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State Sharing of Insurance Exchanges: Options, Priorities, and Next Steps from the West Virginia Regional Exchange Study

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June 2013

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Acknowledgements

NASHP would like to acknowledge the contributions of Jeremiah Samples and Jeff Wiseman of the West Virginia Department of Insurance to this study, as well as the expert advice from Patrick Holland of Wakely Consulting, and Sandeep Kapoor, Debbie Keith, and Kathy Frye of HealthTech Solutions. NASHP extends our gratitude to all participants of the February meeting and all interviewees for their thoughtful insights and contributions to the discussion. This report was made possible by support from the West Virginia Offices of the Insurance Commissioner.

Executive summary

The Affordable Care Act offers states the option to share elements of their health insurance exchange with each other, and states may take up this option at any time. In this study conducted for the West Virginia Department of Insurance, several states and national experts discussed sharing options, through interviews and in person. This report lays out the reasons for sharing they identified, their priority functions to share, important considerations they believed would affect the outcome of sharing, and their recommended next steps to move states toward beneficial sharing arrangements.

States were highly interested in sharing because of several promising benefits, including cost savings from creating economies of scale, strengthened program design from sharing talent and best practices, consumer benefits like more consistent messaging and coordinated plans across state lines, and reduced administrative hassle for other constituencies including plans and providers.

Participating states ranked their priorities for sharing across three different timeframes. Short term (2013 to 2014) priority functions to share include: intellectual capital, information technology development, marketing and outreach, back office functions, decision support tools, consumer assistance, and plan management tools. Medium term (2015 to 2016) priority functions include: SHOP small business exchanges, procurement, evaluation, and sustainability strategies. Long term (2016 and beyond) functions to share include: insurance market regulations and combined risk pools, quality improvement tools and data infrastructure, and approaches to servicing mixed households to address the issue of churning.

Existing examples of state sharing in other programs provide a good framework to consider the various models through which sharing could take place. Ranging from the simplest to most complex arrangement, these models include: sharing intellectual capital through networking and dedicated tools and programs that encourage sharing of materials and ideas; national services in which states buy into or use a service developed by a non-state entity such as an organization or the federal government; jointly procured services in which states come together to procure a service that will benefit multiple states; and jointly run services in which states actually share a common resource or collection of services.

Several important considerations would have a significant effect on the feasibility, success, and magnitude of cost savings and other benefits from sharing exchange functions. The considerations include timing, different exchange models, diversity of political environments, crossover in populations and businesses, impact on insurance markets, and a legacy of state specific regulation.

Finally, the states involved in the study identified several recommended next steps to move toward developing beneficial sharing arrangements:

1. Model cost savings
2. Demonstrate other benefits
3. Engage the federal government
4. Engage other stakeholders
5. Hold a national conversation
6. Continue a conversation among states
7. Designate a coordinator

Introduction

The Affordable Care Act (ACA) directs states, on their own or with the federal government, to establish insurance exchanges, through which federal subsidies for coverage will be extended to moderate-income individuals and tax credits will be available for small businesses to purchase health insurance.[1] The ACA offers the option for states to work with other states in establishing and operating a health insurance exchange.[2] This option is broad, and there are many ways regional or multi-state exchanges might be configured to meet the goals of lowered costs, enhanced efficiency, and improved exchange customer service in participating states. For example, states could: develop a jointly-run exchange across state lines, partner to share certain administrative functions, enter into jointly negotiated procurements, or share policy and process materials with each other. Importantly, states may enter a multi-state partnership at any time, even after an exchange is operational. In the West Virginia Regional Exchange study, the National Academy for State Health Policy (NASHP) explored various sharing options with state officials and other experts involved in exchange implementation. This report describes the findings from the study, including potential reasons for sharing, priority functions for sharing as identified by states, and recommendations for next steps to make sharing a reality.

Literature review

No analysis has fully explored the options for implementing multi-state exchange partnerships. Shortly after the ACA passed, a few states conducted preliminary analyses on the potential for sharing as they considered exchange models. In 2011, North Carolina asked actuaries at Milliman, Inc. to identify whether sharing could increase administrative efficiencies in their exchange.[3] Milliman concluded that efficiencies may exist, particularly in the realm of information systems, but that challenges of coordinating across states, such as cost allocation and accommodating different political priorities could impede sharing. Several states in New England met in 2010 to explore whether sharing would make sense for their region.[4] These states were awarded a federal Early Innovator grant to further pursue sharing in information technology (IT). While they did not ultimately decide to share IT systems, a report was written on their work which lays out a framework for considering multi-state sharing in IT.[5] An additional brief was written in early 2011 by the Urban Institute which discussed several possible benefits of both shared administrative functions and shared risk. The brief concluded that economies of scale would be possible but that "multi- state exchanges are most likely to focus on shared administrative structures and efficiencies as opposed to risk-sharing."[6]

Study background

In 2012, the West Virginia Offices of the Insurance Commissioner contracted with NASHP to conduct a study of options for a multi-state health insurance exchange. At the time, West Virginia was considering whether to establish a state-based exchange (SBE), federally-facilitated exchange (FFE), or federal-state partnership exchange. West Virginia has a less healthy population than most states, ranking in the bottom three states in diabetes, obesity, and smoking, and 47th for health overall, in the 2012 America's Health Rankings survey.[7] West Virginia's population is also small, with about 40,000 to 60,000 people expected to enroll in exchange coverage in 2014.[8] Given these two factors, West Virginia analysts had doubts that their population could sustain a state-based exchange without imposing excessive cost burdens on consumers and the insurance market. The state officials wanted to explore a multi-state exchange as an option for alleviating the barriers of small size and poor health, while retaining more state control than a FFE would offer. As described in their exchange planning grant, West Virginia officials hypothesized that

multi-state sharing could benefit consumers by reducing costs and increasing continuity of care for border populations, while benefitting the state and carriers by introducing economies of scale to keep operating costs low.[9]

Although West Virginia opted to pursue a federal-state partnership exchange for the near term,[10] this study is important because it develops a framework for considering opportunities for sharing in a systematic manner. As stated by Governor Earl Ray Tomblin in his letter declaring the partnership decision in February 2013, "West Virginia will continue to evaluate all available options concerning the Health Benefit Exchange so as to ensure that the most fiscally prudent and consumer-conscious approach is adopted in West Virginia."[11]

Thus the findings and recommendations presented in this report are intended to help policymakers in West Virginia and potentially other states make informed decisions as they move toward a long-term, sustainable exchange after 2014.

Methodology

The West Virginia Regional Exchange study consisted of an interview phase, an in-person meeting, and a follow up phase. In the initial phase of the study, NASHP staff interviewed state officials in six states and other experts by telephone in November and December 2012 (see Appendix B: Study Participants). Along with West Virginia officials and other experts, NASHP developed a protocol that asked interviewees about a broad spectrum of exchange functions that hold promise for sharing: consumer assistance; eligibility, enrollment and premium and fee collection; insurance markets; the Small Business Health Options Program (SHOP); IT; and back-end functions and business operations. Across all topics, interviewees were asked to identify which aspects of functions might be generic enough to share with other states, and where opportunities of greatest benefit may lie.

NASHP wrote a background brief that presented the interview findings and laid out a framework for analysis to be used to explore further potential opportunities and efficiencies in multi-state sharing. This brief informed an in-person meeting held in West Virginia in February 2013. At the meeting, participants (see Appendix B: Study Participants) homed in on their priority functions for sharing, explored possible benefits and drawbacks to sharing various functions including the magnitude of potential savings, and discussed the timing and next steps for a sharing strategy. Following the meeting, NASHP held a conference call with those who had been at the meeting and/or interviewed to reaffirm the priorities identified at the meeting, discuss this final report, and continue the discussion on a future strategy and next steps.

This report captures the outcomes of the interviews, meeting, and conference call. The first section describes possible reasons for sharing that states and experts identified to explain their motivation for continuing the conversation around multi-state sharing. The next section lays out states' priority functions for sharing, sorted into short-, medium-, and long-term possibilities. The third section describes various models for sharing arrangements that could occur across states, including examples of existing sharing arrangements in other health-related state programs. The fourth section lays out important considerations that could affect the success or likely benefit of a sharing arrangement. Finally, the report concludes with several recommended next steps that study participants agreed could advance states' work toward realizing the benefits of sharing.

Reasons for sharing

States continue to explore sharing between and among exchanges because they see a broad variety of benefits. These benefits include the promise of cost savings, as well as benefits to the exchange design itself, benefits to consumers and to other constituencies.

Cost savings

A key motivation for states to share exchange functions is the potential for cost savings. In its report for North Carolina, Milliman Inc. identified "executive office," "information systems," and "infrastructure" as areas where the estimated impact of sharing would be "significant," with several other areas rated as having "moderate" potential for achieving economies of scale through sharing. Savings could be achieved by purchasing jointly and driving down the cost per person covered for a service, such as with a call center that is typically priced based on volume of calls. Savings could also be achieved by reducing the need to build duplicative services, such as if states re-used each other's training curricula or technological components. Further, allocating the costs of a service across states could reduce the cost for any one state, compared to purchasing the service alone. The remainder of this report discusses many factors that would impact the magnitude of savings to states, such as the type of sharing arrangement and the timing of when sharing begins.

Strengthened program design

In addition to the potential financial benefits, sharing across states could result in better designed, more robust exchanges than would be possible in a single state alone. First, sharing lessons and best practices broadens the range of experience that a state can take into account in its program design, compared to relying only on lessons learned in only that state. Further, the economies of scale that could come from sharing materials, documents, and whole program elements could allow states to take on more ambitious work collectively than a state could acting alone. Finally, given the limited pool of consultants and experts available nationwide, joint projects could allow states to share the talent that exists, leading to better designed and better implemented programs.

Consumer benefits

A broad variety of benefits could come of sharing arrangements devised with consumers in mind. For example, states sharing a marketing campaign could design their messaging to reduce confusion for consumers in cross-border media markets. More extensive sharing arrangements, such as coordinating on plan design or eligibility, could help reduce the amount of churning into and out of different programs or could mitigate the negative impact of frequently switching programs, especially for populations that live and work in cross-border areas. Sharing could improve continuity of care as well. One state suggested using common plan certification standards to require health information exchange across providers in different states, which could facilitate care coordination. Risk pooling across states could lower the cost of coverage in the exchange to consumers, and a larger pool of lives might attract more insurers to compete and innovate, leading to better delivered care.

Benefits to other constituencies

For many constituencies, the primary benefit of sharing would be reduced administrative hassle from streamlining processes for those who would otherwise have to navigate systems in multiple states. For

instance, states could jointly certify plans or collect the same data from carriers operating in multiple states. The administrative burden could also be reduced for providers serving a population from multiple states, if patients could have the same plan across states, rather than having slightly different versions of the same plan, that each comply with a different state's exchange rules. Sharing could also simplify decisions and administration for small businesses in border regions that may have employees living and working in multiple states. Agents and brokers certified in multiple states could also have reduced administrative work with shared exchanges.

Exchanges will need to carry out many functions, from determining applicants' income and eligibility for assistance, to marketing and educating consumers and their assisters about how to access coverage on the exchange, to certifying insurance plans that can be sold on the exchange, to developing the online platform and process through which consumers will choose their coverage. Some of these functions may be more feasible to share across states than others. In addition, sharing certain functions may yield more benefits than sharing others. In the study, states and experts identified those functions that would be the highest priority to share, because they are generic enough to make sharing feasible, and the benefits could be great enough to justify the work of establishing a sharing arrangement. The priorities are grouped across the timeframe when a function could begin to be shared (short-term, medium-term, or long-term), although sharing on a function could continue beyond the initial timeframe that is identified.

Short-term: 2013 to 2014

The short-term of exchange implementation is already occurring, and will last through the initial implementation stage in 2014, during which states are still funded by federal grants to develop and run their exchanges. While extensive shared services are likely not feasible to develop within this quick timeframe, certain functions might be possible to share. Listed in order of priority, these functions include the following:

1. Intellectual capital

Intellectual capital includes sharing lessons learned, best practices, documents, and artifacts such as diagrams, test cases, use cases, process flows, and product specifications. Each state's talent and expertise pool are different, thus each state could learn from others in at least some areas, and all states could benefit from each other's resources. In particular, states would place a high value on intellectual capital around stakeholder engagement, change within and across agencies, sustainability, and IT systems, as decisions and policies in these areas will continue to be made throughout 2013 and 2014.

2. Information technology

In 2013 and 2014 states are continuing to develop their information technology systems to support exchanges. In the short-term, states could share easily parsed elements such as identity proofing systems, testing and training modules, and even, for states that have not yet built them, eligibility rules engines to determine applicants' income and program eligibility. Sharing in IT can be particularly attractive because of the large expense required to build an IT system.

3. Marketing and outreach

As of spring 2013, states are heavily underway developing marketing and outreach campaigns that will be launched before October 2013 and will continue in phases throughout exchange operations. States could quite feasibly share information and components of their campaigns, working in conjunction as they develop and roll out marketing. For example, states with similar demographics could share market research results and inform each other's research efforts. States could also share materials they have developed to be distributed, and training for outreach workers. Aside from the efficiencies of reusing existing research and materials, states with shared media markets have a compelling reason to coordinate marketing, to

avoid confusion among consumers and present information that reaches both states' populations. This is particularly important for individuals who work in one state and reside in another, or for individuals who seek provider services in other states.

4. Back-office functions

Exchanges will require back-office functions, such as accounting, document management, and evaluation infrastructure, among others. These functions are largely generic across states, and purchased as separate components, thus they could be relatively easy to share.

5. Decision support tools

States could share the tools they are developing to help consumers and businesses who are shopping on the exchange make decisions about which plans to buy and compare plan offerings in both the individual and SHOP exchanges. Sharing could involve reusing another state's actual technological code for a tool to compare issuers, or sharing research and design to inform the development of a state's own tool.

6. Consumer assistance

A large part of exchange work will include assisting consumers through an unfamiliar process as they enroll in coverage for the first time. Although the process of enrollment and online systems will be different across states, many of the elements of consumer assistance are more generic. Although joint procurements for shared consumer assistance functions may take too long to be feasible as quickly as needed, in the near-term, states could share consumer assistance materials, documents, and research. For example, states could share training design and curricula for navigators, agents and brokers, and other assisters. Although the training would differ in specific aspects, information about the ACA, insurance coverage, making decisions, and the distinctions between programs will be fairly similar across states. Developing training and curricula is a resource-intensive effort for states in the near-term and sharing could help ease the burden on individual states. In addition to training, states could share assistance materials, such as the design for call center trees, and scripts for call center workers.

7. QHP management tools

States can share information and analytic tools for managing Qualified Health Plans (QHPs). These tools and information will be generic across states to the extent that they must comply with national regulations and are difficult to develop, thus sharing could be useful in this area. Such tools and information may include workflows, screens, exams, and tools for determining meaningful difference and discriminatory benefit design.

Medium term: 2015 to 2016

The medium term of exchange development will occur around 2015, when federal funding for exchanges ends. In the medium time frame, states may have a longer lead up to lay the groundwork for more extensive sharing arrangements. This may allow states to share functions that are less generic than an "off the shelf" product, developing a more thoughtfully integrated component that works for partnering states. States will also have an opportunity to share as they begin to develop "phase two" components that were not essential for the bare minimum of early operations, but are intended to improve the ongoing exchange functioning. Listed in order of priority, functions ripe for sharing in the medium term include the following:

1. SHOP

Many states are building rudimentary SHOP exchanges for small businesses to purchase coverage in the near-term, with plans for more sophisticated development in the future. Exchanges to serve small businesses are complicated and involve different policy decisions than the individual exchanges that states are focusing more energy on for 2013 and 2014. Around 2015, states may begin to revisit their SHOP exchanges. At this point, states could look to sharing back-office functions, services such as premium aggregation tools and consumer service functions that can handle very detailed questions about small business insurance purchasing. In addition to sharing intellectual capital, states may have a longer lead-up to more collaboratively develop and procure these functions compared to what they could do with the individual exchange. States may be strongly motivated to share within SHOP and keep administrative costs low, because federal funding will be unavailable, and the group of possible businesses across which to spread costs will be limited. In addition, helping small businesses is a broadly accepted value held in diverse states, so political barriers to partnering may be lower.

2. Procurement

The 2015 timeframe gives states sufficient time to coordinate procurement, both for SHOP and individual functions, particularly the phase two functions that will be newly procured at this time. States could jointly develop and share Request for Proposals (RFPs), information and lessons, and even procurements themselves, as discussed in the Sharing Arrangements section. Functions that could be procured jointly in this timeframe may include more sophisticated phase two call centers and premium billing tools, in addition to SHOP functions.

3. Evaluation

By 2015, states will be evaluating what is and is not working well in their exchanges. States could learn important lessons by sharing their results with each other, as a kind of positive feedback mechanism to spread best practices. In addition, states can share their evaluation strategies as they learn which methods work best to provide the information needed to show success and improve their program functioning.

4. Sustainability strategies

When federal grant funding expires at the end of 2014, states will need to ensure that their exchanges are self-sustaining. In the medium term states may be able to share strategies and constructs for sustainability, and potentially leverage each other's contracts and documents where applicable. As these strategies are implemented, states will be able to learn from each other which models work to sustain an exchange.

Long-term: 2016 and beyond

Long-term exchange planning and development will occur once exchanges are a few years past initial implementation (2016 and beyond). At this point, states will have had more time to assess the impact of exchanges as well as other relevant provisions in the ACA, on their insurance markets and on their consumers. States will also benefit from hindsight of early lessons drawn out of the initial implementation of exchanges. For the long-term, priorities for sharing are listed in order of study participant interest.

1. Insurance market regulations and combined risk pools

Traditionally, insurance markets and related reforms have fallen under the purview of states, fostering an environment of state-specific health insurance regulation. Once fully implemented, insurance market reforms mandated by the ACA will provide states with a universal baseline of regulations that all insurance

carriers and plans across states will be required to meet. While it is yet to be seen how new regulations will impact insurance markets overall, the regulations provide states with a new opportunity to examine their ability to share and collaborate across more similar insurance markets. This may even include an exploration of sharing risk pools, especially where states share other common market characteristics like shared carriers, providers, employers and employees. States may also look to coordinate on carrier regulations or develop reciprocal agreements with partner states to ease carrier participation across states. Meeting participants acknowledged that this latter strategy would likely receive significant support from important stakeholder groups across the states including carriers.

2. Quality improvement tools and data infrastructure

Many states anticipate future phases and uses of their exchange beyond the initial minimum capacity for insurance shopping, including ways to use exchanges to drive improvement of care delivery at lowered cost. This may include tools that can provide consumers with enhanced information about plan and/or provider performance or the cost of care services. Tools built into exchanges for these purposes will likely be fairly standardized and states could opt to collaborate early on in their development of these tools to share strategies and resources for incorporating them into individual or shared exchanges. States are also considering how exchanges will fit into their larger health information technology (health IT) infrastructure. This includes how exchanges might connect with claims and clinical databases (e.g. all-payer claims databases, health information exchanges) to easily cull and share cost and quality data across the delivery continuum, from patients to carriers to providers. As with other functions, states may collaborate to share lessons, schematics, and strategies on how to connect exchanges with other health IT infrastructure.

3. Approaches to servicing mixed households

After exchanges have been in place for a few years, states and others can develop more sophisticated solutions to the complicated problem of churn (populations moving between exchanges and other coverage programs, including Medicaid, due to shifts in their income and eligibility status). States with mobile border populations could coordinate to offer exchange plans and even Medicaid-like plans that bridge both states or are sufficiently similar in benefits and provider networks, to mitigate the impact of frequently changing coverage for consumers. Data sharing for these cross-border populations, such as access to other states' income data, could also smooth the way for states to automatically determine eligibility even for people with income coming from two states, or a complex residency or household situation.

Sharing arrangements

Across the priorities that states identified, sharing could be operationalized through different models. Ranging from the least to most integrated arrangements, states could: share intellectual capital through calls and the internet; buy in to a nationwide service; jointly procure services together; or even more closely interweave the development of a joint program. This section describes benefits and drawbacks to various arrangements, and gives examples of existing models.

Intellectual capital

A basic way to operationalize sharing is working with peers in other states in meetings, calls, and over email to send documents, ask questions, and share lessons learned. Indeed, this sharing is already taking place, such as the documents shared on the federal Collaborative Application Lifecycle Tool (CALT), the public sharing of documents taking place on state websites and on State Refor(u)m, private sharing on listservs, calls, and at meetings hosted by the State Health Exchange Leadership Network, National Association of Insurance Commissioners (NAIC), National Governor's Association (NGA), and State Health Reform Assistance Network, among others. States see this type of sharing as absolutely essential to meeting the deadlines for exchange operation because no one state has the talent and resources to develop all of these materials and best practices alone.

National services

States could buy into or use a service developed nationally by a non-state entity, thus eliminating the need for states to develop or procure this service either jointly or alone. Those services that states can opt to have the federal government run would fall into this category. For instance, states had the option to develop their own risk adjustment programs or defer to the federal government to run this service, and nearly all states deferred to the federal government.

Besides the federal government, other national entities can also run a service for states. For example, the NAIC operates the System for Electronic Rate and Form Filing (SERFF), a web-based system that facilitates the flow of rate and form filing information from insurance companies to states. Within SERFF, states are able to store and approve or reject insurance rates and form filings. Forty-nine states, the District of Columbia, Puerto Rico, Guam and more than 3,600 companies use SERFF.[12] Launched in the late 1990's, SERFF was developed under the guidance of a consortium of states and insurance companies to increase efficiencies and reduce the cost and time required for regulatory filings. The decentralized infrastructure allows states to benefit from the system without making large investments in technology and support staff individually. SERFF has also reduced filing turnaround through standardization of filing types and promoting uniformity of transmittals and product naming conventions.[13]

Having a national entity develop a service allows states to reap the economies of scale of a joint service, while reducing the need for extensive coordination across many states contributing funds to develop the services. However, a challenge is finding a national entity willing to take on the development and operation of a particular service that states want to share. For instance, states requested that the federal government perform a standardized income determination for applicants to state exchanges, but the federal government was not willing to take on this function for states. An additional challenge is that a nationwide service may be less customized than a service developed by a single state or a few likeminded states. SERFF gets around this issue by giving states standardized output information about carriers, but having each state perform its own analysis for those factors important to that state. In other programs, the

federal government has also found a way around the customizability issue, such as through its Meaningful Use process for electronic health records (EHRs).[14] In Meaningful Use, the government performs the intensive job of working with vendors to develop data standards and certify products that can produce standard data elements, which allows each state or other entity to use the standardized data to conduct the analysis that best fits its own needs.

Thus, the best services to share via a national non-state entity are likely those that an entity is willing to develop and operate, and those that are generic yet offer some sort of customizable output if necessary.

Jointly procured services

States can jointly procure services that an outside entity is unwilling to develop without a specific procurement, or that the states want to maintain a higher degree of influence over. Although there are many ways states could procure a service together, the most straightforward to conceptualize—working through a procurement process that combines each states' own procurement process and meets all states' procurement requirements—is likely to be overly burdensome to make it feasible or worthwhile.

A useful example of a successful joint procurement arrangement occurred with the Medical Assistance Provider Incentive Repository (MAPIR) tool. MAPIR is a software application developed by Hewlett-Packard (HP) that is used by 13 states to manage their Medicaid EHR Incentive Programs. Participating states include: Arkansas, Connecticut, Delaware, Florida, Georgia, Indiana, Kansas, Massachusetts, Oregon, Pennsylvania, Rhode Island, Vermont, and Wisconsin, with Pennsylvania serving as the lead state. The MAPIR tool integrates into existing state Medicaid Management Information Systems (MMIS) and allows states to confirm provider and hospital Medicaid EHR Incentive eligibility, issue incentive payments, and track provider implementation of certified EHR technology.[15]

Development of MAPIR began in 2010 when the Pennsylvania Department of Public Welfare's Office of Medical Assistance Programs requested that HP build a core system that multiple states could use to administer the EHR Incentive Program. Other states that had been contracting with HP as their MMIS fiscal agent needed this tool as well, thus with Pennsylvania as a lead state, they formed a collaborative to guide development of the application with the goal of increasing efficiencies and savings.[16] The Centers for Medicare & Medicaid Services approved "90/10 funding"* for the development of the application and administration of the collaborative. The 13 participating states signed individual sole source or contract amendments in their pre-existing HP MMIS contracts to pay their portion of the 10 percent state share, while Pennsylvania was the lead signer of the contract.[17] Crucially, Pennsylvania was able to use 90/10 funding to hire a dedicated staff person to coordinate the procurement with the 12 other states.

By sharing development expenses, the collaborative has been able to significantly reduce the costs of developing MAPIR for individual states. In addition to the initial procurement, the MAPIR collaborative has served as a forum for states to discuss operational issues and ongoing development of the application. Participation in the collaborative has also reduced the burden on individual states to interpret and analyze new regulations. When a new regulation is announced, HP updates the MAPIR application and configures any needed changes in each state-specific MMIS system, thereby saving time and resources at the state level. In recognition of its work with the collaborative in building MAPIR, HP was awarded the National Governors Association's 6th Annual Public-Private Partnership Award in 2012.[18]

*"90/10 funding" refers to a 90 percent federal financial match available for design, development and implementation of state Medicaid IT systems, through 2015. For more information see http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/Eligibility-and-Enrollment-Systems-FAQs.pdf

A key element in MAPIR's success has been a provision that states must pay extra to have the vendor re-develop a more customized version of any MAPIR component. This gives states the option to have customization; however, faced with the choice of paying more or using the consensus tool that they developed with the state collaborative, participating states have opted for the more generic version of the tool.

Given the MAPIR example, the best services for a joint procurement may be those that are sufficiently generic (as one state put it, "commoditizable") for which a lead state is willing to play an intensive coordination role. Depending on the service to be shared, having an existing common vendor could facilitate this type of sharing. If the service is not an add-on to an IT system as MAPIR was, this requirement may be less important. Further, a joint procurement process takes time, so this is likely feasible for medium- and long-term projects. Finally, in considering the benefits and drawbacks of a joint procurement, it is important to keep a longer-term vision in mind. Although it may take additional upfront work to set up a procurement collaborative, the long-term benefits such as increased negotiation leverage with vendors even past the initial contract, the ability to more easily make upgrades as systems and regulations evolve, and the potential to enter into procurements for other services through a collaborative once it is established, could all provide states an incentive to work through the start-up hurdles.

Jointly run services

The most intensive sharing arrangement would be two or more states literally sharing a service or collection of services. This is likely the easiest sharing to conceptualize, but the most difficult to operationalize. In states that want a sufficiently similar service, one state could rely on the other state to run a service for it, for example rather than reusing another state's IT components, a state could arrange a transfer from its system to another state's to run a particular component (such as identity proofing). Alternatively, states could jointly develop a shared policy plan, and jointly procure elements of the plan for a fully shared component, such as a call center, consumer assistance function, or IT tool. In this case having a smaller group of states may make sharing easier.

Considerations for sharing

Several important considerations would have a significant effect on the feasibility, success, and magnitude of cost savings and other benefits from sharing exchange functions. These cross-cutting considerations apply to multiple functions that could be shared, and to different sharing arrangements. The considerations include timing, different exchange models, diversity of political environments, crossover in populations and businesses, impact on insurance markets, and a legacy of state specific regulation.

Timing

Timing is a key determinant of whether sharing of exchange functions is feasible. With exchanges needing to be operational in each state by January 1, 2014, it would be extremely difficult to negotiate jointly run functions in time for the initial implementation of exchanges. Instead, short-term sharing opportunities are limited to those described earlier. Both interviewees and meeting participants saw greater potential for full sharing of exchange functions in future years, starting in approximately 2015. However, they also noted that relationships between states interested in sharing should be established soon (ideally 2013) in order for states to be poised to leverage a future shared model in either the medium or long-term. Early conversations between states would enable them time to adequately evaluate gains from sharing specific functions, establish mutual goals for shared work, and garner necessary political support.

Different exchange models

Whether opting for a state-based, partnership, or federally-facilitated model, exchange type impacts the capacity and perspective individual states bring to sharing exchange functions. It is possible that states with different models could share with each other (e.g. partnership states reusing or buying into services that an SBE state has built); however, conversations would need to take into account differences between unlike exchange models, including ability to share and need for sustainability.

Through 2014, states may receive full federal funding through establishment grants to cover the costs of implementing exchanges. This access to funding enables SBE states to more easily build unique exchanges, yet also gives them limited capacity or need to work with other states while rushing to get their exchanges launched by tight implementation deadlines. However, after exchanges are implemented and must be self-sustaining, SBEs may seek opportunities to leverage efficiencies from and share lessons with other states. Partnership states are designing exchanges in conjunction with the federal government, building a collaborative model where the federal Department of Health and Human Services (HHS) and the state will work together to operate a state's exchange. Experiences from partnership states' collaboration with HHS may readily translate to sharing functions with other states as these states consider transitioning to an SBE or regional exchange model. FFE states are not taking on any exchange functions in the near term, and thus have limited opportunity to share with other states. In the future, these states may transition to a partnership or SBE model in which case they may also seek to partner with other states or at least seek opportunities to share or leverage functions already established in existing partnership or SBE states.

Diversity of politics and political priorities

One reason why strategies for exchange implementation are uncoordinated is because each state is unique, and thus far have had large flexibility to tailor exchanges to meet their own state's needs. As one state official described, "[states] find we are all dealing with common problems, but we have to approach

them from different directions." This means that states that share similar political characteristics or goals for their exchange may be more able to enter into successful sharing arrangements. Alternatively, states that are different in key ways may need to develop special sharing methods that allow for these differences.

Decisions about whether and how to implement exchanges in states have been especially politically charged. Part of the political drive for states opting to implement SBEs was to maintain state control over their exchanges. State agencies and legislatures may be reluctant to negotiate with another state if it means compromising on state policy priorities. For example if one state wanted plans to meet much higher standards to sell on the exchange, another state may be unwilling to share on plan management functions. As one state noted, "we want to build our house and get it right for [our state]," though the state also expressed willingness to share functions with other states willing to work within the priorities of the original state. On the other hand, partnership and FFE states may be able to accomplish greater state control by partnering with other like-states than by their current arrangement partnering with the federal government. Politics around exchanges continue to evolve and states may consider establishing relationships with states now that could benefit them if they decide to pursue shared models in the future.

In addition, some exchange functions are less divisive, such as back-end functions or IT systems. States may be able to share these components with each other without appearing to dilute state control. Such arrangements have succeeded in the past: MAPIR was a procurement for a non-controversial function that included a very diverse group of states, from Florida, Georgia, and Indiana, to Oregon, Massachusetts, and Vermont.

Crossover in populations and businesses

States with shared populations, employers, providers, and/or carriers, may find sharing particularly beneficial. First, it may be easier for these states to share with each other. States with a common population or a shared carrier market are often similar in terms of geography and/or demographics, and thus may have common drivers motivating them toward a shared solution. States with crossover may also derive unique advantages from sharing exchange functions. For example, on a small scale, states with shared populations may be able to coordinate on functions like consumer outreach by sharing media buys in border regions and coordinating on messaging to ensure that consumers are clear about their exchange. States with similar demographic makeup of their exchange consumers may share market research and outreach materials developed to meet similar cultural or linguistic needs or that will resonate with like populations. On a more extensive scale, shared providers or carriers may open opportunities for states to collaborate to build shared data resources to benefit both states, including robust provider directories, health information exchanges for clinical data, or all-payer claims databases for claims data.

Impact on insurance markets

Sharing may have an impact on state insurance markets. Similarly, state demographics (including size and health status and indicators), impact a state's overall insurance market and the potential for benefits that could be achieved by sharing exchange functions related to insurance markets or even sharing the market pools themselves. States with healthier demographics, for example, may have more flexibility in terms of high standards for plans, or may not want to enter into a risk-sharing arrangement with a state with a less healthy population. Or, states with smaller populations may be able to more easily enter into a partnership than a very small state partnering with a much larger state, the latter of which would ultimately have greater market share.

Legacy of state specific insurance regulation

While the ACA poses a departure from past state-specific insurance regulation, these changes will not all come to fruition for several years. Moving from state-based to more uniform insurance markets is a major shift for state insurance agencies and explicit attention to culture change will be critical to the success of a shared services arrangement. However, state insurance agencies have long shared mutual goals, including lowered costs and improved efficiencies. One participant likened this to the implementation of the NAIC's SERFF, discussed earlier in this report, which is used by 49 different jurisdictions. Despite the differences across states using the tool, they all are able to use the uniform system to drive efficiencies and bring down costs.

State insurance agencies may also look to draw lessons from other agencies more accustomed to sharing arrangements, like Medicaid. Medicaid has historically been a shared federal-state program that involves standardization across states and shared policy control between federal and state governments. Accustomed to this environment, Medicaid officials interviewed for this project were generally more open to leveraging sharing opportunities and could more readily cite previous experiences sharing with other states.

Recommended Next Steps

States recommended several next steps to advance the work toward capitalizing on the potential of sharing. The next steps move from studying and modeling benefits of sharing, to raising awareness and buy-in, to settling upon functions to share and entering into an actual sharing arrangement.

- **Model cost savings**
  Although sharing seems to hold promise for financial savings through economies of scale, further work to estimate savings could guide states in determining their sharing priorities and help leadership make decisions about investing in a sharing arrangement. Savings could be estimated by comparing the cost of implementing and operating a service alone with the cost of establishing a sharing arrangement and spreading operations costs across multiple states. Having this information broken down to a per-member per-month cost or savings could help states compare the benefit of sharing functions of different scales. An actuarial analysis of the market impacts of sharing, such as lowered premiums and/or lowered administrative costs, could also provide useful information. States could use grant funds to pay for this type of analysis, or have vendors project costs and savings as part of a procurement. In the philosophy of sharing, to the extent possible, states may want to coordinate with each other on these analyses, or on developing an analytical framework that can be customized to each state, rather than each conducting their own study.

- **Demonstrate other benefits**
  As described in the sections above, sharing could have other benefits in addition to cost savings. States can conduct additional analyses to demonstrate or more accurately predict those benefits that seem promising, such as faster progress in exchange development, reduced government staffing needs, or more satisfied consumers. Further, states could work with stakeholders and each other to brainstorm more realistic benefits that could help stakeholders understand the logical benefits to them of sharing a particular function.

- **Engage the federal government**
  Through regulation and grant making, the federal government has substantial leverage to promote or discourage sharing across states. States interested in sharing could work with the federal government, encouraging the federal agency to send a signal that plans for sharing will be accommodated, approved, and otherwise facilitated. This signal could be spelled out explicitly in guidance around sharing, implied through approval of state plans to share, or even by requiring states to share with each other. In the past the federal government has indeed endorsed sharing, such as by giving states a 90 percent match to fund the MAPIR collaborative work and establishing the CALT tool for online sharing of documents. As the federal government is shouldering so much of the exchange start-up cost, and is accountable for exchange success, economies of scale and more efficient exchanges could be beneficial from the federal perspective in addition to the state perspective.

- **Engage other stakeholders**
  Other stakeholder groups, such as providers, carriers, consumers, agents and brokers, and small business, may derive specific benefits from sharing, as described in previous sections. If these groups foresee a benefit, they could help advocate for and spread information about sharing, especially at the state and federal policymaking level. Active engagement of stakeholders will be especially crucial to

building support for and willingness to implement more intensive sharing arrangements, such as shared risk pools.

In the stakeholder engagement process, the predicted savings analyses will be useful, but states need not wait for this data before engaging stakeholders if they can help stakeholders understand the logical benefit to sharing. For example, with the Patient-Centered Medical Home (PCMH) model of primary care practice, carriers and consumer groups understood that the model made sense, and worked to implement PCMHs before data proved that it would save money or improve the consumer experience. Already, groups of small businesses and insurance carriers have shown interest in sharing exchange functions because they see a benefit of reduced administrative hassles or improved exchange services that could come of sharing. States could do further outreach with national organizations such as NAIC, NGA, or provider groups like the American Hospital Association. A group of states working together to engage national stakeholders could be an efficient way to send a widespread message about the benefits of sharing.

- **Hold a national conversation**
  Besides engaging specific stakeholders around targeted benefits to one constituency, states can promote a more inclusive nationwide conversation on sharing. The initial step would be disseminating the results of this study broadly, including wide publication of the final report, and holding a national webinar to discuss the findings and recommendations. Future steps could include presentations at conferences with a national audience, disseminating further publications, and media engagement around the topic of sharing.

- **Continue a conversation among states**
  Although widespread engagement will be important to building support, a dedicated group of states will need to convene intensively to lay the groundwork for a sharing arrangement. This could be a group of demographically or politically similar states, all of the partnership states, or another group. States could have regular phone conversations, a listserv, or in-person meeting to advance the conversation and identify options before proceeding to a more formal sharing arrangement.

- **Designate a coordinator**
  As those who carried out the MAPIR work can attest, once states are ready to actually implement a sharing arrangement, a designated coordinator fills a crucial role. This could be a point person or a lead state willing to dedicate multiple staff resources. The coordinator manages the sharing process by facilitating communication among all of the states involved, and could also be the primary signor on contracts.

Conclusion

Many states agree that sharing components of insurance exchanges holds great promise for both cost savings and other benefits that could lead to better designed and better implemented programs. Some sharing could take place in the near term, and indeed some already has, such as states sharing best practices and customer assistance materials. More extensive sharing arrangements with possibly greater benefits seem feasible in future years. The study elucidated various sharing arrangements and priority functions for sharing that West Virginia policymakers can consider. The benefits of shared exchange functions seem promising enough that states expressed interest in continuing to explore sharing. The recommended next steps could help to more accurately predict the promise of sharing, and advance the conversation so that states may develop future beneficial sharing arrangements.

Appendix A: Summary of priority functions to share

Timeframe (dates)	Priority Functions to Share
Short term (2013 to 2014)	• Intellectual capital • Information technology development • Marketing and outreach • Back office functions • Decision support tools • Consumer assistance • Plan management tools
Medium term (2015 to 2016)	• SHOP small business exchanges • Procurement • Evaluation • Sustainability strategies
Long term (2016 and beyond)	• Insurance market regulations and combined risk pools • Quality improvement tools and data infrastructure • Approaches to servicing mixed households to address the issue of churning

Appendix B: Study participants

Interviewees

State Interviewees

Crystal English
Senior Administrator, Health Benefit Exchange, Delaware Division of Medicaid & Medical Assistance

Bettina Tweardy Riveros
Advisor to Governor, Delaware

Carrie Banahan
Executive Director, Office of the Kentucky Health Benefit Exchange

William Nold
Deputy Executive Director, Office of the Kentucky Health Benefit Exchange

Rebecca Pearce
Executive Director, Maryland Health Benefit Exchange

Roni Mansur
Chief Operating Officer, Commonwealth Health Insurance Connector Authority, Massachussetts

Camie Berardi
ACA Implementation Manager, Commonwealth Health Insurance Connector Authority, Massachussetts

Julia Lerche
North Carolina Department of Insurance

Anthony Vellucci
Program Director, North Carolina Department of Health and Human Services

Cindi Jones
Director, Virginia Department of Medical Assistance Services and Director, Virginia Health Reform Initiative

Molly Huffstetler
Senior Policy Analyst, Virginia Department of Medical Assistance Services

Jack Quigley
Virginia Department of Medical Assistance Services

Other Expert Interviewees

Sally McCarty
Senior Research Faculty and Project Director, Georgetown University Health Policy Institute

Katie Dunton
Assistant Research Professor, Georgetown University Health Policy Institute

Jay Himmelstein
Professor and Principle Investigator, New England Early Innovator Collaborative, University of Massachusetts Medical School

Michael Tutty
Director, Office of Health Policy and Technology, University of Massachusetts Medical School

Brian Webb
Manager, Health Policy, National Association of Insurance Commissioners

Brian Haile
Tennessee Insurance Exchange Planning Initiative, Tennessee Division of Health Care Finance and Administration

Norman Thurston
Health Reform Implementation Coordinator, State of Utah

In-person meeting participants

Colorado

Jim Sugden
Small Business Health Options Program Exchange Manager, Colorado Health Benefit Exchange

Delaware

Linda Nemes
Assistant Director, Market Regulation, Delaware Department of Insurance

Kentucky

Miriam Fordham
Director of the Division of Health Care Policy and Administration, Office of the Kentucky Health Benefit Exchange

William Nold
Deputy Executive Director, Office of the Kentucky Health Benefit Exchange

Massachusetts

David Lemoine
Manager of Information Technology Partnerships, Commonwealth Health Insurance Connector Authority, Massachussetts

Brian Schuetz
ACA Implementation Manager, Commonwealth Health Insurance Connector Authority, Massachusetts

West Virginia

Diana Hypes
Information Technology Lead, West Virginia Offices of the Insurance Commissioner

Pam King
Research Specialist, West Virginia Offices of the Insurance Commissioner

Jeremiah Samples
Health Policy Director, West Virginia Offices of the Insurance Commissioner

Stacey Shamblin
Chief Financial Officer, West Virginia Children's Health Insurance Program

Jeff Wiseman
Health Policy Consultant, West Virginia Offices of the Insurance Commissioner

Expert Contributors

Patrick Holland
Managing Director, Wakely Consulting Group

Sandeep Kapoor
Chief Executive Officer, HealthTech Solutions

Debbie Keith
Medicaid Policy Advisor, HealthTech Solutions

NASHP

Abigail Arons
Policy Analyst, NASHP

Anne Gauthier
Senior Program Director, NASHP

Christina Miller
Policy Analyst, NASHP

Kimm Mooney
Research Assistant, NASHP

Endnotes

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