2-8-22 OHIM response to Jim Houser on questions RE 2019 SBM RFI comparisons

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Disclaimer: The information below is based on various assessments and other information over time that I've gathered on this subject. The analyses have not been subjected to strict peer review or fact-checking, and I have no citations added.
Aside from what was actually contained in our 2019 RFI, the rest is in large part prediction, estimation, and assessment based on what we have observed from other state experiences. I could explain the bases for any statements further if needed.

(original questions in bold)

***How different is what we were requesting in the RFI, and would be our relationship with a potential vendor than Oregon's experience with Oracle during the Cover Oregon period? What role would a tech vendor play if we chose them for our SBM tech?**

I could probably write a series of books on this question alone (that no one would read).

In the 11 or so years since work began on Oregon's first health exchange, the landscape of options and technology available to SBMs has completely changed.

To summarize:

- The primary differences between our 2019 RFI and the Cover Oregon IT project are:
    - Limited scope: The 2019 RFI did not include a solution for a replacement Medicaid system, nor would a future RFP unless it were over our objections. It did include the contracted call center concept, but both were specific to SBM needs only.
    - The technology portion of an SBM system now would only consist of a single procurement - in this market, states now have an option to engage a single vendor to handle the technology solution and implementation from front-to-back, including any needed hardware, software, programming, and related infrastructure.
    - Consequently, a procurement based on the RFI would be for a deliverables-based contract - if the vendor does not hit the milestones, they wouldn't get paid, and we wouldn't be out up-front infrastructure investment - which is substantially different than the original exchange setup.
    - Since this newer generation SBM migration has already been done by other states, and ours would be nearly identical, the associated timelines, risks, and roundabout costs are already known. Those are basically the opposite of what they were leading up to 2013, when no state had done this and each that was trying was doing it for the first time.

- Along with the Moore's Law kinds of changes that just happen naturally with IT tech over time, all of this together adds up to an implementation cost that's currently estimated around 1/20th of the Cover Oregon project costs, with maybe 1/10th of the ongoing FTE requirements if both IT and call center are contracted out.

- The relationship with the vendor would now be closer to a collaboration with them providing the services, while the vendor's role could be viewed as a contracted partner with mutual business interests in state successes:
  - The vendors know the health exchange business: Solutions must adhere to ACA rules, and unlike those first state exchanges, vendors now require a pre-existing in-depth knowledge of what we do just to have a presence in the market.
  - Consequently, vendors don't just need to meet requirements in a contract, they need to evolve their knowledge with ACA policy developments like we do in order to stay competitive. It's hard to overstate how much more efficient it is at every stage of the project when the vendor has done it before and does not to have to learn our business from scratch – we've had experience with this on a smaller scale with our window shopping tool
  - Now that there is an established SBM tech market, state vendor requirements rely more heavily on proven successes for this exact work rather than just general reputation as a big multi-national – and vendors need those proven successes to capture future business
  - If a vendor works with a state to successfully implement an innovative idea outside of the standard exchange setup (premium assistance program, public option, other wrap-around programs, etc.), it can then also market that success to other states.
  - In other words, since hitting all of the important milestones - full functioning on go-live, implementing a new program with an SBM technology, etc. - impact future business prospects for the vendor, there is much more incentive for vendors to plan for these realistically and successfully, with a much deeper well of specific experience to draw from.
  - There is also a business interest for the vendor in getting new ideas implemented correctly and efficiently to be able to market those and add to their proposal resumes for other states.
  - Vendor performance requirements and expectations would be written into the contract, so managing the vendor boils down to managing the contract – we'll need some IT expertise for validation of milestone deliverables, QA, and development of any future desired features, but nothing like what would be required to build and maintain a whole system.

For additional context:

On the question of what we were requesting in the 2019 RFI, we can probably boil that down to two primary difference "buckets":

Bucket 1 – limited scope that does not include Medicaid

The requirements in our 2019 RFI were substantially the same as what Nevada and New Mexico had asked for in 2018, both of which excluded Medicaid. So one of the two giant differences is that we are not also proposing a new OHP solution:

- We don't want to try and do a Medicaid integration right now, while Cover Oregon's project was attempting to create a new exchange system AND migrate OHP to that new system.
- Without the Medicaid piece, you've easily reduced the complexity and associated risk by at least half, while the base rules for every state exchange technology are based on the ACA and essentially the same
- Companies can (and do) therefore have repeatable implementations that don't have to be substantially customized unless the state wants to - the base model can be pretty much the same for everyone because they're based on existing and well-known federal requirements applicable to all states.

Bucket 2 – vastly reduced procurement complexity generally, resulting lower costs

The second big difference is the change in what a state is required to procure in order to have an SBM, and how it needs to plan for the related implementation. In the traditional large IT project structure like Oregon's original health exchange project, there would be a need to:

- Hire a systems integrator to create and execute a plan to make what you need, and to procure the things you need to make it
- Purchase all of the different software and hardware (such as servers and network equipment) pieces required by the plan
- Procure all of the other required infrastructure and pieces around those things to make them work according to the plan.
- Lots of money, lots of time, lots of infrastructure investment - and most of it up-front.
- That is HARD to get right. It takes bulletproof project prep methodology and project scope discipline, it takes a long time for any entity to do that for any purpose, and it comes with a relatively high built-in risk of at least over-budget and over schedule for any such project that, if severe enough, could lead to an abandonment or essential failure altogether
- Unfortunately, this is sometimes the only way to procure a large IT system with no "template" - such as the original exchange, or really any state program with variations unique enough that you can't just copy what another state has

In the SBM tech market that has now evolved, these vendors ARE the systems integrators. Their business is the creation and stewardship specifically of SBM technology systems, and what they sell is a bundled service and technology package that is vendor-hosted and cloud-based.

Vendor-hosted and cloud-based has many implications in many different contexts, but for a state procuring an SBM technology, a key operational implementation impact is that instead of dozens of separate state procurements and associated coordination for all of the various pieces, it is instead one procurement for the vendor to then handle all of that work:

- It's not that the systems are simpler or less complicated; if anything, they're moreso now. They are still a vast combination of sub-systems, with each doing many separate tasks.
- It's that vendors have already succeeded at this exact SBM technology task and evolved over time to where this is now a market with actual competition, and with known parameters around risks, limits, and timelines.
- The ability to have this structure set up in a vendor-managed cloud means that states don't actually need to make that infrastructure investment anymore - the contracts essentially lease the SBM technology as a service from the vendors, and in exchange, they take on all of the IT implementation, infrastructure, and maintenance responsibilities and risks.
- The resulting efficiencies on both sides means that the startup costs are easily 1/20th or less of what the Cover Oregon project was, while vendor reliability is far more robust.
    - It's still millions of dollars, but there's now no hardware for the state to buy and then pay additionally to develop, maintain, and support with specialized IT FTEs for the SBM technology.
    - There are enough players in this vendor market to create competition. This benefits the state in a couple of ways:
        - Price - like any other market, competition between vendors provides incentive to keep prices down while trying to win bids
        - Post-contract execution performance -
            - One reason vendors can deliver the technology at a lower cost than a state could implement on its own is economies of scale.
            - Each additional state under these vendors' umbrellas not only increases revenue, but also (conceptually) lowers its cost per supported State.
            - Future business depends heavily on reputation: This gives extra incentive to the vendor to perform as well as possible under the contract, and only agree to deliverables it is relatively certain it can achieve - bad news travels fast between SBMs, and failures would vastly reduce future business opportunities for the vendor.
            - For those reasons (I believe), vendors in this market are now very unlikely to take on unnecessary risks.
                - we have yet to hear of one OE go-live failure out of any of the implementations so far.
                - That's not to say that all were flawless - Nevada had some speed bumps in their first OE, but this was smoothed out

without a system failure or having to go offline for a significant amount of time.

- Walking the walk: vendor confidence and ability to deliver is high enough that it's now common practice (offered at the state's option) for vendors to defer the first year of design, development, and implementation (DD&I) costs leading up to the first OE, spreading them over the life of the contract.
    - This is a huge up-front investment of time and resources, and vendors would not offer it if they could not both easily shoulder the cost *and* be relatively certain of hitting milestone deliverable dates leading up to, and including, OE
    - This accommodates many states that have just started their move to an SBM, and therefore don't really have any reserves built up for DD&I - see Maine, Pennsylvania.
    - This means that it would be possible for a state to begin a contract relationship with a vendor, go through the first year of development to prep, and not begin paying invoices for the technology until you have a working product at your first open enrollment.
    - This also means that it would be more possible for the Marketplace to get through startup under its current statutory revenue and reserve limits without additional funding from other sources.

*** Since the tech New Mexico and Nevada are using are fully functional, and at least one tech/vendor received high CSI ratings from the state agency involved, can you think of tech/vendor questions we have not asked the vendors that might be troubling in a transition to full SBM?**

- There are perhaps a couple, but one I know we haven't explored in-depth is: When the current contract expires, what provisions do vendors have to enable or facilitate migration to another system if a different vendor is awarded the next contract?

Part of that is definitely up to the due diligence requirements of the state planning, so it's not really on the vendor to provide that unless the state has asked about and planned for it in advance. The planning is so, so important.

- It's very likely we wouldn't know what a lot of the other questions would be until something unique and urgent came up that required some outside-of-the-box solutions - and that might not happen until well into a contract period.

This is why most states opt to add scope and funds provisions to potentially develop additional functionality if needed – that's for the things we know we want to add later, but also for the things we don't know are going to happen yet.

*** Are you familiar with other similar tech enrollment programs that OHA currently administers and how successful has OHA been in administering them?**

Not one that matches this model, but for context:

- OHA's ONE system is managed in-house with the help of a contractor, but that's not quite the same - there's a lot more risk, complexity, and maintenance handled directly by the state, along with all of the required IT staff to manage it.
- It is a couple orders of magnitude more complex than administering an SBM tech contract would be, and handles easily at least 8 times as many people as an Oregon SBM tech would at any time. Think of the difference between what would be needed to manage an ocean cruise liner and a medium-sized fishing trawler, and you'd kind of get a sense of the scale. If you have the resources to do the ocean liner, adding the trawler will not likely present too big a challenge – as long as you have the right people on it 😉
- It's hard to point to really any other state program with something like a bundled SBM technology solution at all because I can't think of one that has an existing market for complete technology solutions with a "base model" that can apply to almost any state like SBMs do
- Employment, Workers' Comp, Medicaid, PEBB/OEBB - the requirements for the tech systems for all of those programs vary so much between states that you're not going to find 4 or 5 vendors with repeatable implementations meeting substantially similar requirements. Every implementation is custom and unique to each state, so while there may be vendors that specialize in systems for those state programs, the procurements and implementations end up taking on the shape of that more traditional large IT system project structure.

*** Currently there is a coalition of healthcare reform advocates preparing with OHA to present a bill, HB 4035, to the current short legislative session that would include the legislature authorizing taking the steps to transition OHIM to fully state based. I know there will be questions about state agency capacity to successfully administer such a program. Can you think of anything further I can highlight, or that I have missed, in my conversation with state legislators about moving forward with a SBM?**

A few that could be of interest:

Minimal additional FTE investment at the state's option, manageable administrative burden

- With the IT nuts-and-bolts know-how mostly contracted out, the agency can focus on what it knows best: policy.
    - The Marketplace already administers Health exchange policy for Oregon
    - Unfortunately, our hands are tied in many respects relative to our authority since we don't own the system used to enroll Oregonians

    - Vendors have an option to provide a 3rd party consumer assistance center (call center) as part of the service delivery
    - It's unclear where Oregon legislators would stand on this concept (since we've never had a chance to present it), but reports from other states indicate mostly positive experiences when proper care is taken to establish expectations and customer service level deliverables in the contract
    - Essentially, with responsible contracting, you can relieve the state of the FTE burden of hiring front-line call center staff, preparing the associated infrastructure, and adjusting for seasonal staffing levels.
- IT system and infrastructure provisioning along with call center represent the overwhelming majority of what the FTE investment and administrative effort would normally be for becoming a full SBM, and current vendor models allow for the contracting of both with minimum service level requirements and contingencies
- Agency ability to administer would then only require the staff necessary to manage those contract relationships and make the associated policy decisions along with what we already manage now.
- That will also require additional dedicated staff with the appropriate IT expertise to act as liaisons and QA to assist with contract administration, as well as some third-party consultants for additional QA and related audits, but that's well within our projected capabilities as a full SBM.

Data, data, data:

- We don't have access to healthcare.gov enrollment data, and Oregon doesn't own it for Oregonians.
- An SBM tech would give us that, and with it the ability to inform policy and program efficiency and effectiveness.
- That not only affects us, but any other state programs we could help or inform with that data.

Costs less, works better, gives the state more control

- All analyses point to an overall savings vs. healthcare.gov - as long as the ACA is law, we'll need to use something, and getting our own will save money by any measure
- All analyses point to a vastly improved customer experience for Oregonians overall - we could help them better and more efficiently, saving them and our partners hundreds or thousands of hours of valuable time per year. We would have a much more accurate estimate of those savings if we had our own data.
- All analyses point to not requiring additional funds other than the Marketplace's existing other-funds revenue stream, unless there were some special customizations or fast-tracking needed.

- An Oregon-controlled SBM technology would give Oregon the ability to do more as an SBM and have more control over its costs
    - All decisions regarding our SBM have to clear the HealthCare.gov hurdle first. There are a number of things we have the authority to do as a state, but can't because HealthCare.gov won't support it.
    - Along with the lack of control, we have no accounting for where the money we pay for using HC.gov goes. We may or may not be subsidizing other states.
- All of these together means there's no reason not to start now - it really doesn't need an urgent project or to be coupled with something else. These are good enough reasons on their own.
- These are also politically agnostic reasons
    - Pennsylvania did this math, and presented it to their legislators in 2018.
    - Though a purple state with a legislature nearly balanced between parties, the SBM enabling legislation had unanimous bipartisan passage out of both chambers in 2018.
    - Go-live in November of 2020 gave instant state exchange cost savings and control, allowing them to extend that first open enrollment into January 2021 to give pandemic-burdened Pennsylvanians more time to enroll. Because they felt like it. Because it was the right thing to do, and now they could. That's the kind of control we want for Oregon.