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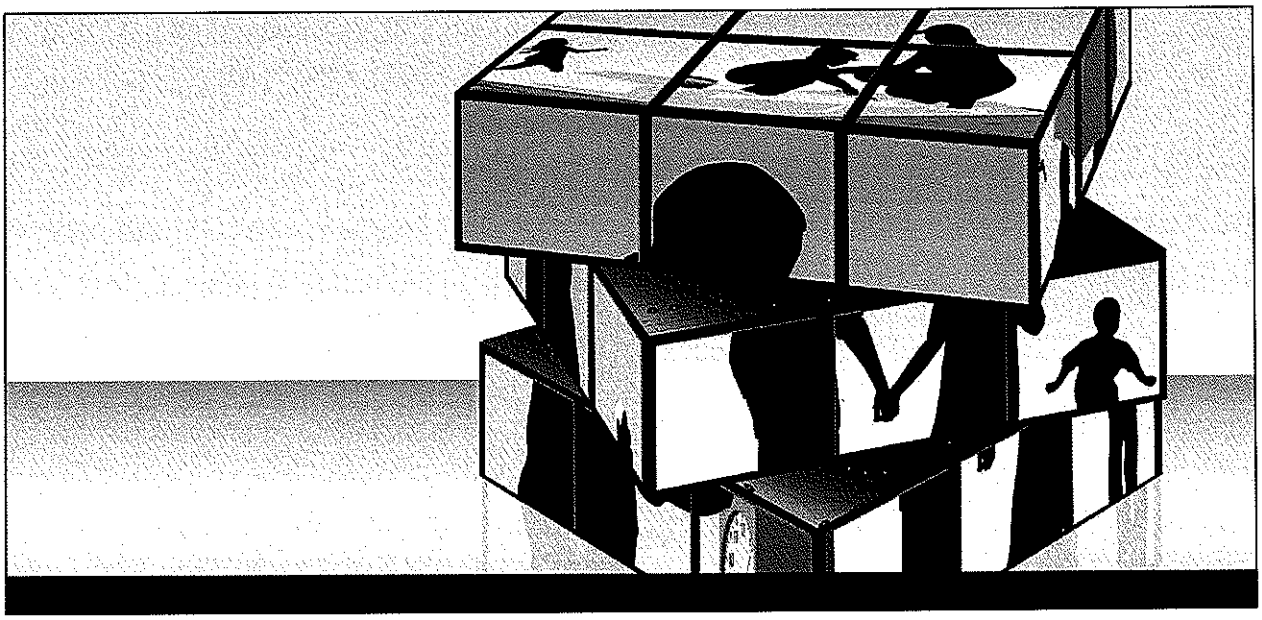

Response to

West Virginia Offices of the Insurance Commissioner

Request for Information (RFI) No. INS11012 - Actuarial and Economic Modeling of West Virginia's Health Insurance Exchange

Submitted by:
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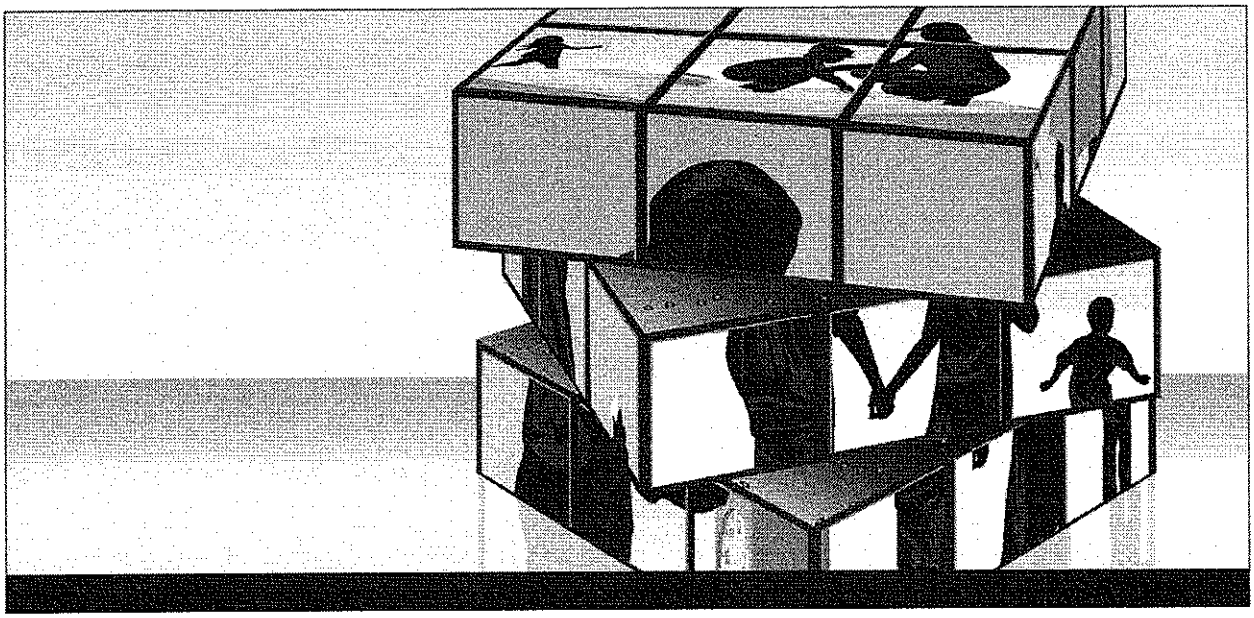

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Contact Information

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Introduction

Cúram Software is pleased to have this opportunity to provide input to the information-gathering process for use in the development of the State of West Virginia's Health Insurance Exchange.

While Cúram Software is not an actuarial firm, we do have some thoughts on risk adjustment methodologies, on revenue sources for administration of health exchanges, on the types of change principles that states must address for effective management of state health care reform policies (including changes to income, households, coverage, policy and technology), and on governance approaches, including the initiatives and experiences we are seeing in other states.

We also provide information about the Cúram health care solution and platform, and how it is designed to be a vital component in the operation and administration of the Exchange.

We recognize that health care reform represents a tremendous challenge for states. Implementing a full health care reform solution is complex, with a wide array of systems and processes coming together to support broad, sweeping reforms. At the core of health care reform is eligibility and enrollment. This system will serve as the central hub for orchestrating all supporting processes.

Cúram Software understands the challenges states are facing and is committed to helping them meet that challenge and capitalize on opportunities for modernization. Cúram delivers unparalleled eligibility and a comprehensive, unified front end that offers the most advanced screening, intake, and enrollment support available. Further, Cúram can be integrated with existing legacy systems to protect your current investments, while providing a modern, common front end.

Understanding that the health care reform policies and requirements are still being defined, Cúram is uniquely positioned to quickly incorporate these requirements into the solution. We hope that our comments and recommendations will assist the State of West Virginia in its research and decision-making regarding the implementation and management of its Health Insurance Exchange, and we look forward to providing input to the process in the months ahead.

Comments

Responses should include recommendations on governance of the Exchange and whether specific functions should be performed by existing state entities, by newly created state entities, regional entities or by other outside entities, keeping in mind that current state strengths and resources should be leveraged, while maximizing opportunities to improve health care delivery and financing infrastructure.

The Patient Protection and Affordable Care Act (PPACA) encourages states to establish health insurance exchanges in order provide access to an array of options within the health insurance marketplace while at the same time providing needed assistance to those now required to purchase insurance as part of the law.

Simply stated then, a public health insurance exchange must accomplish three high-level activities: 1) Determine eligibility for assistance in obtaining health insurance, 2) Support enrollment in health plans, and 3) Qualify health plans to be included in the exchange. Health insurance exchange governance is the first decision a state must make towards accomplishing these three high-level activities.

Within PPACA, states are offered four options for structuring the governance of a health insurance exchange: an existing state agency, a newly created state agency, a nonprofit organization outside of state government, or, possibly, a multi-state exchange. Understanding the current environment within each state through careful consideration of the variety of stakeholders is important when making a recommendation regarding governance.

In each of the states that have implemented exchanges thus far, they have all done so differently due to mitigating circumstances. Utah, for instance, enjoys a 50% part-time employment rate thus making health insurance unattainable for 50% of Utah employees. Their driving factor was to create an exchange in which small employers could purchase insurance affordably for their employees. With that impetus in mind a new division within an existing state agency, as the Office of Consumer Health Services (OCHS) was established under the Governor's Office of Economic Development (GOED). This market-driven approach to governance came prior to passage of PPACA and will perhaps evolve based on the need to determine eligibility for public programs available under PPACA. However, at the time, with

the economic situation, the political environment, the desire to drive down premium expenses for small businesses and a desire to improve the number of small businesses offering insurance to their employees, this was the direction Utah chose.

Massachusetts, another state with an exchange in place, faced soaring costs for the uninsured. They chose to establish an independent public authority within state government, the Commonwealth Health Insurance Connector Authority. In operation for a while now, they have a 97% rate of participation. They also have documented a rate of 25,000 individuals who change their eligibility each month. Currently they insure up to a 300% of FPL and will need to change their policies to adhere to the new rules of the ACA of up to 400% FPL coverage.

A third state, Florida, began Florida Health Choices in 2010. This non-profit organization operates outside of the state government with a governing board that includes community leaders including state representatives and was established to run the Florida health exchange. Although with a gubernatorial change in November of 2010, it appears that Florida may see a change in their approach in the near future.

Three disparate models – no right answer for everyone.

The key is the following – identify key contributors and stakeholders to the success of the exchange and make sure they are involved in the process. If any party feels left out, they have the power to affect the success or failure of the exchange. Leverage the participation of key state government officials from health, human services, the department of insurance, local insurance brokers, insurance carriers (national and regional), the small business community, local chambers of commerce, community advocates, whomever may be affected by the plans that are laid out to affect the success or failure of the exchange.

By leveraging these key stakeholders and making sure they feel they are a part of the decision-making process, you can avoid pitfalls in the long run and have all parties working strategically towards a common goal of building a successful exchange. Consider that within the governance structure, sub-committees are built and chaired by the various stakeholders to address the needs of the exchange.

Officials from health, human services, as well as community advocates and others can participate in a sub-committee to address the needs of the first high-level activity to 'Determine eligibility for assistance in obtaining health insurance. This same sub-committee can then address outreach to those who may not have health insurance and desire to obtain it.

Local small business leaders, the insurance broker community, chambers of commerce, as well as state government officials from the Department of Insurance, can work together on a sub-committee to address the issues around the second high-level activity of 'Support enrollment in health plans' within the health insurance exchange.

Finally, the Department of Insurance could chair a sub-committee that addresses the final high-level activity of making sure plans within the exchange are qualified and while doing so, assist with providing quality and transparency to the exchange overall. This group in particular will need to be in step with federal and state guidelines which are in a state of steady flux as new information comes out about exchanges on a regular basis.

Of course, any state attempting to properly implement a PPACA-compliant health exchange must create an environment of inclusion and avoid prejudices against any particular constituency within the governance of the exchange. This final point has had unfortunate repercussions in some states where in the end, a party was not invited to the table and when that party was needed to create a successful exchange, the party did not participate. In Utah, for example, it was determined during a pilot that there would not be any particular training or outreach to the insurance broker community, and during the pilot, participation by small employers suffered. As an outcome of that pilot, when it came time for general availability, Utah's Office of Consumer Health Services, the Department of Insurance (DOI) and the regional health underwriter's organization (UAHU) worked together to build a series of training courses, certified by DOI to help ensure better participation by the insurance brokers. While it is early, it appears that the inclusion of this constituency is improving the overall small employer participation in the health exchange.

In summary, the state can choose any of the four options for overall governance and oversight of the health insurance exchange, but our recommendation would be that whatever direction is chosen, there must be sub-committees embracing the various constituencies with specific

domain knowledge of determining eligibility for assistance in obtaining health insurance, and supporting enrollment into health plans; and that qualifying health plans are included in the health insurance exchange.

Please provide your evaluative comments on the project description and requirements outlined in this document. Include any suggestions or advice regarding the design, implementation, management, technology, etc. of this contemplated project.

Healthcare Reform requires states to navigate complex legislation to implement sweeping changes in U.S. social policy. To fully implement Healthcare reform, states must design new approaches to financial management, health insurance exchanges, records management, reporting and eligibility and enrollment. Each of these projects on their own introduces vast changes in business processes and IT architectures, combined they represent a complete transformation.

The challenge of implementing a health insurance exchange is that at the 30,000 foot level, some organizations will try to convince states that there is a single vendor who can comply and deliver all requirements outlined in PPACA to provide an exchange. But, the complexities are too great, the timelines too short, and the final solution requires a broad array of components that clearly require domain knowledge and best of breed technology and service integrations.

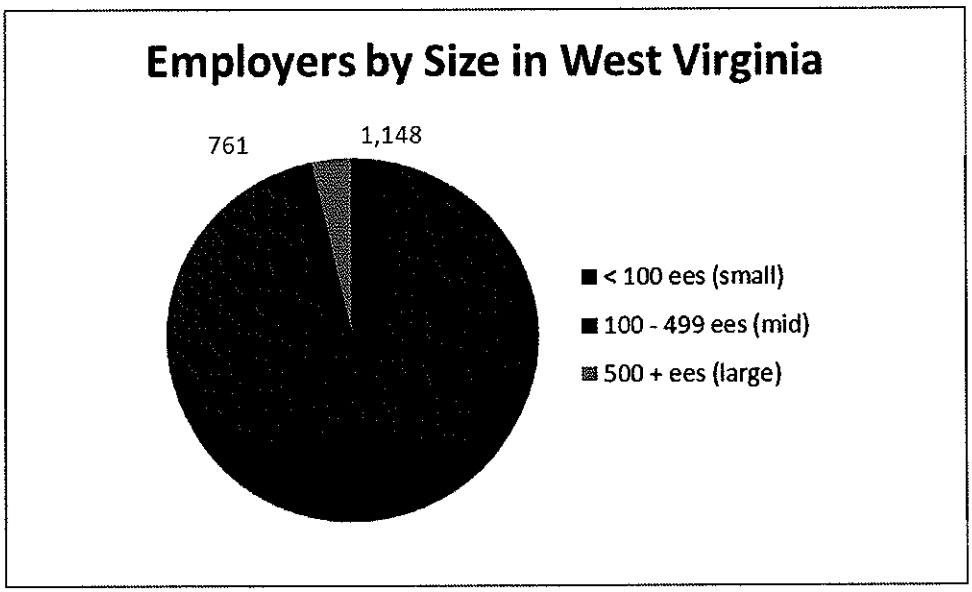
Consider the simplified high-level activities we have already discussed: 1) Determine eligibility for assistance in obtaining health insurance, 2) Support enrollment in health plans, and 3) Qualify health plans for inclusion in the exchange. Drilling down into each of these activities, the implementation of a solution requires technologies and services unique in many ways with little cross-over. For example, the eligibility worker familiar with public policy trained to assist a citizen in need of subsidy assistance to purchase health insurance is not likely to also be a licensed broker trained to understand the intricacies of insurance terminology, such as co-pays and out-of-pocket maximums. Certainly the path of social services required to deliver eligibility determination has not crossed that of the health insurance broker or online website that sells health insurance in the past; nor has the need to qualify a plan based on actuarial value been required.

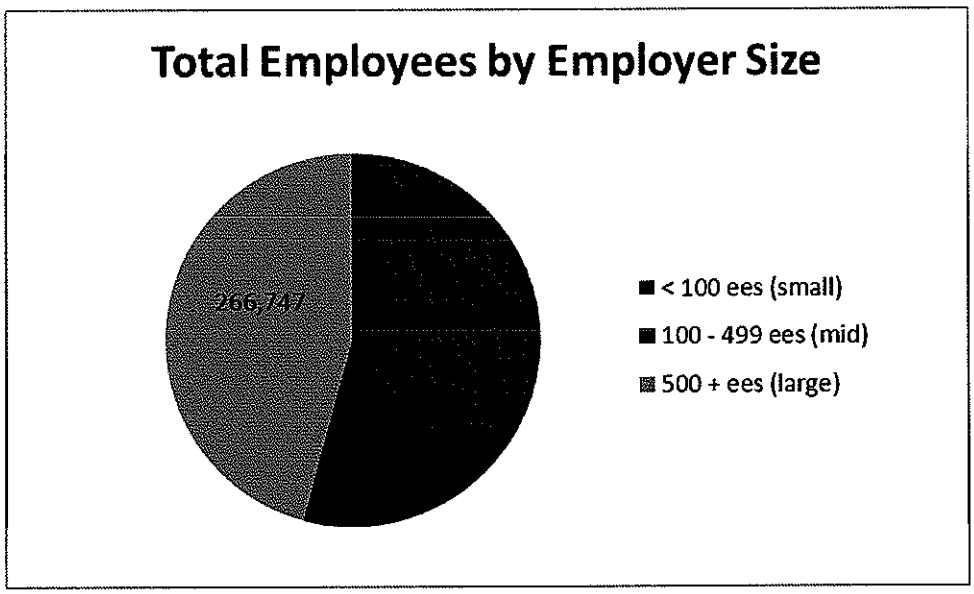
A state should be wary of a solution that does not require integration of multiple sub-contractors at many integration points, such as eligibility determination, enrollment, financial services, call center, underwriting, and of course, the online shopping experience (otherwise known as "the tip of the iceberg").

The impact of ACA is going to be strongly felt in West Virginia. With currently 15% of the population uninsured, more than 260,000 individuals will be eligible for insurance in 2014. Furthermore, with 45% of the West Virginia population between 139% and 400% of FPL the individuals newly eligible for assistance are going to be overwhelming. The 12% of individuals between 133 and 200 FPL pose an interesting issue – should West Virginia create a basic health plan for this population? States that have tried this approach, most notably Washington, have been overwhelmed and have actually closed admission to their programs – or established waiting lists.

The 45% of West Virginia's population between 139 and 400% of FPL have a tendency to change program eligibility frequently. Oklahoma, who has a large population that changes eligibility frequently, utilized their CHIP model when faced with this situation. They went to a 12-month eligibility model in which an individual is eligible for a program for a year regardless of an upward change in circumstance. In terms of a negative change, they recertify eligibility for a broader program, again for 12 months. In some cases, this is to their monetary detriment but it has saved much overhead.

Another population to contemplate is that of employers who provide and who don't provide insurance to their employees. The average insurance premium for Employee-only coverage in a small group in West Virginia is $4,986 (*source*: Kaiser Family Foundation). With 30,425 small employers (<100 employees on their payrolls), 761 mid-size employers (100 – 499 employees on their payrolls) and 1,148 large employers (500+ employees), the small employers make up the lion's share of the employer market. These populations will have an impact upon the exchange – whether employer or employee led.





Statistics show that across the nation, only 61% of small businesses today offer health benefits to their employees, leaving 39% of employees without insurance. The health insurance exchange is an excellent option for employers to once again offer insurance to their employees.

One of the best ways to communicate with small employers and encourage participation in a health exchange is through the local chambers throughout the state as well as the insurance broker community. The brokers represent a large portion of the small businesses who currently participate in health insurance benefits in West Virginia.

Based on data of the uninsured, combined with an understanding of the breakdown of small employers in the State of West Virginia, we believe 135,000 – 167,000 policies will be purchased in the health exchange, representing a little over 300,000 individuals.

While Cúram Software is not an actuarial firm, we do have some thoughts on risk adjustment methodologies. We recommend the use of both prospective and retrospective risk adjustment mechanisms to attract health plans to participate in the exchange. This would allow them to participate in a Risk Adjustment Board chaired by the Department of Insurance to address the concern of adverse selection within the exchange. Adverse selection, or the concern that insurers have that they will receive an unfair portion of the unhealthy population within the exchange, can be addressed through a combination of a prospective risk adjuster along with a retrospective risk adjuster on the back-end. The prospective risk adjuster could do some light underwriting to score the health of the individuals within the exchange and then premiums could be adjusted based on those scores to balance insurance premium payments across the multi-carrier environment of the exchange. Carriers may then have some reassurance that even if they receive a disproportionate number of unhealthy individuals in the exchange, they will receive some financial remuneration for accepting the additional risk.

Furthermore, a retrospective risk adjustment could take place among the participating carriers so that after an agreed upon period, claims could be reviewed and then claims that fall within a certain range could be reinsured across all carriers. The combination of prospective and retrospective risk adjustment along with oversight from a Risk Adjustment Board could help protect from adverse selection and help manage margins in the new era of ACA where Medical Loss Ratios (MLRs) strictly manage the ability of the carrier to make margins within their business.

Typical revenue sources for administration of health exchanges have thus far been a fee attached to the purchase of an insurance product in the shopping portal – 2.5% - 3.5% seems to be an average. Additionally, a broker fee could be imposed on top of the insurance

product cost. In some states, the broker commission comes from the same administration fee and in others, a flat fee has been attached above and beyond the exchange administration fee.

Keep in mind that if West Virginia chooses to have the broker fee paid by the exchange rather than the carrier issuing the policy, it may then be advantageous to charge the carrier a referral fee as they will not have the additional expense of paying a broker. This strategy ultimately helps the MLR calculation in favor of the carrier and can increase their margins. This savings should be passed on in the way of premium reductions in an exchange where the broker fees are paid by the exchange and then the exchange may choose to receive the additional benefit of sharing in that favor by charging the carrier a referral fee.

This strategy is controversial inside the broker community, but as MLR restrictions are being implemented, brokers are seeing their commissions shrink in the traditional market. Having brokers receive commissions from the exchange or even directly from employers may be better in the long run for both the carrier as well as the broker.

Ultimately, the financial stability of the exchange must likely be accomplished through a creative strategy of administration fees on policies sold through the exchange, referral fees from carriers for policies sold, and possibly training and/or referral fees assessed to brokers selling policies in the exchange.

Detail what additional information or clarifications would be needed in order to prepare a comprehensive proposal in the future.

The following items would be of value in the preparation of a comprehensive proposal in the future:

- In order to provide additional modeling information, it would be necessary to understand in more detail the number of small employers currently operating within the State of West Virginia as well as average annual salaries within the small employer community.
- It would also be helpful to understand the details of workgroups that may already be in existence to address the needs of the health insurance exchange.

- We would also like to know who are the major insurance carriers in West Virginia and what percentage of the markets do they currently hold in individual and small group insurance.
- Finally, is there a regional president for the National Association of Health Underwriters that may or may not be involved in the process of helping understand the market?

Approach

Based on the project information provided to date, briefly describe the approach you would recommend for this project and why.

The State of West Virginia is seeking expert advice as well as subject matter expertise on best practices to develop and implement a health insurance exchange in the state. It is important while doing so that the provisions of the Patient Protection and Affordable Care Act are accounted for in all aspects of the exchange.

Cúram Software understands the complexity presented through Healthcare reform. Cúram Software is the only product vendor representing industry on the Health Information Technology Committee. Cúram understands the challenge enough to know, no single vendor can deliver healthcare reform in a box.

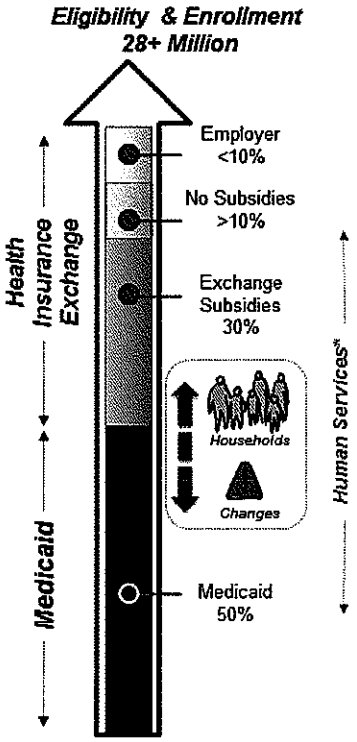
We understand that a public health insurance exchange must accomplish three high-level activities: 1) Determine eligibility for assistance in obtaining health insurance, 2) Support enrollment in health plans, and 3) Qualify health plans to be included in the exchange.

Through our own domain knowledge as well as existing partnerships, Cúram Software can deliver on the requirements of this RFI and make the required recommendations for this project. Cúram Software customers benefit from a wide range of industry subject matter experts, former legislative analysts, and federal employees, charged with remaining on the cutting edge of all developments related to health care reform and how the evolution of reform changes will affect eligibility, enrollment and ongoing life event maintenance in an exchange.

Healthcare reform consolidates a number of processes and systems across multiple functional areas. Cúram Software recognizes that central to success of a health insurance exchange is a flexible eligibility and enrollment solution. The number of new programs being introduced through healthcare reform is still being finalized and the approach to managing eligibility and enrollment to these programs is still being interpreted. Cúram Software is focused on partnering with states to address the healthcare reform challenge. Only Cúram Software has the experience and expertise, combined with the core product and development resources to

ensure states have proper support for meeting not only initial healthcare reform deadlines, but changes that arise as healthcare reform policies are refined.

While all health care reform processes play a key role in delivering a complete solution, eligibility and enrollment are at the core of the transformation that lies ahead.



The ACA will result in an additional 28 - 32 million citizens receiving government health care through a number of program changes:

- Medicaid – The role of Medicaid will expand up to 50% through ACA, this includes traditional Medicaid, Aged, Blind and Disabled and Long-Term Care, as well as expanded Medicaid and Children's Health Insurance (CHIP) options for states.
- Subsidized Plans – ACA introduces cost-sharing, subsidized plans for families earning up to 200% of the federal poverty limit (FPL). Tax credits will be applied to families earning up to 400% of the FPL.
- Qualified and Employer Plans – Individuals shopping for plans will be required to have access to plans through their state health insurance exchange, and small employers will receive incentives to provide employees with insurance through their state's exchange.

The ACA calls for major changes in process design to improve efficiency and effectiveness. The entire eligibility and enrollment experience should be streamlined, seamless, real-time, paperless, channel independent and centered on the citizen. Improved efficiency through automation and simplification is a clear-cut objective. The Act also seeks to achieve greater effectiveness through a citizen-centric approach, which will prove to be a more challenging and transformational goal for leaders of health reform.

Cúram for Health Care Reform provides a seamless user experience via a "unified front end" that spans users, programs, and channels across all required eligibility and enrollment

processes in the health insurance exchange. By leveraging a common system of record for eligibility, it provides critical functionality as families shop for and enroll in coverage across both public and commercial health plans in the exchange and provide on-going enrollment support as their circumstances change over time. All key business processes for enrollment and eligibility are configurable and span initial inquiry, screening, application submission, intake and verification, eligibility determination, renewals, and changes in circumstances. Multiple, program-specific business process models can be supported, including the ACA's streamlined business model and "traditional" enrollment and eligibility models like specialized Medicaid programs and human service programs like SNAP, TANF, etc. Cúram provides role-based access for all stakeholders, including citizens, agency workers, community partners, and providers. As a "no wrong door" solution, it is channel agnostic and permits enrollment through any organization, program, location, and geography. The platform also supports the full range of interaction models for enrollment – full service, assisted service, and self-service – and supports all communication mediums, including Web, phone, and paper.

Change is a Constant

Under health care reform, states will face new complexity in managing the changes that will take place within and around systems supporting health care reform. Cúram Software has identified five change principals that states must address for effective management of state health care reform policies. These include:

- Income Changes
- Household Changes
- Coverage Changes Policy Changes
- Technology Changes

Income Change – The ACA defines income based on an individual's gross adjusted income from his IRS tax return. As a result, a client applying for health care in March will be referencing income information that is 15 months old. A lot can happen to an individual's income in that period of time. Cúram is designed to manage not only the capture and storage of IRS income data, but management issues and verifications required when that data does

not align with current income. In doing so, Cúram provides states with a flexible solution for determining program eligibility.

In addition to supporting income management at the front-end of the process, Cúram also supports the management of changes to income once a client is enrolled in a health care plan. Current health care reform policies do not specify processes when a client loses his job mid-way through the year. Based on experience in the social services industry, Cúram Software anticipates this policy will be refined over time. Regardless of how the federal government decides to implement policies for capturing and managing plan changes, Cúram's flexible rules-based solution is built to support these processes.

Cúram delivers states a common front-end for all eligibility, enrollment, and account management functions. When a client loses his job, Cúram's life event management capabilities initiate a number of activities:

- Understand all relevant information that must be captured to effectively process the change
- Notify the carrier of the changes to the previous health care plan and the effective date of those changes
- Notify the financial broker of changes to the previous health care plan and the effective date of those changes
- Refer the client to new health care programs, if applicable
- Provide clients with an overview of new plan enrollment options
- Refer the client to additional government services, if applicable
- Refer the client to relevant community services
- Send updated client information to relevant back-office systems

By delivering eligibility for all government programs through a unified front end, Cúram provides clients with a seamless experience. From an administration perspective, the unified front end certifies clients are always enrolled in the correct program with much of the reporting required to demonstrate compliance initiated out of the common front end.

Household Change – Similar to income, the ACA follows the IRS tax definitions for households. Over the course of 15 months, clients will have dramatic changes in their household composition. In Massachusetts alone, 25,000 individuals change their status each

month. Just as the Cúram solution captures and manages the reporting of income changes, it also supports states in capturing and managing the reporting of household composition.

The case of household composition represents a unique challenge for states. ACA defines households according to IRS tax filings, but the U.S. Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, defines households based upon who prepares food together, and Temporary Assistance for Needy Families (TANF) defines households based upon individuals residing under one roof. As a result, though a client may report a change in household composition through the common front end, this change can be interpreted differently by at least three programs running in the background.

In addition to providing out-of-the-box capabilities for reporting household change, Cúram provides the ability to manage which programs update their information based on that change. The Cúram solution features an evidence architecture, which supports the storage of evidence (attributes and information) and updates relevant program information based on the evidence rules for that program.

The Cúram evidence management approach is different from a master data management (MDM) strategy. MDM offerings focus on how and when to synchronize information across systems to deliver a "single view of the client." In contrast, the Cúram evidence architecture recognizes the client record needs to be program-aware to ensure compliance. As a result, Cúram supports multiple views of evidence (e.g., household, income, assets) based on the rules governing how evidence should be applied across specific programs. Cúram Evidence Broker™ automates updating of information both across Cúram and legacy systems.

Coverage Changes – The ACA provides broad coverage for a wide variety of clients across multiple programs. As a result of CHIP expansion and the introduction of subsidized plans, states will end up with families that span multiple programs. For example, a mother is on a subsidized plan, a father is on an employer-subsidized plan, and a child is on CHIP. Technically, each of these plans is a "program" with different rules defining which plans are available for each program. The danger of implementing a siloed, program-centric approach to health care reform arises when a family or "coverage unit" spans programs. In the example of the mother, father, and child on separate plans, this coverage unit still wants to coordinate doctors and analyze the best plan selection for the whole unit, not just one individual.

Through the use of rules and pre-built exchange integrations, Cúram will support the ability to shop for plans across the "coverage unit," reviewing options that work best for the unit as a whole.

Policy Changes – The ACA is currently being challenged in courts around the nation. Regardless of the outcome of these court cases, any reform effort this large will undergo a series of policy changes as our elected officials refine their approach to health care reform. As a result, states must implement a solution that adapts to policy changes. At Cúram Software, we believe the management of policy changes starts in the development organization. Eligibility rules and the relationship between those rules and core systems are essential to delivering a social services commercial off-the-shelf (COTS) product. As a result, Cúram delivers customers the rules they need to run more than 50 government programs out-of-the-box. This approach dramatically reduces the time and effort required on the part of government agencies to initiate policy changes in house.

Cúram Software customers benefit from a wide range of industry subject matter experts, former legislative analysts, and federal employees, all of whom are charged with culling legislation and policy documents to identify policy changes. Cúram development analyzes the impact of these policy changes and releases a roadmap to customers for product and rules updates. When new legislation is introduced, such as the ACA, Cúram not only provides an initial program module supporting eligibility and enrollment, but also supports states through the political tides by delivering regular product updates – ensuring the Cúram solution maps to federal standards at any given time. Because Cúram is solely focused on social services, the company is not sidetracked by competing priorities. Our commitment is backed by the largest social services development organization in the world.

In addition, Cúram recognizes that, regardless of its commitment to delivering rules out-of-the-box, there are instances where the state is required to initiate policy changes in-house. In these instances, Cúram's existing rules and data definitions provide rules editors for a strong starting point to modify policies. Cúram delivers graphical business editors for managing rules changes so states are able to quickly adapt to ACA policy modifications in a timely fashion.

Technology Change – The ACA provides states an opportunity to implement architecture capable of supporting them into the future. In selecting a partner, it is not only important to

evaluate the future roadmap for the proposed application, but to evaluate the ability of that platform to adapt to emerging trends.

Cúram is a COTS solution dedicated to the health and human services market. Because of this focus, the company is able to invest in applying the latest technologies and trends to support health care reform delivery. Since demonstrating its innovation by being the first true COTS product, Cúram Software has continued to invest in its product and deliver new innovations to the market. The most recent Cúram V6 release incorporates a modern user interface, embedded analytics, graphical editors for configuring programs, and modern approaches to service delivery, such as iPhone applications and outcome management. As the company looks toward health care reform, customers will benefit from out-of-the-box program support, integration with best of breed exchange and financial management vendors, and a service oriented architecture (SOA) capable of communicating with legacy architectures. Because Cúram is a COTS solution, customers can make changes through configuration, not customization. In addition, as new releases ensue, customers can seamlessly upgrade the product to take advantage of next-generation capabilities and maintain technical currency.

Moving Forward

Today, Cúram delivers unparalleled eligibility and a comprehensive unified front end that offers the most advanced screening, intake, and enrollment support available. Further, Cúram can be integrated with existing legacy systems to protect your current investments, while providing a modern, common front end. Understanding that the health care reform policies and requirements are still being defined, Cúram is uniquely positioned to quickly incorporate these requirements into the solution. To this end, Cúram will provide a fully enhanced Cúram Medical Assistance in mid 2011 delivering new rules, new evidence and new workflows meeting all the ACAs Medicaid requirements. Over the next two years, as federal regulations are clarified and modified, Cúram Software will continue to invest, ensuring your agency is able to meet 2014 deadlines.

Conclusion

Health care reform represents a tremendous challenge for states. Implementing a full health care reform solution is complex, with a wide array of systems and processes coming together to support broad sweeping reforms. At the core of health care reform is eligibility and enrollment. This system will serve as the central hub for orchestrating all supporting processes.

Health care reform introduces a number of new programs that will need to be managed through the eligibility and enrollment system. In selecting a partner, states require a vendor committed to the health and social services sector and capable of investing at the level required to meet federal deadlines. Cúram Software understands the challenges states are facing and is committed to helping them meet that challenge and capitalize on opportunities for modernization.

In selecting an eligibility and enrollment partner, states must look toward a vendor capable of adapting to change. Cúram for Health Care Reform was developed to handle all aspects of statutes and eligibility changes, including income, household, coverage, policy, and technology changes.

By investing in Cúram for Health Care Reform, West Virginia has an opportunity to transform service delivery on a platform capable of evolving and supporting you well into the future.

Attachments

Our response includes three copies of each of the following:

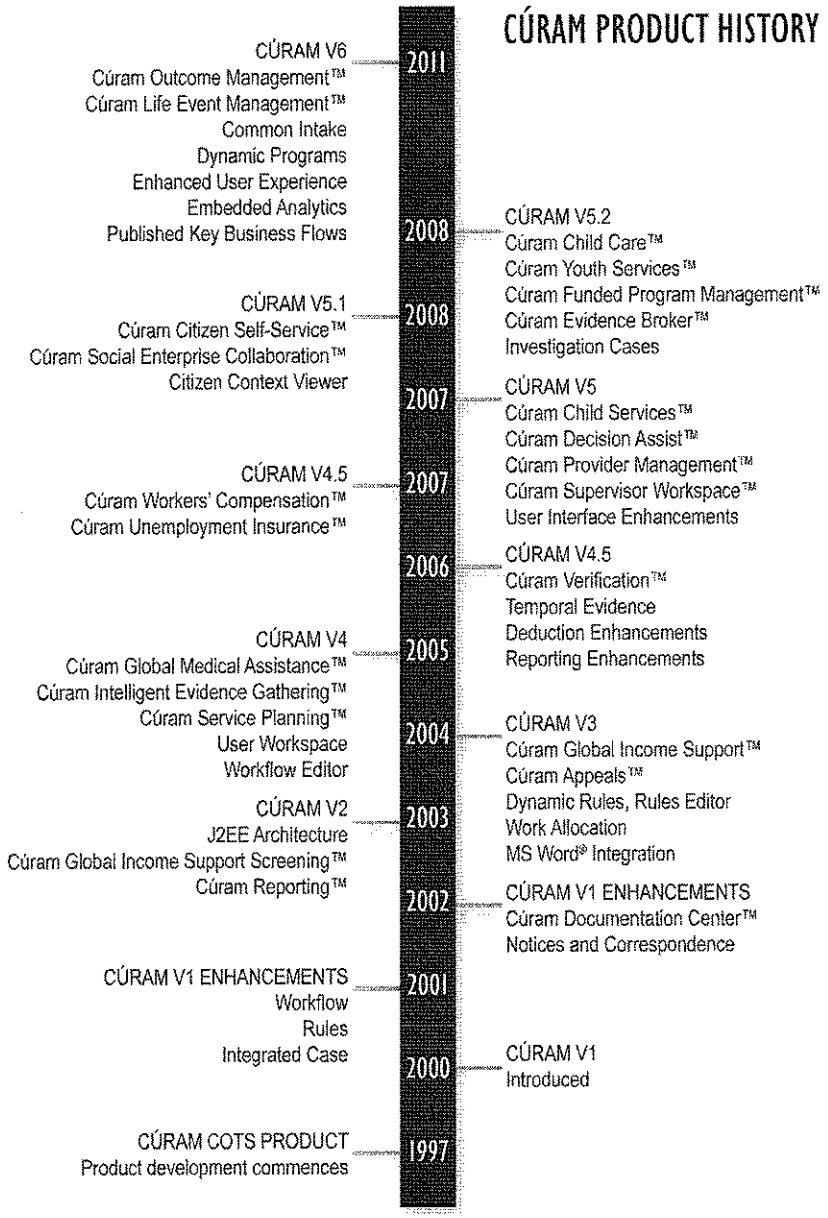
- **Cúram Software Company Overview**
- **Cúram for Health Care Reform** (*Cúram Software brochure*)
- **Affordable Care Act: Questions to Consider** (*Cúram Software brochure*)
- **Governance Issues for Health Insurance Exchanges** (*Health Policy Brief, National Academy of Social Insurance, 2011*)

Cúram Software – Company Overview

Cúram Software Inc. is a software technology company that has developed a suite of enterprise software products known as the Cúram Business Application Suite. Our product suite is designed specifically for organizations that administer human services, social services, and workforce services programs. We also provide a range of accompanying services, such as training, support, and consulting.

Cúram Software created and pioneered the concept of Social Enterprise Management (SEM), a business model based on the key objectives of social enterprises worldwide – to provide care and protection for citizens and their families in times of need and to help them achieve their social and economic potential. SEM is an innovative business and technology blueprint that has been made possible by the Cúram Business Application Suite.

Our company's sole focus is the delivery of solutions for social and human services organizations based on the Cúram Business Application Suite. Since 1997, six major product generations of the Cúram Business Application Suite have been released. Cúram Version 6 is scheduled for release in April 2011 when it will be launched at the Cúram Software International User Conference. The schematic below summarizes the product releases and the key capabilities delivered with each release.



Cúram Software works closely with system integrators and technology partners who have major practices in government and human services. Through the Cúram Software Partner Program, worldwide social enterprises have access to a competitive array of experienced and certified Cúram practitioners. The company's system integration partners include Accenture, CGI, Deloitte, Haverstick, RedMane, HP Enterprise Services (formerly EDS), IBM, and Unisys. Cúram Software has also been successful in working with local partners preferred by state and provincial governments.

Technology partners include such major vendors as Hewlett-Packard, IBM, Oracle, and SAP. Cúram Software's dedication and leadership in the SEM market, together with its practice of engaging with world-class system integrators and technology partners, have resulted in an

expanding list of government clients worldwide who are enhancing their business capabilities, lowering costs and improving results by focusing on outcome-based service delivery.

Cúram Software maintains ongoing dialogues with clients, federal and state agencies, and industry leaders through structured information-sharing sessions, engagements, enhancement requests, and the Cúram Software User Conference. Cúram Software is also involved in industry groups such as the Human Services Information Technology Advisory Group (HSITAG), the American Public Human Services Association, and its IT Solutions Management affiliate (APHSA-ISM).

Headquartered in Dublin, Ireland, Cúram Software's North American headquarters is located in the Washington, DC metropolitan area. Cúram Software offices are also located in Europe (Ireland, the UK and Germany), Canada, India and Australia.

Background and Experience

Cúram Software was founded in 1990 by John Hearne (Chief Executive Officer) and Ronan Rooney (Chief Technology Officer) in Dublin, Ireland. Prior to the company's formation, Mr. Hearne had worked as a technology industry executive while Mr. Rooney was a senior IT manager in the Irish Department of Social Welfare. During their tenure in these positions, they personally experienced the challenges of transferring software from one social services agency to another. As a result of these experiences, together they envisioned a software company dedicated to providing solutions specifically for human services and social security organizations.

Formerly named IT Design, the company has evolved from its custom application development and system integration beginnings to become the leading provider of commercial-off-the-shelf (COTS) software in the social enterprise management (SEM) market, as confirmed by analysts such as Forrester Research. True to the company founders' vision, the Cúram Business Application Suite has revolutionized services delivery for social enterprise by incorporating industry best practices and the guiding principles of a SEM solution, which uniquely allows organizations to implement a true client-centric integrated service delivery model suited to their business needs.

Since 2000, when the first version of the Cúram Business Application Suite was released, Cúram Software has focused on the ongoing expansion and enhancement of its flagship product for deployment in social enterprise organizations throughout the world. This commitment, in combination with the social sector background of its founders and employees, and consistently collaborative relationships with its customers, has led to global recognition of Cúram Software as the thought leader for social enterprise management (SEM) software solutions.

Cúram Software offers unsurpassed experience with social services customers globally and an unparalleled product offering that incorporates best practices from around the world, thus reducing risk and drastically increasing project success.

Cúram Software is the only vendor to provide proven, commercial-off-the-shelf (COTS) product solutions for State health and human services departments. By delivering a robust and flexible platform, the Cúram solution enables organizations to deliver on a strategy that supports the unique requirements of each organization and program and also exploits inherent commonalities, resulting in true integrated case management and service delivery.

A top priority for social enterprises worldwide is the long term well-being and self-sufficiency of the individuals and families they serve; a goal often made more difficult by aging legacy systems which are difficult to use, and costly to maintain and modify. Cúram delivers a modern, comprehensive and componentized solution for social enterprises, supporting a "No Wrong Door" approach for clients and an outcome-focused approach to the enterprise.

Cúram provides a suite of applications and tools for use by caseworkers, supervisors, system administrators, and developers to fully support an integrated eligibility case management model for social services organizations. Cúram supports the full spectrum of social service and social assistance programs and the business requirements—including integrated case management and provider management—of social enterprise organizations in the public sector.

Cúram has been deployed successfully to human, social, and work force services agencies throughout the world, including U.S. state agencies, Canadian provincial ministries, and national government agencies. For each customer, Cúram Software is delivering the benefits of a COTS solution, including comprehensive out-of-the-box capability, documentation, ongoing technical support, product maintenance, upgrade assistance, and continuous research and development. Cúram has been designed from the beginning to meet the unique needs of social enterprise organizations and to address the challenges that these organizations face.

A partnership with Cúram Software brings the collective knowledge and experience of our extensive customer base. Many of our customers have collaborated and successfully partnered with Cúram Software to solve similar business challenges, deploying solutions that transform service delivery, improve outcomes for individuals and families, empower workers, and provide agencies tasked with managing these programs with improved effectiveness and efficiencies. This experience is invaluable and serves as a constant source for enhancing the product, perfecting implementation techniques, and training our global services organization

Currently one of the co-founders of Cúram Software is a member of the Health Information Technology Committee for the implementation of integrated eligibility in support of the Affordable Care Act health insurance exchange implementation by 2014. This is just one example of the industry view of Cúram Software as a thought leader in enterprise social services delivery. Cúram Software will continue to provide enhancements to the product suite and updates to the rules for determining eligibility as a result of the changes in federal policy.

Cúram Software's implementations range in size from several hundred to tens of thousands of internal government users.

CÚRAM®
SOFTWARE

AFFORDABLE CARE ACT: QUESTIONS TO CONSIDER

The Affordable Care Act (ACA) supports two distinct populations - traditional Medicaid enrollees and Individual Qualified Plan enrollees. What is your state's strategy for providing a "no wrong door" approach for these two groups, since 50% of enrollees will migrate across programs?

Cúram Software believes that the biggest challenges facing ACA clients are eligibility, enrollment and the processing of change in circumstance. The two populations, traditional Medicaid enrollees and individual qualified plan enrollees, will experience life events that will force up to 50% of enrollees below the 200% Federal Poverty Line to migrate between the two types of plans throughout the year. As a result, the preferred method to support all ACA participants is through the creation of a common front end, supporting enrollment for all populations, regardless of program.

How does your state plan on governing ACA?

Since ACA applies to both Medicaid and individual qualified plans, there are two agencies that naturally have a stake in managing the process, the health and human services agency and the insurance agency. In a Cúram implementation, the HHS agency manages its enrollment portal and the insurance agency manages its enrollment portal. Underlying both of these portals is a single architecture and data model that supports eligibility and plan selection. Through this approach, the user experience for each agency has its own look and feel. This allows for outreach campaigns and life event capture to its audience, while the state obtains the benefits of a single data model. As clients report life events that move them from Medicaid to Individual Qualified Plans (or vice versa), the Cúram solution enables clients to continue accessing services as they always have without a need to re-apply.

There are a number of healthcare plans introduced through ACA and each is largely dependent upon income which fluctuates greatly within this population. What is your strategy for supporting change in circumstance?

By implementing a unified front end, the Cúram solution is able to provide the agency with a true no wrong door approach to ACA. Clients are able to report change in circumstance to either the Department of Insurance or the Department of Social Services. Regardless of the program or channel, Cúram captures change in circumstance, processes it against all relevant rules and delivers a consistent response. Many solutions are capable of calculating initial eligibility. Cúram, however, is the solution developed specifically for ensuring consistent results by capturing change in circumstance and accurately re-determining the best plan for a client.

What is your state's approach for supporting families where parents may be on Individual Qualified Plans and children are on CHIP?

The Cúram solution is family-centric. As a result, families with split plan enrollment can view information for all members regardless of

Health Policy Brief

January 2011 ■ No. 1

NATIONAL ACADEMY OF SOCIAL INSURANCE

Governance Issues for Health Insurance Exchanges

By Paul N. Van de Water and Richard P. Nathan

Summary

Federal health reform legislation encourages states to establish health insurance exchanges that will promote effective competition for health insurance and offer a wide selection of coverage options to individuals and small businesses. The law gives states four options for structuring the governance of an exchange: a state government agency (either existing or newly created), a nonprofit entity established by the state, or a multi-state exchange. It also provides states the flexibility to establish one or more sub-state exchanges serving geographically distinct areas within a state. If a state does not wish to establish an exchange, the federal government will operate an exchange in the state.

States offer a range of models for health insurance exchanges, and there is no one correct approach. The Utah Health Exchange was established within an existing state agency. The Commonwealth Health Insurance Connector Authority in Massachusetts is an independent public authority inside state government. New Mexico is considering establishing a nonprofit public corporation.

Whatever form of governance a state chooses, it will have to address most of the same issues, including the exchange's political independence and accountability, preventing conflicts of interest, the extent to which the exchange will be subject to various general laws affecting its operations (such as hiring and procurement), the exchange's sources of funding, financial reporting requirements, and more. Establishing a nonprofit entity, multi-state exchange, or sub-state exchanges would raise additional issues. A state must also consider what forms of governance are permissible under its own constitution.

Because a health exchange will face many unanticipated challenges, states should consider giving the exchange substantial flexibility and discretion in setting policies. The statute establishing a state's exchange can leave many issues to be worked out later by the exchange as more information becomes available and the exchange gains experience.

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The new federal health reform legislation (the Patient Protection and Affordable Care Act, or ACA) relies heavily on the creation of state-administered health insurance exchanges to make health coverage available to individuals and small businesses. The Congressional Budget Office (CBO) estimates that by 2019 approximately 24 million people will purchase their own coverage through the new insurance exchanges. In addition, certain employers can allow their workers to choose among the plans available in the exchanges, and another 5 million people will obtain coverage in that way. In total, an estimated 29 million people will be enrolled in exchange plans in 2019.[1]

The ACA offers states several choices for structuring the governance of their health insurance exchange. This paper explores the issues that arise in choosing among the possible forms of governance and identifies advantages and disadvantages of each approach. It focuses on structural issues that need to be addressed in a state's initial legislation establishing an exchange — not on the specific administrative and policy decisions that an exchange will ultimately have to make, which are largely independent of governance.

Functions of a Health Insurance Exchange

In deciding which form of governance to choose, it is important to keep in mind the purpose and functions of an exchange. The governance and organizational design of an exchange, like that of other agencies, must be tailored to reflect the requirements of the programs that it must administer. As a panel of the National Academy of Public Administration has written, "The architectural principle that form follows function also applies to the design of government."[2]

Health insurance exchanges are designed to promote effective competition for health insurance by increasing consumer choice and providing transparency on the cost and quality of plans. Exchanges will offer a wide selection of affordable, good-quality health coverage options to individuals and small businesses. To achieve this goal, exchanges will perform a wide range of functions, including the following:[3]

- Administer a system of qualified health plans
  - —Certify plans that are qualified to participate in the exchange
  - —Rate plans based on their quality and price
  - —Review plans' premium increases
- Support enrollment in health plans and assist consumers
  - —Facilitate initial, annual, and special open enrollment periods for individuals
  - —Facilitate participation by small businesses in a separate Small Business Health Options Program (SHOP) exchange or a single unified exchange
  - —Maintain a website that provides standardized information on the price and quality of health plans, and operate a telephone assistance line

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1 Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Nancy Pelosi, March 20, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

2 National Academy of Public Administration, Standing Panel on Executive Organization Management, *Principles of Federal Organization,* January 1997.

3 Most of these functions are listed in section 1311(d)(4) of the *Patient Protection and Affordable Care Act,* Public Law 111-148. Section 6 of the National Association of Insurance Commissioners' *American Health Benefit Exchange Model Act* also lists the duties of an exchange, http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.

—Establish a system of Navigators, entities that will conduct consumer education activities and facilitate enrollment in qualified health plans

- Determine eligibility for assistance in obtaining health insurance

  —Determine which participants in the exchange are eligible for advance premium tax credits and cost-sharing subsidies, subject to appeal of decisions to the Secretary of Health and Human Services (HHS)

  —Assure that eligible applicants are enrolled in the appropriate health program (Medicaid, CHIP, basic health, or exchange subsidies) and health insurance plan

  —Administer the system of employee free-choice vouchers

  —Certify exemptions from the requirement for individuals to maintain health insurance coverage and from the penalty for failing to meet the requirement

- Consult with relevant stakeholders with regard to carrying out these activities.

Defining Governance

"Governance" encompasses questions such as the following: Where is the exchange located institutionally? Who are the policy-making and administrative officials of the exchange, and how are they chosen? How is the exchange funded? What kinds of policy decisions is the exchange empowered or required to make? What flexibility does the exchange have with regard to personnel, procurement, and other administrative matters?

Issues of governance must be distinguished from issues of policy, although no bright line separates the two. For example, some exchanges may be highly selective in certifying health plans to participate in the exchange, whereas others may decide to accept all plans that meet specified standards.[4] The outcome of that policy choice does not necessarily depend on whether the exchange is operated by an existing state agency, a new state agency, or some other entity. Nevertheless, the governance of the exchange could in some cases affect the outcome of its policy decisions.

The amount of operational flexibility that an exchange is permitted is also distinct from how the exchange decides to use that flexibility. The ACA explicitly authorizes an exchange to contract with a company (other than a health insurer) or the state Medicaid agency to carry out one or more of the exchange's functions.[5] For example, the exchange has the responsibility to determine eligibility for the advance tax credits, but it could contract with a private firm or the Medicaid agency to perform much of that function, subject to review and appeal. Many public entities contract out call centers, websites, or data processing facilities; others operate them in-house.

Current Situation

To be fully operational in 2014, as the law requires, exchanges will have to certify health plans, hold an initial enrollment period, and complete many other tasks in 2013. By January 1, 2013, the Secretary of HHS must determine whether a state's exchange is on track to meet the 2014 deadline; if not, she must establish a federal fall-back exchange in the state.[6] The amount of work required to create a functioning

4 Robert Pear, "Health Care Overhaul Depends on States' Insurance Exchanges," *New York Times*, October 23, 2010, http://www.nytimes.com/2010/10/24/health/policy/24exchange.html.

5 Section 1311(f)(3).

6 Section 1321.

exchange is substantial and will consume all of the time available. Legislative calendars add to the pressure. Some states will hold short biennial legislative sessions in 2011 and will not meet again in regular session before the planning deadline.

Inside state governments, the wheels of implementation are spinning.[7] Since March 23, 2010, when the ACA was signed, rapidly increasing activity, consultation, and planning have been going on. In September 2010, the Secretary of HHS awarded initial planning grants of about $1 million each to the 48 states that had applied for them. Even in states that are challenging the law, lawmakers recognize that they need to be ready to implement it. Some cite the threat of the federal government operating an exchange in place of a state version as motivation, although HHS has not yet specified the form that the federal fall-back exchange will take. Most states have established several planning groups and subgroups addressing a range of issues posed by the ACA. Choosing a governance structure is the first decision that states must make. Many specific implementation issues can be addressed through later legislation, or can be delegated to the exchange to decide, but governance issues must be settled soon.

Choices for Structuring Exchange Governance

The Affordable Care Act offers states four basic choices for structuring the governance of a health insurance exchange: a state government agency (which may be either an existing agency or a new one), a nonprofit entity established by the state, or a multi-state exchange.[8]

Existing State Agency

Several existing state agencies could become the home for the new health insurance exchange. These include:

- The state Medicaid agency;
- The insurance department or commission;
- The consumer protection agency;
- The department of administration and finance or other agency responsible for the coordination and management of state government;
- The department of labor or other agency responsible for overseeing the terms and conditions of the workplace;
- The department of revenue or other agency responsible for tax collection; or
- The agency administering health benefits for state employees.

On the one hand, placing the exchange within an existing agency would allow it to benefit from established administrative systems and procedures. This might ease the job of establishing an exchange and enable states to act with greater dispatch. Relying on a tried and true organizational structure could also facilitate inter-agency coordination, which will be essential for the effective implementation of health reform. Finally, each of these agencies has expertise in at least one area of the exchange's operations.

On the other hand, the work of the exchange will be substantial and could easily overwhelm an existing agency. No existing state agency has experience with all of the functions that an exchange will have to

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7 See National Conference of State Legislatures, *State Actions to Implement the American Health Benefit Exchange,* http://www.ncsl.org/default.aspx?TabId=21388.

8 Section 1311(d)(1) and section 1311(f)(1).

perform. An existing agency might attempt to fit its new activities into old ways of doing business rather than seek better, innovative solutions. It could easily focus on the areas most closely related to its traditional areas of responsibility and not give enough attention to other tasks of the exchange. It is also likely to have long-established relationships with certain interest groups and may be insufficiently attentive to the needs and desires of stakeholders with which it has not previously had much contact.[9]

In particular, a careful balance must be struck between the exchange and the insurance department. The department's current task is to determine that insurers are financially solvent, meet regulatory requirements, and are otherwise legally qualified to sell insurance in the state. The exchange's job is to structure and referee the competition for health insurance and make the market work better for consumers. A single agency would find it challenging to reconcile these two substantially different roles, and locating the exchange within the insurance department could therefore prove problematic.

The Utah Health Exchange is operated by the Office of Consumer Health Services, which was established within an existing state agency (the Governor's Office of Economic Development) in 2008.[10] The Utah exchange currently performs only a few of the functions required by the ACA. It serves exclusively as a technology backbone for the state's new defined-contribution insurance market for small employers. It offers comparative information on health insurance plans, provides a standardized on-line application and enrollment system, and facilitates the aggregation of premium payments by individuals and employers. Premiums in the Utah exchange are not subsidized, and participation by small employers has so far been very limited. The regulatory aspects of Utah's health reform are housed in the state's Insurance Department.

Health planners in Utah recognize that their exchange will need major changes to be able to deliver subsidies to low- and moderate-income families and perform the many other tasks set forth in the ACA. The state has begun a planning process for implementing the new law, but how Utah will respond to the ACA's requirements is still to be determined.

New Governmental Agency

Another possibility is to establish the health insurance exchange as a new state agency, which could itself take various forms. The new agency could be an executive department reporting to the governor, or it could be an independent public entity with its own governing board. A new agency would be able to devote its full energies to establishing the exchange without being distracted by other responsibilities. Depending on its structure, it could also be freed from various existing procedural constraints (such as those on hiring and procurement), more insulated from political influence, and less likely to be swayed by particular interest groups.

Executive Department. The exchange could be operated by a new department in the executive branch of state government, although we are not aware of any state that is currently considering this approach. As with other executive departments, the department head would be appointed by and responsible to the governor. Some people would see this approach as assuring a high degree of political accountability, but others could view it as being overly subject to political considerations. It might also be difficult to exempt the exchange from administrative requirements that applied to other departments of government.

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9 Jost describes these potential problems in more detail. Timothy S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, Commonwealth Fund, September 30, 2010, pp. 6-7, http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf.

10 Utah State Legislature, H.B. 133 (2008), Second Substitute, Health System Reform, http://le.utah.gov/~2008/bills/hbillenr/hb0133.pdf.

Independent State Agency. The Commonwealth Health Insurance Connector Authority, established by the Massachusetts health reform legislation of 2006, exemplifies the independent agency approach.[11] The Connector is a public authority overseen by a board of ten directors. It runs two major programs: Commonwealth Care, which offers a choice of subsidized health insurance plans to those with low incomes, and Commonwealth Choice, which provides individuals and small businesses with access to a range of unsubsidized products. The Connector is also assigned other critical policymaking and administrative responsibilities, such as defining minimum creditable coverage for purposes of the state's individual mandate to obtain insurance, determining when coverage is affordable, establishing regulations for employers' section 125 plans, and informing individuals and employers about their options and responsibilities.

Although independent, the Connector is closely tied to the political process. Four members of the board are state officials who serve *ex-officio*, three are appointed by the governor, and three are appointed by the attorney general. The appointed members come from outside government, are chosen from specified categories (actuaries, health economists, small business, consumer organizations, organized labor, and employee benefit specialists), and serve for three-year terms.[12] The chair of the board, who is the governor's Secretary of Administration and Finance, selects the executive director, but the executive director views himself as being responsible to the entire board.

As a government agency, the Connector has the authority to issue rules and fill in details of the state's health reform that the legislature deliberately did not specify. It is also in a position to work cooperatively with the many other state agencies that also have important roles in Massachusetts health reform. By including on its board consumers, small employers, and other outsiders, as well as state officials, it has been effective in maintaining political legitimacy and popular support. Exemption of the Connector from various state contracting and personnel rules is viewed as making it a more nimble organization. The Connector is not exempt, however, from the state's rulemaking procedures or requirement for open meetings. The Connector operates with a staff of only about 45 full-time-equivalent employees and outsources most of its activities. The state Medicaid agency determines eligibility for subsidized health coverage, and private firms run the Connector's website, call centers, and enrollment and billing processes.

California has recently created the California Health Benefit Exchange, which follows the Massachusetts approach in many ways.[13] The California exchange is an independent public entity governed by a five-member board. The board comprises the Secretary of California Health and Human Services, two members appointed by the governor, one appointed by the Speaker of the Assembly, and one appointed by the Senate Committee on Rules. To avoid conflicts of interest, persons employed in health insurance or health care may not serve on the board. The board is subject to the state's open meeting rules, but its key executives are exempt from state salary limitations.[14]

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11 Amy M. Lischko, Sara S. Bachman, and Alyssa Vangeli, *The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions*, Commonwealth Fund, May 2009, http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Issue%20Brief.pdf. National Academy of Social Insurance and National Academy of Public Administration, *Administrative Solutions in Health Reform*, July 2009, http://www.nasi.org/research/2009/administrative-solutions-health-reform.

12 A recent law increases the size of the Connector board to 11 members in July 2011 and adds an insurance broker to be appointed by the governor. Critics have suggested that a broker member could face conflicts of interest. *Chapter 288 of the Acts of 2010,* August 10, 2010.

13 California State Legislature, *Senate Bill No. 900, Chapter 659, Statutes of 2010,* September 30, 2010, http://info.sen.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.pdf. *Assembly Bill No. 1602, Chapter 655, Statutes of 2010,* September 30, 2010, http://info.sen.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.pdf.

14 For more information about the rationale, purposes, and role of the California exchange, see California Health Care Foundation, *Briefing Transcript: The Role of the Exchange in California's Implementation of National Health Reform*, October 21, 2010, http://www.chcf.org/~/media/Files/PDF/S/PDF%20Sacto10212010HealthBenefitExchangeTranscript.pdf.

States with stronger provisions regarding the separation of powers may not be able to adopt a governance structure like California's, in which legislative leaders appoint members of the board of the exchange. In general, the legislative branch of government enacts laws, and the executive branch is responsible for carrying them out. Also, the legislature may lack the capacity to screen public appointments, which in most states is the task of the executive branch.

Nonprofit Entity

Establishing the exchange as a nonprofit entity, separate from state government, may provide even more independence from politics and more flexibility in operational matters. Too great a degree of separation, however, could leave the exchange politically isolated and make it difficult to communicate and coordinate with the other state agencies involved in implementing health reform. Since the state would retain ultimate responsibility for the exchange, it might be reluctant to assign its operation to an organization over which it would have limited control.

A state's constitution will affect in important ways its ability to establish a nonprofit exchange. In some states certain functions of the exchange could be considered inherently governmental because they involve exercise of one of the government's sovereign powers, such a levying taxes or regulating economic activity. Any such functions could probably not be turned over to a non-governmental nonprofit entity and would have to be performed by the state government or subject to state review. As Washington and Lee University law professor Timothy Jost emphasizes, "it is imperative that before considering the delegation of exchange responsibility to private entities states determine that doing so is constitutionally permissible."[15] Regardless of a state's constitutional constraints, to promote legitimacy and accountability, a nonprofit exchange should be required to adhere to the minimum constitutional requirements for due process. In addition, a nonprofit exchange could be required to meet additional statutory requirements applicable to government agencies, such as those regarding disclosure of public records, open meetings, conflicts of interest, financial reporting, auditing, and so on. The authorizing statute would also need to specify the immunity of employees and board members of the exchange from liability arising from performance of their legal duties.

In New Mexico, the Legislative Health and Human Services Committee has endorsed a bill that would create the New Mexico health insurance exchange as a "nonprofit public corporation, separate and apart from the state."[16] New Mexico's proposed nonprofit exchange would have many similarities to state-run exchanges. It would be run by a nine-member board that included two state officials as *ex-officio* members, three members appointed by the governor, and four members appointed by the legislature from designated categories. Although outside government, the proposed New Mexico exchange would be subject to the state's Open Meetings Act, Administrative Procedures Act, and "other statues and rules applicable to state agencies." Employees of the exchange would be considered public employees for purposes of New Mexico's Tort Claims Act, thereby shielding them from most tort liability. The day-to-day operations of the exchange would be carried out by an executive director, who would be authorized to hire and fix the compensation of staff members. The exchange would be authorized to contract with the state Medicaid agency, other state or local public health coverage programs, insurance brokers ("producers"), or other vendors to carry out one or more of its functions — but not with an insurance company. As a non-governmental entity, however, the exchange's decisions about eligibility for participation in the exchange, exemption from the individual mandate, and certain other matters would not be final and would be subject to review by the state's Superintendent of Insurance. Because the proposed New Mexico exchange would lack rulemaking authority, the superintendent rather than the exchange would also be responsible for promulgating rules to certify health benefit plans as qualified plans and for certify-

15 Jost, *Eight Difficult Issues*, p. 3.

16 New Mexico, Legislative Health and Human Services Committee, *An Act Relating to Health Insurance*, Endorsed Bill, November 10, 2010, http://www.nmlegis.gov/lcs/handouts/183033%205.pdf.

ing plans, although the exchange would determine which qualified plans could be offered through the exchange. Of course, other states interested in establishing a nonprofit exchange may face more or fewer constitutional constraints than New Mexico.

States have created a large number of public authorities and public-benefit corporations to construct, operate, or provide financing for a range of infrastructure projects and other activities.[17] These entities combine aspects of government agencies and private corporations and may suggest additional governance models for health exchanges. The legal arrangements are often specific to a particular state, however, and may not be applicable elsewhere.

Assigning governance of an exchange to a nonprofit entity is likely to raise a number of issues that would not arise if the exchange were a state agency or authority. For example, establishing the exchange as a private entity with providers or insurers in positions of control could increase the potential for conflicts of interest and heighten the likelihood of scrutiny under the antitrust laws. Whether the exchange's actions could be found to be in restraint of trade, or whether they would be protected as actions of the state, is not clear. Giving a non-governmental entity access to personal tax information, as would be necessary to determine eligibility for advance premium credits, could raise privacy questions. Other federal and state laws that do not apply to state governments could also have uncertain implications for a nonprofit exchange.

Multi-State Exchange

For some states — particularly small states, states with interstate metropolitan areas, or other states served by overlapping health plans — a multi-state exchange may be an attractive option.[18] A multi-state exchange could achieve economies of scale in administration. With a larger pool of participants, it might also attract more health insurance plans and lead to greater competition and lower premiums. Several states are said to be exploring the possibility of establishing regional multi-state exchanges.

Establishing a multi-state exchange would be more complicated than setting up a single-state exchange, however, and this paper can only touch on some of the issues involved. The participating states would have to enter into an interstate compact, most likely through the adoption of identical statutes, and Congressional approval might be required.[19] Most existing interstate compacts involve the operation of parks, bridges, or other infrastructure and provide little guidance for creating multi-state health exchanges. Since states could be reluctant to relinquish substantial authority and flexibility to an interstate body, working out the details could be time consuming, and states might be reluctant to embark on the process of creating a multi-state exchange when time is short and the probability of success uncertain.

Once created, a multi-state exchange could also face operational challenges. It would have to coordinate its activities with Medicaid, the insurance department, and other relevant agencies in each participating state. It would also likely have to deal with different regulatory regimes in each state. If the rules governing plans within a multi-state exchange differed from those governing plans operating outside the exchange in even one state, the exchange would find it difficult to prevent risk segmentation.[20]

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17 See, for example, Public Authorities Information Clearinghouse of the Government Law Center, Albany Law School, http://www.publicauthority.org/.

18 States may operate multi-state exchanges starting in 2014 if the participating health plans meet all the regulatory requirements of each participating state. Section 1333 of the ACA allows two or more states to enter into health care choice compacts that would allow qualified health plans to be sold in all such states but not be subject to all their laws and regulations; these compacts could not become effective until 2016.

19 See Council of State Governments, *Introduction/Overview: Interstate Compacts,* undated, http://www.csg.org/knowledgecenter/docs/ncic/Overview.pdf. The provision of the ACA authorizing multi-state exchanges could be interpreted as implicit Congressional approval of such compacts.

20 Linda J. Blumberg and Karen Pollitz, *Cross-State Risk Pooling Under Health Care Reform,* Urban Institute, March 2010, http://www.urban.org/UploadedPDF/412124-cross-state-risk.pdf.

Other Governance Issues

In addition to or as part of choosing an appropriate governance structure for an exchange, states must consider several related issues.[21]

Funding Sources

The ACA provides federal start-up funding to plan and establish the exchanges.[22] Beginning in 2015, states are to assure that the exchanges are self-sustaining, and an exchange may "charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations."[23] If an exchange is financed through assessments solely on plans that are offered in the exchange, plans that are offered only outside the exchange would have a competitive advantage.[24] Moreover, some functions of the exchange — notably the responsibilities to determine eligibility for subsidies and certify exemption from the individual mandate — constitute governmental tasks whose cost should be widely shared. States may therefore wish to consider a broad range of funding possibilities that are not limited to assessments on health insurance plans inside the exchange. Possibilities include a tax on all health insurers, including administrators of self-insured plans, or a tax on health care providers.[25]

Operational Flexibility

Whatever an exchange's form of governance, the state will need to determine the extent to which the exchange will be subject to various general laws affecting its operations. They include civil service and other personnel rules, contracting and other procurement requirements, and freedom of information or government-in-the-sunshine rules. These requirements were originally adopted to assure organizational accountability or prevent misuse of public positions and funds, but they are now sometimes viewed as impediments to government efficiency. Depending on a state's constitution, choosing a particular organizational form need not preclude granting additional operational flexibility. Conversely, public-private organizations can be made subject to some of the same procedural requirements as government agencies. In any event, the statute authorizing the exchange should avoid imposing overly detailed administrative requirements or constraining the exchange's operational decisions through personnel ceilings, limitations on contracting, or other legislative directives.

Political Independence and Accountability

A public or public-private exchange must maintain political accountability yet avoid undue political interference. There is no clear line, however, that separates accountability from interference, and different observers may view the same circumstances differently. State agencies and authorities are generally subject to established rules and procedures for executive management and legislative oversight. In contrast, a new nonprofit entity will be starting from a largely blank slate, and the authorizing legislation will need to specify the entity's legal responsibilities and the procedures for holding it accountable. In any event, maintaining a high level of public awareness and transparency is particularly important, as success of the Massachusetts Connector demonstrates. No matter what organizational form is chosen for the exchange, voters will hold their elected officials responsible if anything goes wrong.

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21 Some of the material in this section is based on Paul N. Van de Water, "Designing Administrative Organizations for Health Reform," in Terry F. Buss and Paul N. Van de Water (eds.), *Expanding Access to Health Care: A Management Approach*, Armonk, NY: M.E. Sharpe, 2009.

22 Section 1311(a).

23 Section 1311(d)(5).

24 Section 1301(a)(1)(C)(iii) requires a qualified health plan to charge the same premium both inside and outside the exchange. However, some plans may be offered only inside or only outside the exchange.

25 Jost, *Eight Difficult Issues*, p. 50. Medicaid provides a precedent for the use of provider taxes.

Management Structure

Independent authorities and nonprofit entities are generally governed by a multi-member board rather than a single administrator. Multi-member boards can help insulate agencies from possible political interference, but they may also impede accountability, since no one person is fully responsible for decisions, and they may be less capable of timely decision making. A relatively small board would be more efficient but would encompass fewer types of expertise and points of view. Whatever its size and makeup, the board must be constituted and viewed as impartial, experienced, and professional. A key issue is whether the board should include health care providers, health insurers, or brokers, who might stand to gain financially from the position, or whether it should be comprised largely of individuals representing consumers and small businesses, who will be the exchange's customers.[26]

The ACA requires exchanges to consult with various relevant stakeholders, including health care consumers, representatives of small businesses and the self-employed, individuals with experience in facilitating enrollment in health plans, and state Medicaid offices.[27] Some of these categories are likely to be included on an exchange's board. An exchange will have to develop procedures for additional consultation, if needed, but these procedures need not be specified in the authorizing statute.

Sub-State Dimensions

In many states, health insurance markets do not encompass the entire state. The ACA requires states to establish one or more health insurance rating areas, within which rates for a plan can vary only by age and tobacco use.[28] For example, the Commonwealth Connector in Massachusetts — with 6.6 million residents — has three rating areas. The California public employee system (CalPERS) has five rating areas. In addition, the ACA allows network health plans, such as health maintenance organizations, to have service areas that cover only portions of a state.[29]

The ACA gives states the flexibility to establish one or more "subsidiary exchanges" serving geographically distinct areas (but no smaller than a rating area) within a state.[30] The law does not specify, however, whether subsidiary exchanges would be independent or would be subordinate to state-wide governance. If subsidiary exchanges allowed more local control, they could lead to significant variations in policies, procedures, and health plans from one region of a state to another. For example, if subsidiary exchanges adopted different criteria for certifying health plans, the choice of plans could vary depending on where in a state an individual lived or worked. However, such variation would seem to conflict with the ACA's requirement that plans accept every individual or employer in a state that applies for coverage — a provision that might ultimately limit the independent authority that subsidiary exchanges could be allowed.[31]

A state considering the establishment of subsidiary exchanges should carefully examine which functions of the exchange would best be carried out uniformly throughout the state and which ones might benefit from regional variation. The state must then weigh these benefits against the additional administrative costs that would result from the duplication of activities by multiple exchanges. States looking at this option should also consider whether and how to coordinate subsidiary exchanges to avoid confusion among consumers and employers, achieve efficient administration, and facilitate dealing with insurance carriers and state and federal agencies.

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26 Jost, *Eight Difficult Issues*, pp. 6-7.

27 Section 1311(d)(6).

28 Section 2701 of the Public Health Service Act, as amended by section 1201 of the ACA.

29 Section 2702 of the Public Health Service Act, as amended by the ACA.

30 Section 1311(f)(2).

31 Section 2702 of the Public Health Service Act, as amended by the ACA.

Few, if any, local health program structures now exist that could serve as the basis for sub-state health exchanges, so new entities would have to be created. Health planning bodies have atrophied and, moreover, never had the capabilities and clout that would be needed for such a major undertaking. Similarly, neither county health departments nor county-based public-benefit corporations for health are likely to be prepared to take on the operation of a health insurance exchange.

Conversely, organizing a single state-wide exchange appears to have a number of advantages. It can provide residents with information the availability and cost of plans in different parts of the state without incurring the expense of establishing multiple exchanges. At the same time, it still might administer or deliver certain services (such as outreach, education, or enrollment) on a local basis.[32]

Small Employers

The ACA allows for two types of exchanges: one to serve qualified individuals and another (termed a "SHOP exchange") to serve qualified small businesses and their employees. A state may establish a single unified exchange to provide services to both individuals and small employers, however, as long as the exchange has sufficient resources to assist both classes of customers.[33] Creating separate individual and SHOP exchanges would raise many of the same issues of coordination and administrative efficiency that would apply to subsidiary exchanges within a state. Structuring exchanges to make them attractive to small businesses also involves many other issues that go far beyond governance.[34]

Conclusions

Several conclusions emerge from this analysis. First, there is no single right way to organize a state-based health exchange. Whatever form of governance a state chooses for its exchange, it will have to address most of the same issues, and the pieces can be combined in many different ways. For example, a given funding source or a particular set of operational flexibilities could be combined with virtually any organizational form, subject only to a state's constitutional requirements.

Second, the way an exchange is governed and organized does not determine its substantive policy choices. There is no reason to believe that an independent public authority would make systematically different decisions than a nonprofit entity in the same state. Nor would an independent authority in one state necessarily adopt the same policies as a similar authority in a different state.

Third, because a health exchange will face circumstances and challenges that cannot be fully anticipated, states should consider giving the exchange a substantial amount of flexibility and discretion in setting policies. Just as the ACA did not attempt to specify in law every detail of federal health reform, the statute establishing a state's exchange need not resolve all the important policy issues but can leave many of them to be worked out by the exchange as more information becomes available and as exchanges gain experience in performing their assigned responsibilities.

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32 Robert Carey, *Health Insurance Exchanges: Key Issues for State Implementation*, AcademyHealth and State Coverage Initiatives, September 2010, p. 4, http://www.rwjf.org/files/research/70388.pdf.

33 Section 1311(b).

34 Jost, *Eight Difficult Issues*, pp. 22-27. Note that establishing a unified individual and SHOP exchange does not require merging the individual and small-group insurance markets (that is, charging the same rates for the same plan in both markets).

This brief was produced as part of a project funded by the Robert Wood Johnson Foundation to develop a model state statute for health insurance exchanges and assist the states in understanding design and implementation issues under the Patient Protection and Affordable Care Act (ACA).

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