamless one-stop shop for individuals and families who may encounter fluctuating incomes from year-to-year, move to a new geographical location or may have a disability that qualifies them for enrollment. Real-time eligibility decisions will need to be made through the proper flow of information between Medicaid, CHIP and the exchange. In addition to maintaining proper flow of infor-

mation, the enrollment and eligibility systems must be able to verify citizenship and income levels – state CIOs need to ensure that these systems are interoperable and will be able to thwart off fraud and abuse.

Coordinating the flow of information from Medicaid, CHIP and the exchange is a massive undertaking, but state CIOs should consider how to integrate other social services programs into a single point of entry and break down the siloed atmosphere of these systems. States that commit to combining these social systems will reap the rewards of improved customer service and efficiencies. Due to the importance of streamlining eligibility and enrollment, it will be discussed in further detail in section three.

Fulfill Core Functions of the Affordable Care Act

One of the main deliverables that governors will want to see is that the state is able to fulfill the core functions that are set forth by the Affordable Care Act. State CIOs should begin planning with stakeholders to achieve these core functions of the exchange:

- Maintenance of a web portal for providing information on plans or programs to current and prospective enrollees
- Operation of a toll-free hotline
- Ability to provide transparency of price and quality rating to plans
- Presentation of plan benefit options in a standardized format

States will also be responsible for provisioning of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs. As states begin to promulgate strategic plans, state CIOs should first address core functions that will need to be met for implementation.

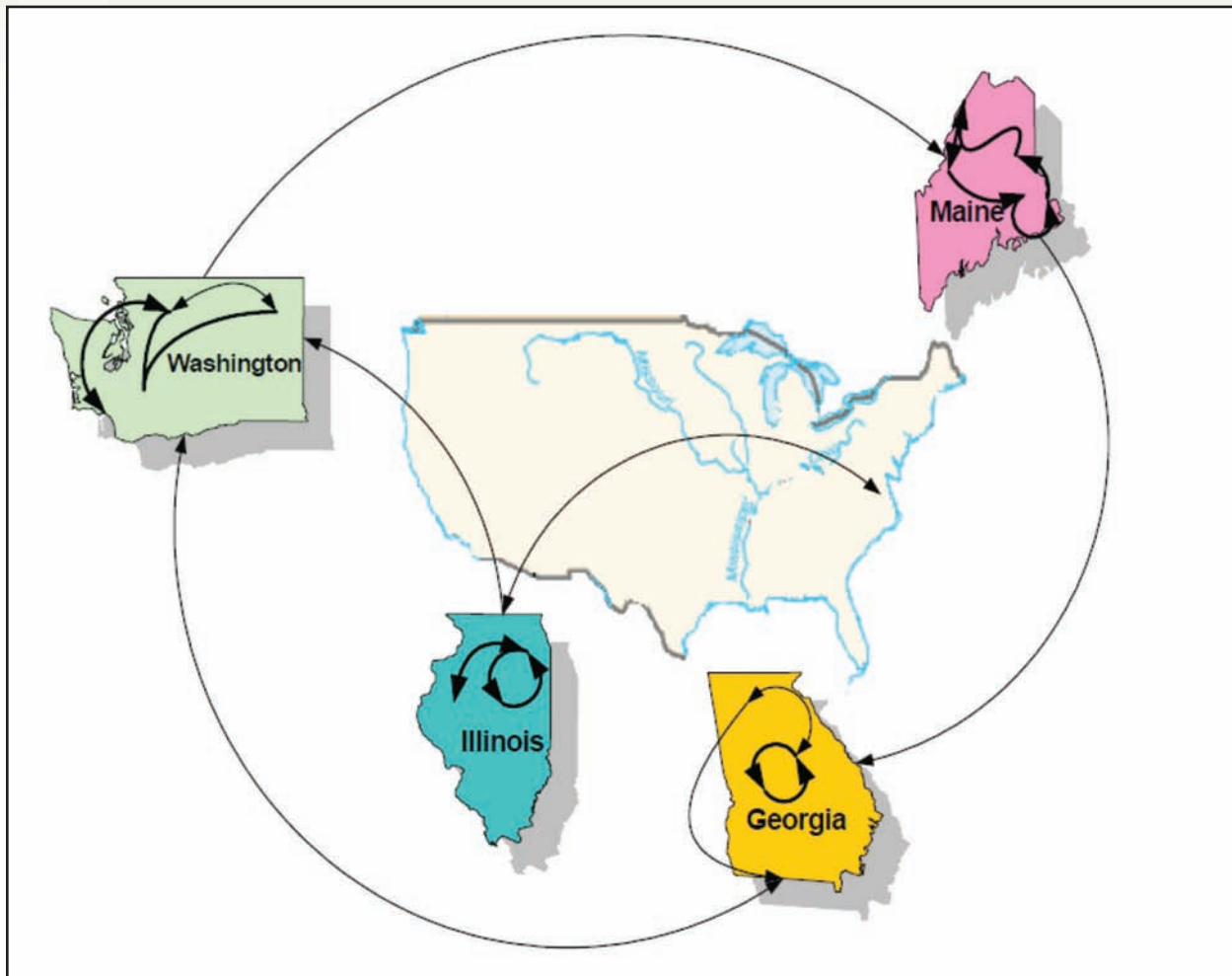
Making Data Interoperable

Federal, state, local and tribal governments continually face mandates for information sharing and providing bundled services to one another. The use of Information Architecture, which is one of the most important assets of an enterprise, can help define data into usable formats in a timely and accurate manner. State CIOs should consider Information Architecture as a way that can provide demonstrable and repeatable approach in assuring the align-

ment of information assets and business processes throughout the enterprise. Not only will this information be shareable at the enterprise level, but also across organizational boundaries. Figure 7 depicts how Information Architecture enhances interoperability between all government bodies. For more information on Enterprise Architecture (EA) please reference the NASCIO EA Development Toolkit at:

www.nascio.org/resources/EAsources.cfm

Figure 7: Information Architecture Enhances Interoperability





Follow Sound Principles When Developing the Technical Architecture

When developing IT systems, architects seek to sustain secure interoperability through the use of standards and this should remain consistent with state CIOs involved with implementing the health benefit exchanges.

- **Use Transaction Standards** – The use of Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction standards will make systems interoperable and more secure through the use of national standards, code sets, employee and provider identifiers, and will strengthen protection for security and privacy of personal health information. In addition to using HIPAA, Secretary Sebelius approved the use of the National Information Exchange Model (NIEM) as a unified method of facilitating the enrollment process and common data exchange.²² NASCIO has long been an advocate of the NIEM discipline and recently released the following [letter of support](#) and [Call to Action](#).
- **Secure Protected Health Information (PHI)** – While HIPAA will provide specific privacy and security guidance, state CIOs and state Chief Information Security Officer’s (CISO) should also be aware of state laws that may impose further regulation.
- **Apply Flexible Approach to System Development** – Systems will need to be able to integrate through seamless coordination with numerous stakeholders such as health plans, small businesses and employers, health plans, brokers and the entitlement programs that states provide.
- **Plan for Scalability** – States should anticipate a large expansion of citizens who will qualify for entitlement programs and

for subsidies from the Affordable Care Act. Leveraging resources like cloud computing should be taken into consideration for storage of large amounts of data.

- **Fulfill Transparency Goals** – Providing state constituents with public transparency, program benchmarks, and policy analysis will reaffirm that your state is performing the necessary processes and is striving for a high level of system quality and performance.

Recruiting the Right Team

Many state CIOs face recruiting and retention barriers due to budget constraints, lack of qualified applicants and the protracted steps within the hiring process. Finding the right individuals to implement the IT requirements of the Affordable Care Act may require innovative recruitment and retention strategies in the ever-changing state IT workforce.²³ Partnering with human resources or civil service leaders in your state to identify a clear and concise strategy will ensure you have the most qualified staff for implementing IT systems.

In addition, state CIOs should consult with department or agency leaders to identify staff that can contribute to a more seamless system. This may also include stakeholders or members of the vendor community that will be involved with the implementation process.

You May **NOT** Have to Reinvent the Wheel

While each state may have unique circumstances, it is imperative to consider the similarities that exist in state IT systems. State CIOs should take into consideration the potential savings from the reuse of existing architectures and systems. The state recipients of “Early Innovator” grants are likely candidates for multi-state collaborative efforts and should be consulted as leaders in system design. In addition, states should take into account the two states that have already implemented a health benefit exchange – Massachusetts and Utah.

Figure 8: Massachusetts and Utah Exchange Web Pages



Multi-State Collaboration: Driving Cost Savings and New Innovations

Despite the numerous challenges that exist for establishing and maintaining a multi-state collaborative, these agreements can be the catalyst for innovation in states. State CIOs who plan to embark on partnerships with other states will need to first identify the key drivers and any possible pitfalls that may exist in reaching mutually defined goals. States that seek to collaborate with other states may consider some of the key benefits that may come to fruition²⁴:

- Cost reduction
- Establishing relationships between organizations
- Providing increased and better services to citizens
- Streamlining processes and speed transactions
- Improving information-sharing and quality
- Leveraging enterprise solutions
- Sharing risk
- Addressing fiscal constraints and lower administrative costs by leveraging mutual resources
- Taking advantage of enterprise information sharing

III. Streamlining Eligibility and Enrollment Systems

It is imperative that, under the Affordable Care Act, states are able to seamlessly direct consumers to information about enrollment in programs related to health care and make available to lower income individuals and families the proper channel for coverage. The Affordable Care Act could potentially put a strain on outdated legacy systems and may require state CIOs to upgrade to new systems all together in order to handle the largest expansion of health coverage for lower-income people since the enactment of Medicare and Medicaid.²⁵

At the crux of the Affordable Care Act, the law requires that the new health benefit exchanges serve as enrollment “portals” that will allow people to sign up for either Medicaid or the exchange through real-time income reporting.²⁶ The two main groups of eligible citizens are:

1. Medicaid Eligible: This category of eligible individuals and families consists of everyone under 133 percent of the



federal poverty level and will bring approximately 16 million new people into the entitlement program.²⁷

2. Citizens Receiving Subsidies: Individuals and families with incomes between 133-400 percent of poverty will be eligible for subsidies in the exchange and it is expected that nearly twenty-four million people will qualify.²⁸

Because enrollment will increase by 50 percent overall and by a much larger proportion in some states, it is important for state CIOs to be pro-active in working with leadership and determine strategic planning goals and timelines for success. As part of the planning process, the Department of Health and Human Services (DHHS) released a document in November of 2010 that was entitled *Guidance for Exchange and Medicaid Information Technology (IT) Systems*. While Version 1.0 is the ini-

tial document issued and helps create a primary framework and approach for developing IT systems, it will be updated and expanded on over time.

The DHHS IT guidance should be considered to be a critical source of information as states move forward with implementation. DHHS does not intend to impose a single IT solution on states and has stated they would like to give them flexibility in meeting key business objectives. There will be numerous variables as states begin to construct and assemble their exchange, Medicaid, and CHIP systems - including business models, size of the state, maturity of the current systems, governance models and other contributing factors. States should continue to follow guidance announcements from DHHS at:

http://www.hhs.gov/ociio/regulations/health_insurance_exchange_info_tech_sys.html

Wisconsin – Leading the Way for States

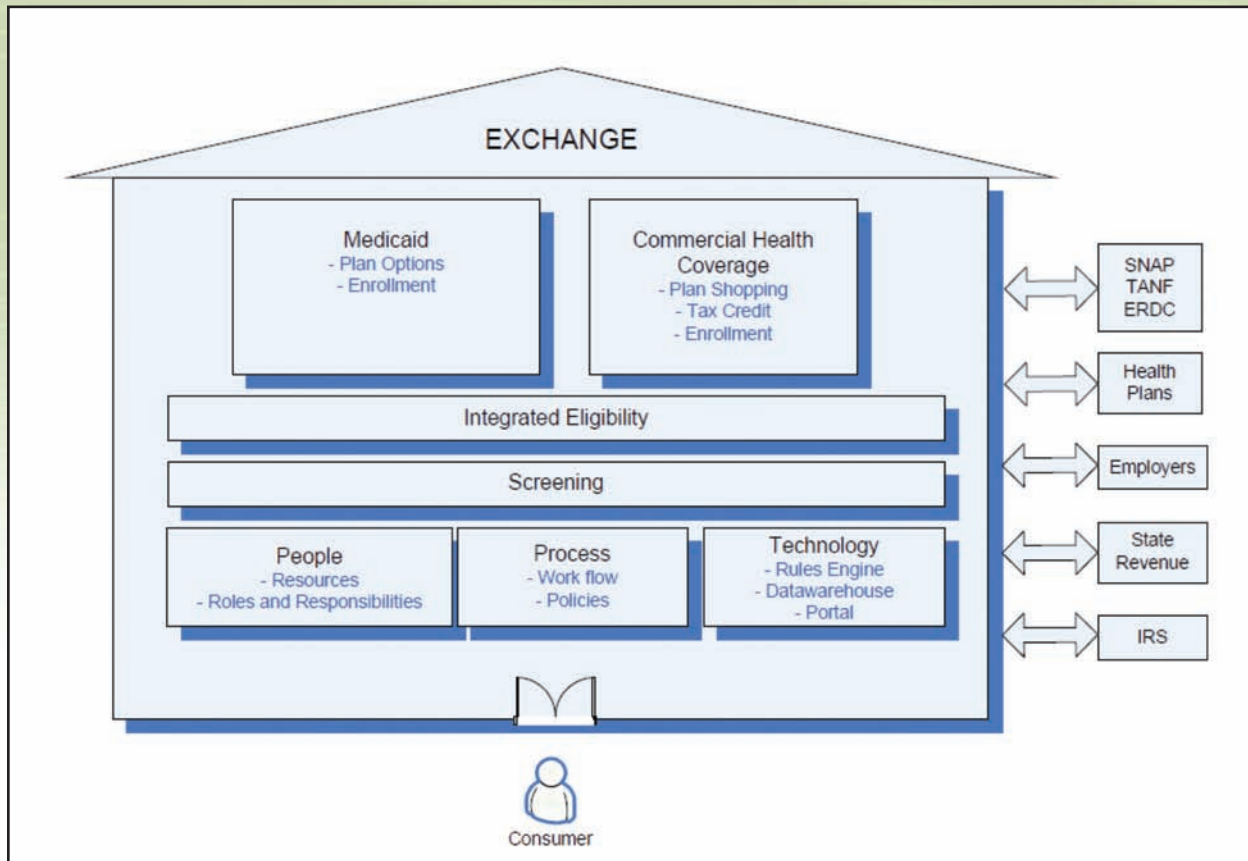
Figure 9: Wisconsin’s ACCESS Tool



ACCESS is Wisconsin’s web-based, self-service tool that makes it easy for Wisconsinites to check whether they may be eligible for health benefits, food stamps and other assistance, apply for benefits, check benefits, renew benefits, report changes to keep their eligibility current.²⁹ The consumer centric sys-

tem allows citizens to use ACCESS from anywhere there is internet access and the service is available 24 hours a day and 7 days a week. Figure 10 demonstrates how Oregon plans to model an integrated system that includes additional social programs and conforms to the requirements of the Affordable Care Act.

Figure 10: Oregon Model for System Integration



A One-Stop Shop

ACCESS is the gateway for citizens seeking assistance and through a sophisticated information system states will be able to determine eligibility and enroll individuals. Because ACCESS is fully integrated with both Wisconsin’s eligibility system, known as CARES, and its Medicaid management information system (MMIS), consumers enter basic data like age, income, and household size. ACCESS can then take that consumer data that has already been submitted and do an assessment on whether citizens are eligible for BadgerCare Plus or any of the numerous other programs. This information would include data from exchanges between CARES and other federal and state databases.³⁰

Wisconsin’s Transition by 2014

Building upon the existing IT infrastructure through the use of Service-Orientated Architecture (SOA), Wisconsin is preparing for 2014 and has already received an “Early Innovator” grant from DHHS. Wisconsin’s proposal envisions a single, intuitive portal through which residents can access subsidized and non-subsidized health care and other state-based programs (e.g. Medicaid, CHIP, child care). The Exchange will integrate across health and human services programs to promote efficiency and lower overall administrative costs.³¹ The ACCESS web-based system will be used to integrate with the current eligibility system, ensuring an easy to use and streamlined eligibility and enrollment system. For states that are interested in the re-use of this system they are able to test the ACCESS



experience through a prototype of the exchange. Demonstrations have already begun in Wisconsin and collaboration with other states continues. States that have successfully integrated ACCESS are the State of New York, the State of Georgia, the State of Colorado, the State of New Mexico and the State of Michigan. For more information on the ACCESS initiatives go to:

<https://access.wisconsin.gov/access/>

IV. State CIOs and the Exchange Ahead

Whereas politicians and the courts will continue to weigh the merits and legality of the Affordable Care Act, there are a few key areas that states will need to act on in the near future. They will need to plan whether the state will run the exchange or let the federal government, what means will be used to establish authority to implement the exchange and determine the governing body. During this process state CIOs should anticipate being called upon to provide guidance on coordinating the numerous IT systems. Extensive work will need to be done in order to provide a gap analysis of what IT resources would be needed to meet performance metrics.

Key Questions State CIOs Should Consider

- ✓ This is an unprecedented time for health IT funding from the federal government. What is your state doing to prepare?
- ✓ If your state plans to establish a state-run health benefits exchange, what is or what will be the role of the state CIO in the new governance structure?
- ✓ Medicaid eligibility and enrollment systems will need updating. What is your state doing to prepare for updating legacy Medicaid Management Information Systems (MMIS)?
- ✓ States should always find ways to eliminate costs through the consolidation of IT services. Has your state considered moving away from a “siloed approach” and integrating existing state benefit programs in the exchange?
- ✓ Has your state identified what standards (such as HIPAA, NIST guidance, NIEM and MITA) will be used to achieve secure interoperability?
- ✓ Have you started to work with the stakeholder community to identify specific functions that will need to be provided through the exchange?
- ✓ Many states have already made a substantial amount of progress that could be replicated and re-used to create savings. Has your state considered collaborating with other states on prospective system models or using existing methods and technology?
- ✓ Is your state prepared to establish and maintain a standardized web portal that can provide information on health insurance plans to current and future enrollees?
- ✓ If your state plans to defer the responsibility of establishing an exchange to the federal government, what coordination will be required for system integration?
- ✓ Has your state considered collaborating with other states on a multi-state initiative?



Appendix I: Awardees of the Early Innovator Grants³²

The U.S. Department of Health and Human Services (HHS) announced on February 16, 2011 the award of seven cooperative agreements to help a group of “Early Innovator” states design and implement the Information Technology (IT) infrastructure needed to operate Health Insurance Exchanges.

Using these new funds, the Early Innovator states will develop Exchange IT models that can be adopted and tailored by other states. Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin, and a multi-state consortium led by the University of Massachusetts Medical School will receive a total of approximately \$241 million.

All Early Innovator states have committed to assuring that the technology they develop is reusable and transferable. Using the grants, they will develop the building blocks for Exchange IT systems, providing models for how Exchange IT systems can be created. This will help states establish their Exchanges quickly and efficiently using the models and building blocks created by the Early Innovator states. At the same time, states continue to have the flexibility to develop an Exchange that best meets the needs of their unique health insurance market without having to start from scratch.

The seven grantees offer a diversity that will be valuable to all states as they work to set up their Exchanges. The grantees represent different regions of the country, as well as different Exchange governance structures and Information Systems. This diversity will help ensure that a wide range of IT models are developed, and every state will benefit.

Grant Specifics

The seven grantees were selected based on their readiness to develop and use innovative IT approaches for their Exchange IT systems. Grantees showed that they have begun planning work for their Exchanges and are committed to establishing an Exchange that will serve their state. Grantees must have demonstrated their technical expertise and ability to develop these IT systems on a fast track schedule, and their willingness to share design and implementation solutions with other states.

To ensure the Exchange IT systems are comprehensive, they must handle eligibility and enrollment in the Exchange as well as premium tax credits and cost-sharing reductions for eligible consumers. The Exchange IT systems must also be interoperable and integrated with state Medicaid programs to allow consumers to easily switch from private insurance to Medicaid and the Children’s Health Insurance Program as their eligibility changes. In addition, the IT systems must be able to provide data to HHS or other Federal agencies as needed.

Summary of State Proposals

Grantee: Kansas Insurance Department
Award Amount: \$31,537,465

Procured and implemented by the Kansas Health Policy Authority (KHPA), Kansas is extending the new Kansas Medicaid/CHIP eligibility system (K-MED) and integrating K-MED with the Kansas Health Insurance Exchange. The State of Kansas is in preliminary discussions with the State of Missouri to partner on an Exchange and other aspects of this initiative. Kansas is committed to sharing knowledge, work products and other intellectual property with other states that will be de-



ploying their exchange using a similar strategy. Depending on the interest of other states and potential arrangements with strategic business partners, Kansas may explore the possibility of creating a “cloud” solution for other states to have their own instance of one or more of these healthcare applications.

Grantee: Maryland Dept of Health and Mental Hygiene

Award Amount: \$6,227,454

Maryland proposes to build off a prototype it has already developed that models the point of access for the Exchange, integration with Maryland legacy systems and the federal portal systems, and Maryland’s consumption of planned federal web services (e.g. verification and rules). The technology foundation used by Maryland in its Healthy Maryland initiative is currently being used by several other states. This “point” solution will extend the existing Healthy Maryland platform, which was recently implemented.

Grantee: University of Massachusetts Medical School

Award Amount: \$35,591,333

This is a multi-state consortia proposal led by the University of Massachusetts Medical School and will include individuals and small businesses in Connecticut, Maine, Massachusetts, Rhode Island, and Vermont. These consumers will be able to shop for, select, and purchase affordable and high-quality health plans consistent with national reform goals for 2014. The proposed project approach will be to create and build a flexible Exchange information technology framework in Massachusetts and share those products with other New England states. The proposal hopes to learn from the Massachusetts Exchange implementation and gain efficiencies so it can accelerate Exchange development for participating New England states.

Grantee: New York Department of Health

Award Amount: \$27,431,432

New York proposes to build off its eMedNY Medicaid Management Information System (MMIS) system to build products for the Exchange. The eMedNY Medicaid Management Information System (MMIS) processes payments for approximately one of every three health care dollars paid in the state. It is also the primary source of Medicaid data used for financial reporting, program analysis, auditing, and quality measurement. The Department plans to use MMIS’ assets as the basis for designing and developing an Exchange to serve all New York State health insurance consumers. This approach will also result in the development of Exchange IT components fully extensible and scalable to any other jurisdiction.

Grantee: Oklahoma Health Care Authority

Award Amount: \$54,582,269 – Note that the State of Oklahoma returned the grant dollars.

The development of a model for eligibility and enrollment via an exchange is the primary goal of this grant initiative. Oklahoma proposes to extend its current technical architecture of Medicaid Management Information System (MMIS) and several other systems to implement the Oklahoma Health Infrastructure and Exchange initiative. It will leverage tools such as the web-based real time claims processing provider service portal created in 2003 by the Oklahoma Health Care Authority. Providers may now enroll or re-enroll with SoonerCare Online Enrollment (OE) using the provider service portal. Oklahoma will issue an RFP under this grant to conduct a gap analysis to determine the necessary steps for its systems to become operational for the Exchange factoring in portability and reuse.



Grantee: Oregon Health Authority (OHA)

Award Amount: \$48,096,307

Oregon is using commercially available, off-the-shelf software to create the Exchange. The Exchange Early Information Technology Innovation Grant will help Oregon create a modular, reusable IT solution that will provide the Exchange's customers with seamless access to information, financial assistance and easy health insurance enrollment, with no gaps in coverage or assistance cliffs for anyone up to 400% of the federal poverty level. The OHA estimates that 516,000 Medicaid clients and 277,000 commercial insurance consumers will use the Health Insurance Exchange to shop for and enroll in health coverage. Oregon is concurrently replacing the states eligibility systems for Food Stamps, Temporary Assistance for Needy Families (TANF), and Medicaid using the Health and Human Services Framework.

Grantee: Wisconsin Department of Health Services

Award Amount: \$37,757,266

Wisconsin anticipates that the health insurance exchange will help drive improvements in the delivery of affordable, quality care for up to 160,000 individuals in the non-group market, one million employees of small businesses, and 770,000 participants in the BadgerCare Plus and Medicaid programs, representing nearly 35% of the state's population. Wisconsin's proposal envisions a single, intuitive portal through which residents can access subsidized and non-subsidized health care and other state-based programs (e.g. Medicaid, CHIP, child care). The Exchange will integrate across health and human services programs to promote efficiency and lower overall administrative cost.



Appendix II: Additional Resources

The U.S. Department of Health and Human Services guidance for exchange and Medicaid IT systems can be found at:

www.hhs.gov/ociio/regulations/health_insurance_exchange_info_tech_sys.html

The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many provisions of the Affordable Care Act. CCIIO oversees the state based health insurance exchanges and more info can be found at:

<http://cciio.cms.gov/>

The National Academy of State Health Policy has formulated several resources that showcase states' current work on health care reform. Information on states implementation strategies can be found at:

<http://www.statereforum.org/>

The State Health Access Data Assistance hosted an in-depth presentation and virtual tour of Wisconsin's eligibility and enrollment system. The presentation can be found at:

www.shadac.org/publications/wisconsins-eligibility-and-enrollment-system

The President's Council of Advisors on Science and Technology (PCAST) released a report to the President on realizing the full potential of health information technology. The report can be found at:

www.whitehouse.gov/blog/2010/12/08/pcast-releases-health-it-report

The National Governor's Association (NGA) Center for Best Practices has covered a broad range of health financing, service delivery, and policy issues, including containing health-care costs, health insurance trends and innovations, state initiatives in public health, aging and long-term care, disease management and health care information technology, healthcare quality, mental health and substance abuse, and health workforce. More information can be found at:

www.nga.org

The National Council of State Legislatures (NCSL) provides an extensive amount of updates on recent state legislation and has also released guidance on implementation of the Affordable Care Act. More information from NCSL can be found at:

<http://www.ncsl.org/IssuesResearch/Health/tabid/160/Default.aspx>

NIEM, the National Information Exchange Model, is a partnership of the U.S. Department of Justice, the U.S. Department of Homeland Security, and the U.S. Department of Health and Human Services. It is designed to develop, disseminate and support enterprise-wide information exchange standards and processes that can enable jurisdictions to effectively share critical information in emergency situations, as well as support the day-to-day operations of agencies throughout the nation. More information on NIEM can be found at:

<http://www.niem.gov/>



Appendix III: Endnotes

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- ⁵ “Guidance for Exchange and Medicaid Information Technology (IT) Systems,” Department of Health and Human Services, November 2010.
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- ⁷ Patient Protection and Affordable Care Act, Section 1311.
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- ¹⁰ California Exchange Law, AB 1602 and SB 900, National Council of State Legislatures.
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- ¹⁵ “Health Insurance Exchanges Under PPACA,” HIMSS Conference Presentation 2011.
- ¹⁶ CRS Report, Variation in Analyses of PPACA’s Fiscal Impact on States, September 8, 2010.
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- ¹⁷ “Building Oregon’s Health Insurance Exchange,” Oregon Health Policy Board, December 2010.
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