Washington State Auditor's Office

Government that works for citizens

Performance Audit

Costs and Sustainability at the Washington Health Benefit Exchange

June 30, 2016

Washington's Health Benefit Exchange helps customers purchase health insurance plans, and determines whether they are eligible for subsidies that help pay for them. In part due to concerns about whether the Exchange was self-sustainable, the Legislature required the Washington State Auditor's Office to examine the Exchange's operating costs.

We found the Exchange has not been fully reimbursed by the state and the federal Medicaid program for nearly $90 million in Medicaid services provided on behalf of HCA from January 2014 through June 2016. The Exchange must use fees charged to insurance companies to cover a portion of these unpaid Medicaid services. The Exchange also does not have a working reserve, a capital reserve or a long-term financial plan, which it needs to manage its self-sustainability, and determine how and when it will fund needed IT investments. Establishing such reserves and correcting past and future cost reimbursements should ensure it can successfully sustain its operations financially.

We also found that the Exchange's largest cost areas, which include IT maintenance and operations, call center expenses and wages, appear reasonable. Management has already made decisions to stop collecting insurance premiums that will help it avoid nearly $9.1 million in costs over a two-year period; we identified additional opportunities to save on call center expenditures. Finally, we found that leasing the federal health exchange platform now would increase the Exchange's overall operating costs.

Report Number: 1016997

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Executive Summary

As a result of the Patient Protection and Affordable Care Act passed by the U.S. Congress, as well as Washington legislation, the Health Benefit Exchange (Exchange) was created in 2011 to provide a one-stop marketplace where customers can purchase health insurance plans or enroll in Medicaid, known in Washington as Apple Health, the state-administered health insurance program for low-income individuals.

Due to concerns about the Exchange's operating costs and its fiscal sustainability, in 2013 the Legislature passed RCW 43.71.080 (8), requiring the State Auditor to conduct a performance review of the Exchange's operational costs. In response to this legislation, this audit looked for ways to lower those costs, including opportunities to partner with the federal government or other states, and how the Exchange could improve its sustainability.

The Exchange has not been fully reimbursed for the cost of the Medicaid services it provides

The Exchange has not been fully reimbursed for the Medicaid services it provides. Although the Centers for Medicare and Medicaid Services (CMS) approved the annual reimbursement plans, the Exchange and the Health Care Authority (HCA) did not ensure the plans included all costs for Medicaid services provided by the Exchange. When the Medicaid program does not fully pay for the costs of these services, qualified health plan (QHP) enrollees must pay for them through higher premiums. The Exchange and HCA partially corrected the cost reimbursement plan in 2015 but further corrections are needed. Although the two agencies have no plans to work with CMS to fully correct past and present CMS-approved plans, if the Exchange obtained full reimbursement for the Medicaid services it has provided, it would recover $12 million more for the second half of state fiscal year 2016 and more than $77.1 million for calendar years 2014 and 2015. We estimate the state's share is between $22.3 million and $44.6 million. If the Exchange is fully reimbursed for the past Medicaid services it has provided, and for the future Medicaid services it will provide, this should ensure its self-sustainability.

Because the Exchange did not receive full reimbursement in 2014 and 2015, it used at least $51 million in federal establishment grants to cover the costs of these Medicaid-related services. In addition to repaying those grants, the Exchange may need to repay additional grants that it used to fund its 2015 operations.

The Exchange is taking several steps to contain its operating costs, which appear reasonable

The Exchange stopped billing and collecting individual insurance premiums, which we estimate will result in biennial savings of about $9.1 million in bank fees, wages and call center costs through June 2017. Consumers now pay insurance companies directly. Management has also brought more information technology (IT) services in-house, and is using state resources to reduce its IT maintenance and operating costs, which appear reasonable compared to other states.

Management has implemented compensation policies to control payroll costs and has reorganized staff and processes to further reduce call center costs, which also appear reasonable.

Although operating costs appear reasonable, we identified additional opportunities to reduce them

Explore partnering with Covered California for lower hourly call center rates – California and Washington use the same vendor for call center services. California pays this vendor a lower hourly rate and sees potential benefit to partnering with Washington. If the Exchange partnered with Covered California and obtained the same contracted rate, it could save between $756,000 and $1.3 million per year, depending on call volume.

Make improvements to further reduce call center volume and costs – Giving call center staff more tools to assist customers could reduce call duration and repeat calls. Making customer correspondence and the Healthplanfinder website simpler to understand could also reduce the number of calls. The Exchange could collect additional information about why customers call to identify where it should make these simplifications. Although there are challenges that would need to be considered, shifting certain calls to brokers is another possibility for reducing costs.

The Exchange can improve its fiscal sustainability and increase its operating revenue by increasing enrollment in Qualified Health Plans

Increasing QHP enrollment would result in additional revenue and further strengthen the Exchange's ongoing fiscal sustainability. The Exchange can potentially achieve this by improving its website, Healthplanfinder, to provide better guidance around automatic renewals and to better highlight the financial subsidies that are available to customers.

Establishing a long-term financial plan and improving other financial management practices can better ensure its long-term sustainability

Although it recently adopted a strategic plan, the Exchange has been slower than other states to develop long-term financial planning that focuses on self-sustainability. Without a long-term financial plan that considers future IT investments and when and how it will pay for them, the Exchange will have greater difficulty managing its sustainability. Its sustainability is further challenged by its lack of both a working and capital reserve.

Although partnering with the federal exchange would not be cost-effective at the moment, the Exchange should periodically assess the viability of doing so should future costs come down.

Recommendations

We recommend the Exchange:

1. **Work with the Health Care Authority (HCA) to ensure it is fully reimbursed for the Medicaid services it provides by doing the following:**
   a) Insist on mutual adherence to the cooperative agreement with HCA, which requires the equitable sharing of all applicable costs between the Exchange and HCA.
   b) Work with HCA to seek payment from the state and the federal Medicaid program for past unreimbursed services the Exchange provided.
   c) Work with CMS to determine if it must repay federal grant funds that were used to pay for these unreimbursed Medicaid services.
   d) Work with HCA to submit a corrected cost reimbursement plan to CMS so the Exchange is fully reimbursed for the future services it provides to Medicaid clients on behalf of HCA.
   e) Consistent with the Dispute Section of its cooperative agreement, pursue arbitration through the Governor's office if a fair and equitable cost reimbursement plan cannot be readily achieved.
   f) Work with HCA to more quickly establish future cost reimbursement plans and to obtain timely reimbursements.
   g) Retain system-generated QHP enrollment figures to better support the recovery of Medicaid related costs incurred on behalf of HCA.
   h) Ensure the following are reported in its financial statements:
      - Receivables related to the unpaid reimbursements for Medicaid-related costs incurred by the Exchange.
      - Obligations to the federal government, if any, for those establishment grant funds that were used for Medicaid services and the Exchange's operating costs after January 1, 2015.
2. **Reduce call center costs and increase enrollment and resulting revenues by doing the following:**
   a) Partner with California to obtain the same low hourly rates or use the contract's best pricing guarantee to negotiate a better rate.
   b) Ensure all call center contract costs are capped to the CPI or other third-party inflation sources.
   c) Pursue cost-effective Healthplanfinder and website improvements to achieve reduced call volume and increased enrollment.
   d) Collect additional information to better identify the key issues that customers call about, so issues can be avoided and call center calls can be reduced.
   e) Develop a searchable knowledge library to help staff assist customers faster.
   f) Plain-talk all boiler-plate correspondence to QHP customers to reduce the number of calls.
   g) Explore ways to use brokers more to improve customer service, reduce call center costs, and increase enrollment.
   h) Track how customers enroll in plans, such as through brokers, navigators, the website, etc. to measure progress towards cost containment through increased self-enrollment and broker-assisted enrollment.

i) Highlight the income levels that qualify for subsidies and Cost-Sharing Reduction plans on Healthplanfinder's homepage, and advertise the benefits of Cost-Sharing Reduction plans throughout the application process.
j) Clarify and improve information on automatic renewal to increase QHP enrollment.

3. **Improve long-term financial planning and other financial management practices by doing the following:**
   a) Create a long-term financial plan that will help the Exchange better manage its sustainability. Share this plan with the Legislature and HCA so it is factored into the appropriation and cost allocation process.
   b) Add self-sustainability to the Audit Committee's charter since it is a legal requirement the Exchange must meet.
   c) Require periodic considerations of moving to the federal exchange and the criteria it will use in making those assessments.
   d) Work with CMS to resolve the Inspector General's concern that unallowable operational costs may have been charged to federal grants. If they identify unallowable costs, the Exchange should work with CMS to reimburse the federal government.
   e) Work with OFM and the State Treasurer to establish one account for premium taxes and another for carrier assessments. Afterwards, make sure that carrier assessments are only used for QHP-related purposes.

We recommend the Legislature:

4. **Consider the following as part of the appropriation process:**
   a) Eliminating any requirement that the Exchange spend minimum amounts on navigators and outreach.
   b) The Exchange's need to obtain full reimbursement for all Medicaid-related costs.
   c) The Exchange's long-term financial plan, its planned list of IT investments, its need for both working and capital reserves, and how sweeping those reserves adversely affects planning.

Introduction

The U.S. Congress passed the Patient Protection and Affordable Care Act (ACA) in 2010 with the intent of making health care more affordable and accessible to people nationwide. Two key provisions required most people in America have health insurance by 2014, and that states create health insurance exchanges in order to give people without access to either affordable employer coverage or public coverage programs such as Medicaid a place to purchase coverage. To comply with the ACA, Washington's Legislature passed RCW 43.71 in 2011, establishing the Washington Health Benefit Exchange (the Exchange). The Legislature's primary intent was to:

> *"Increase access to quality affordable health care coverage, reduce the number of uninsured persons in Washington State, and increase the availability of health care coverage through the private health insurance market to qualified individuals and small employers…"*

Before the Exchange opened for business on October 1, 2013, nearly 17 percent of Washingtonians were uninsured. By the middle of 2015, Washington had reduced its uninsured rate to nearly 6 percent, which is one of the sharpest reductions in the country. Some of these newly insured people purchased private health insurance through the Exchange, although many more obtained insurance through the expanded Medicaid eligibility authorized by the ACA.

State-run exchanges nationwide got under way with the help of billions of dollars in federal grants that helped them develop necessary technology, build their websites and train workers to help people sign up. According to CMS guidelines, the grants were not intended to fund operations: the ACA specifies that exchanges must figure out how to make their marketplaces pay for themselves – be self-sustaining.

To ensure the Health Benefit Exchange operates in a fiscally sound fashion, the Legislature enacted legislation (RCW 43.71.080 (8)) in 2013 that required the State Auditor to conduct a performance review of the Exchange by July 1, 2016. We were asked to examine cost performance, the potential for partnerships with other state exchanges or with the federal exchange, and other practices to achieve cost savings.

Background

The Patient Protection and Affordable Care Act

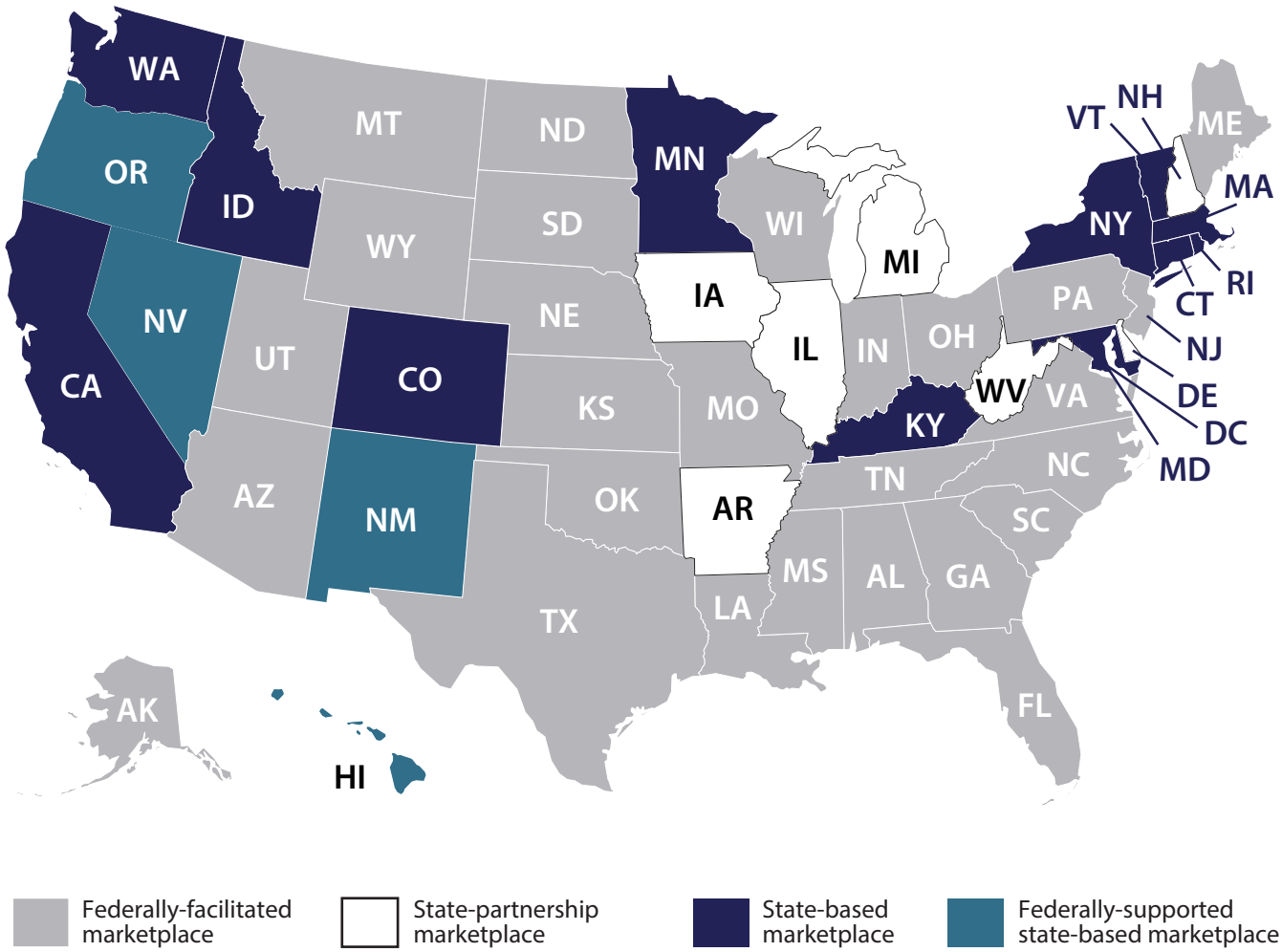
To make it easier for people to comparison-shop for health insurance plans, the Affordable Care Act (ACA) required states to create insurance marketplaces or use the federal exchange. The ACA also specifies what services the exchange must provide. These requirements include: enrolling eligible customers in qualified health plans (QHPs), operating a toll-free call center to assist customers, maintaining a website that allows customers to compare and enroll in health plans, and maintaining a navigator program to give customers free face-to-face assistance. The ACA also requires exchanges to certify the plans offered meet certain requirements. There are currently four models states can use: in one model states are responsible for meeting all ACA requirements, and in the other three models states rely in varying degrees on the federal Healthcare.gov platform.

Four exchange model options for states

- **State-based** – States that opted to develop their own exchanges were free to tailor the scope, structure and composition of their exchanges to meet the specific needs of their populations. These exchanges must meet all requirements of the ACA, including eligibility determination, enrollment in QHPs, customer service and outreach, plan management, and other required services. As of December 2015, Washington is one of 13 state-based marketplaces (includes District of Columbia).
- **State-federal partnership** – In this model, a state has flexibility to work with the federal exchange and may assume primary responsibility for carrying out some exchange activities, such as plan management, consumer assistance and outreach, or both. A state-federal partnership exchange uses the federal Healthcare.gov platform, and the federal government retains responsibility for the overall operation of the exchange. This model can serve as a path toward future implementation of a state-based exchange. (seven states)
- **Federally-supported** – A state-based marketplace that uses the federal Healthcare.gov platform for eligibility determination and enrollment in QHPs, as well as customer assistance through the federal call center. The state exchange maintains responsibility for customer outreach, plan management and other services required by the ACA. (four states)
- **Federally-facilitated** – Where states did not create their own exchanges, residents may use the federal Healthcare.gov platform to determine their eligibility for federal subsidies and enroll in QHPs. The federal exchange also provides customer service, plan management, plan certifications, and other services required by the ACA. (27 states)

The various exchange models are shown in the map in **Exhibit 1.**

Exhibit 1 – Exchange marketplaces by state



Source: Kaiser Family Foundation, as of January 2016.

The Washington Health Benefit Exchange

Washington's Exchange is a public-private partnership that is governed by a bipartisan, 11-member board. Most members are nominated by the Legislature and appointed by the Governor. The Exchange has 124 non-state employees and an operating budget of $110 million for the 2015-17 biennium. It also received $38.6 million in federal grant funds that are being used primarily for improvements to the Exchange's information technology (IT) systems.

The Exchange offers customers three options for obtaining health insurance:

- **Medicaid Program** – Also called Apple Health in Washington, is administered by the Health Care Authority (HCA), and offers health insurance to low-income individuals and families, pregnant women, the elderly and the disabled. Medicaid is funded by a combination of federal and state money, with different levels of state matching depending on the characteristics of program participants. In partnership with DSHS, the Exchange conducts eligibility determinations on behalf of Medicaid and allows customers to enroll in that program through its Healthplanfinder website (www.wahealthplanfinder.org). HCA reimburses the Exchange for money it spends on services related to Medicaid using federal funding and state funding that has been legislatively appropriated to the Exchange for this purpose.

- **Qualified Health Plans** – Health insurance plans sold by private insurers that meet requirements of the ACA and that have been certified by the Exchange to offer high quality insurance. Depending on their income and circumstances, customers may be eligible for federal subsidies to help them pay their plan premiums and additional assistance to meet their deductibles and co-pays.
- **Small Business Health Options Program (SHOP)** – SHOP allows small businesses to purchase group health insurance plans for their employees. The Healthplanfinder website directs small-business owners to a separate, business-oriented website.

In its September 2015 Health Coverage Enrollment Report, the Exchange reported that 1,447,294 Washingtonians were enrolled in Apple Health, 152,517 were enrolled in QHPs, and 121 employers had enrolled 505 employees and 119 dependents through SHOP.

The Exchange is funded by insurance premium taxes, carrier assessments and Medicaid reimbursements. It also is receiving a small portion of federal funds during fiscal year 2016. **Exhibit 2** sets out the Exchange's revenue sources. The Exchange works with the Office of the Insurance Commissioner (OIC) and insurance companies to establish the amount of carrier assessments.

Exhibit 2 – Exchange revenue forecasts for fiscal years 2016 and 2017

Dollars in millions

Revenue	Description	Budgeted 2016	Budgeted 2017[2]
Premium tax (appropriated)	A 2% premium tax paid by insurance carriers for plans sold on the Exchange. Collected by the OIC.	$12.1[1]	$31.6
Carrier assessments (appropriated)	A $4.19 per member per month assessment paid by insurance carriers offering plans on the Exchange. Collected by the Exchange. The assessment increased to $7.46 per member per month for calendar year 2016.	$8.8[1]	
Medicaid reimbursements (appropriated)	Cost paid by HCA for Medicaid-related services provided by the Exchange.	$28.6	$22.9
Federal grants	Federal money provided through the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health & Human Services, for system development and a limited amount of maintenance and operations.	$29.5	$0
Total revenue		**$79.0 million**	**$54.5 million**

Notes: *[1]Totals for state fiscal year 2016 include actuals through November 2015 and projections through the end of the state fiscal year. [2]Budgeted revenue for state fiscal year 2017 does not differentiate premium tax revenue and carrier assessment revenue.*

Source: Washington State Health Benefit Exchange Reports to the Legislature dated January 31, 2016 and November 30, 2015.

The Exchange's two state agency partners have additional responsibilities

The OIC regulates Washington's insurance industry, reviewing and approving the rates submitted by insurance companies. OIC works in partnership with the Exchange to review the QHPs to ensure they meet minimum federal requirements. It also collects the premium taxes which help fund Exchange operations. The Commissioner serves as a nonvoting member of the Exchange's board.

As the Exchange's state agency partner, HCA submits the Exchange's budget to the Governor's Office of Financial Management for legislative appropriation and administers the state account for the revenues that fund the Exchange. Because the HCA is the recipient of federal Medicaid funding, HCA reimburses the Exchange for most of the eligibility and enrollment functions it performs for customers applying for Medicaid, using federal funding and state funding that has been legislatively appropriated to the Exchange for this purpose. HCA's director also serves as a nonvoting member of the board.

Healthplanfinder: The Exchange's online service platform

To comply with the ACA requirement that customers have an online place to access and compare health plans, the Exchange developed the Healthplanfinder website. The ACA specifies a "no wrong door" approach through which customers can explore both private insurance and Medicaid, and so Healthplanfinder provides this "one-stop shop" for customers. Customers can determine their eligibility for Medicaid or federal subsidies for QHPs, compare different health plans, and enroll for coverage. See **Appendix A** for the enrollment process.

The Healthplanfinder's first open enrollment in late 2013 had some significant challenges. Thousands of customers found their accounts tangled in IT problems that impacted the payment information shared between the Exchange and the insurance companies. Although improvements were made by the second open enrollment in late 2014, IT issues continued to affect the payment information shared. To address these IT issues, the Board voted to shift responsibility for collecting insurance premiums from the Exchange to the health insurance carriers. This resulted in a much smoother customer experience during the third open enrollment in late 2015.

The Exchange must be self-sustaining as of January 1, 2015

State and federal law require the Exchange to operate in a self-sustaining manner, which means the Exchange must bring in enough revenue to cover its operating expenses and the IT improvements necessary for future growth.

Before January 2015, the Exchange was funded primarily by federal grants intended to help the state establish its systems and operations, and reimbursements from the Medicaid program. Although the federal government authorized the Exchange to spend some of these grant funds in 2015, the Exchange is now primarily funded by premium taxes, carrier assessments and Medicaid reimbursements. (Exhibit 2 shows a breakdown of these revenues.) The Exchange projects $79 million in total revenue during state fiscal year 2016 and $54.5 million in 2017. A significant portion of the decrease in revenue is due to the elimination of federal grant money.

Scope & Methodology

We designed this audit to answer this question:

Are there opportunities to reduce the Health Benefit Exchange's operating costs and improve its self-sustainability over the next three years, including partnering with other states or the federal exchange?

We reviewed the Exchange's actual and projected revenues and expenditures from January 2013 through June 2017. Our audit focused on the three largest operating cost areas at the Exchange during 2015:

- Call center
- IT maintenance and operational costs
- Payroll

To find opportunities to reduce operating costs, partner with the federal exchange or other states and to improve the fiscal sustainability of the Exchange, we also obtained benchmarks and an understanding of at least some operations at other insurance exchanges operated by about a dozen other states. We also reviewed numerous industry publications to identify ways to reduce operating costs.

Our audit focused exclusively on the Exchange. Our review of HCA was limited to understanding the reasons why the Exchange was not being fully reimbursed for the Medicaid services it provides. Our review of OIC was limited to understanding some challenges to shifting assistance for QHP enrollment from call center staff to brokers and how the assessments that the Exchange charges insurers affects the premiums that are paid by customers who purchase plans both on and off the exchange.

The audit did not assess how known or unknown legal challenges to the Affordable Care Act could affect the sustainability of the Exchange.

See **Appendix B** for more information on our methodology.

Certain problems with data and information limited our analysis

Challenges with enrollment data – The Exchange did not retain QHP enrollment information generated by its IT system. The accuracy of our calculations depend on the accuracy of publicly reported enrollment numbers, but because we could not substantiate these numbers, our audit calculations concerning the services HCA did or did not pay for may be higher or lower than the actual amounts.

Challenges with Exchange financial information – During the audit, we had difficulty obtaining reliable general ledger account balances, reliable and timely financial reports, and other reliable information related to past budgets, revenues, expenditures and enrollment. In its most recent report, the Exchange's external audit firm expressed concern about the Exchange's ability to effectively prepare financial information in a timely manner. As discussed in the final section of the report, the Exchange is taking steps to address these challenges.

To ensure our conclusions were based on reliable information, we reviewed underlying accounting records such as contracts and invoices, and we verified wage information through the Exchange's third-party payroll payment processor.

Also, because the Exchange recently changed its financial report period, our calculations for unpaid cost reimbursements used calendar year 2014 and 2015, and state fiscal year 2016. To avoid overestimating the total amount of unpaid reimbursement, we only included half of the state fiscal year 2016 amount in the total since it includes the second half of calendar year 2015.

Comparing costs to other states – We also had difficulty obtaining cost information from other state exchanges. For example, some states chose not to share information with us, or do not report information to the public on their websites. As a result, the states included in those sections of the report that discuss costs or practices in other states vary depending on the data available for that topic. None have been audited by our Office.

Audit performed to standards

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards (December 2011 revision) issued by the U.S. Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Appendix B contains more information about our methodology.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the State Auditor's Office will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time, and location (www.leg.wa.gov/JLARC). The State Auditor's Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion.

Question: Are there opportunities to reduce the Health Benefit Exchange's operating costs and improve its self-sustainability, including partnering with other states or the federal exchange?

Answer in brief

We identified opportunities to reduce the Health Benefit Exchange's (the Exchange) operating costs, including obtaining complete and accurate reimbursements from the Health Care Authority (HCA) for Medicaid services provided by the Exchange, using Consumer Price Index caps in its contracts to control cost increases, clarifying its forms and website content to reduce call volume, and negotiating lower call center costs with its vendor. We also identified website improvements and other actions that could contribute to lower costs or increased revenue.

The most important factor in the Exchange's fiscal sustainability are the unpaid Medicaid cost reimbursements: the Exchange is not being fully reimbursed by the state and the federal Medicaid program for money it spends serving Medicaid clients on behalf of HCA. The Exchange will need to work with HCA to renegotiate the reimbursement plan for Medicaid costs.

Aside from the possibility of partnering with California to reduce call center costs, we found that partnerships at the state or federal level would not improve the Exchange's sustainability in the near term. Finally, the Exchange will need to establish working and capital reserves as well as a long-term financial plan that shows when and how it will pay for IT investments and meet its sustainability requirements.

Revising the cost reimbursement plan used by the Exchange and HCA can help recover money spent to help Medicaid customers

The revenue the Exchange receives through insurer assessments may only be used to fund its QHP-related operations, while the Medicaid services it provides are funded by similarly restricted state and federal money. The Exchange and HCA must have a process to identify costs that benefit the two programs so the Exchange can be properly reimbursed. Multiple sources, including the federal Office of Management and Budget (OMB) Circular A87 and the Centers for Medicare and Medicaid Services (CMS), provide guidelines to help state Medicaid administrators share costs with other agencies.

The cost reimbursement plan that HCA submits to CMS for its approval (also known as the Advanced Planning Document) specifies the costs and services provided by the Exchange that benefit the Medicaid program, and how those costs will be shared. Under HBE's/HCA's Cooperative Agreement, HCA must ensure the plan accurately shares all costs that benefit the Medicaid program. Unless it is updated, the Exchange cannot request reimbursements that exceed the CMS-approved plan, even if it incurs additional Medicaid-related costs.

The Exchange has been unsuccessful at working with HCA to fully adhere to their agreed-upon reimbursement process

The Exchange and HCA have agreed to use a three-step process for identifying Medicaid costs for reimbursement, shown in **Exhibit 3**. However, the Exchange has been unsuccessful at completing these steps when it works with HCA to develop, discuss, review and determine the activities proposed for cost allocation and the methodology they will use. As the exhibit shows, the process currently used to identify operating costs that benefit Medicaid does not fully capture all those costs. The current process prevents the Exchange from ensuring that assessments are properly used. This also does not properly repay the Exchange for its expenditures. **Appendix C** shows the effects of the Exchange not successfully implementing these steps.

Exhibit 3 – Medicaid cost reimbursement process required by the Exchange's cooperative agreement with HCA, which is consistent with OMB Circular A87, is not being followed

Step 1 – Identify all cost areas that provide a benefit to the HCA administered Medicaid program (including those that also benefited the Exchange).

- The resulting cost reimbursement plan did not include all costs and services that benefit the Medicaid program.

Step 2 – For all costs that benefit the Medicaid program and the Exchange, determine how these costs should be accurately split (for example, use enrollment in Medicaid and qualified health plans to distribute costs to the Medicaid program and the Exchange, respectively).

- Some of the cost methodologies used were not supported with data that was current and accurate, and did not accurately distribute costs to the Medicaid program and the Exchange.

Step 3 – Combine the Medicaid-only costs and the Medicaid portion of shared costs, and seek reimbursement for the total.

- Because the above steps were not fully achieved, the Exchange did not seek reimbursement for all Medicaid-related costs that should have been reimbursed.

Source: Auditor summary of Article III, Section 2 and Schedule A-1, Sections III and IV, in the cooperative agreement between HCA and the Exchange.

The Exchange has not been fully reimbursed by the state or the federal Medicaid program for services it provides to Apple Health

HCA is responsible for administering the state's Medicaid program, Apple Health, and it reimburses the Exchange for the Medicaid services it receives using federal Medicaid funding and state funding that has been appropriated to the Exchange for this purpose.

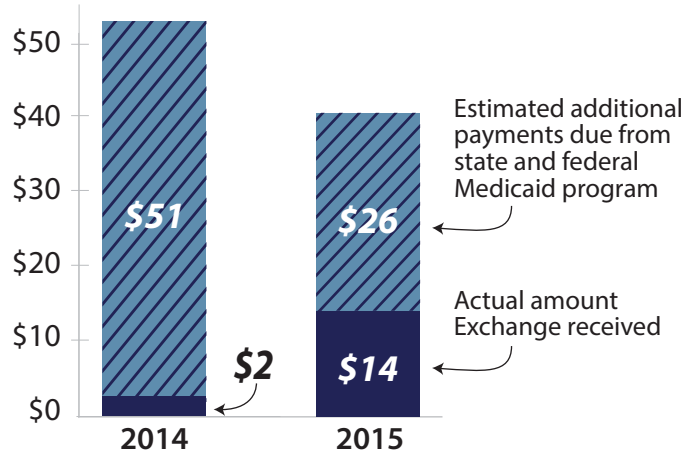
Although the Exchange works with HCA to ensure the Exchange is reimbursed for these services, we estimate the state and the federal Medicaid program should have further reimbursed the Exchange for Medicaid services totaling $89.2 million from January 1, 2014, through June 30, 2016. The Exchange was unsuccessful at working with HCA to ensure the reimbursement plans, which were approved by CMS, were sufficient to cover all costs for Medicaid services provided by the Exchange. The Exchange has not recorded any related obligations in its financial statements. Since Medicaid services are partially funded by CMS and assuming CMS pays its portion of this total, the state's share of the $89.2 million is between $22.3 million and $44.6 million.

Calendar years 2014 and 2015 – We estimate the Exchange should have received at least $50.8 million and $26.3 million in additional Medicaid reimbursements for calendar years 2014 and 2015, respectively. **Exhibit 4** shows our estimates compared to what the Exchange actually received for calendar years 2014 and 2015. The unallocated costs shown in blue stripes represent expenditures borne entirely by the Exchange – such as navigators (2014 only), marketing and administrative overhead – that should have been divided between the Exchange and HCA. **Appendix C** lists the additional cost areas that should have been shared. Our audit calculations excluded capital costs, which are not operational in nature but are nonetheless subject to a separate cost-sharing agreement between the Exchange and HCA.

State fiscal year 2016 – If the Exchange works with HCA to revise the CMS-approved reimbursement plan to more equitably share all reimbursable operating costs, we estimate the Exchange could receive nearly $24.1 million in additional Medicaid reimbursements in fiscal year 2016, as shown in **Exhibit 5**. The necessary revisions range from raising the reimbursement rates for IT maintenance and operations, navigator and other costs that are included in the current plan, to adding other costs that are not now included. Because there is six months of overlap between calendar year 2015 and state fiscal year 2016, we have only included half of this amount ($12 million) in the total amount of $89.2 million noted on page 15 that should have been reimbursed to the Exchange.

Exhibit 4 - We calculated the Exchange should have sought additional reimbursement for Medicaid costs

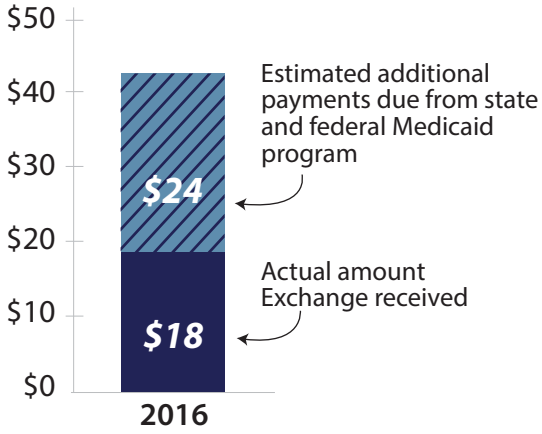
Dollars in millions by calendar year



Source: Auditor calculations using HBE financial, enrollment and other data.

Exhibit 5 - Cost recovery challenges continue into FY 2016

Dollars in millions by state fiscal year



Source: Auditor calculations using HBE financial, enrollment and other data.

Low Medicaid enrollment estimates used in the past should also be revisited when the cost reimbursement plan is revised

Prior to the first open enrollment period in October 2013, the Exchange's actuary provided low, medium and high enrollment estimates. The Exchange and the HCA based their cost-sharing calculations on the high qualified health plan (QHP) enrollment estimates and on estimates for new Medicaid enrollment, not total Medicaid enrollment. **Exhibit 6** shows the estimated enrollment numbers used in the cost-sharing plan and the actual numbers at the end of the first enrollment period in March 2014.

Exhibit 6 – Incomplete cost recovery was partially based on low Medicaid enrollment estimate

Numbers of enrollees, first enrollment period ending March 2014

Program	Estimated	Actual
Medicaid	194,000 (32 percent) *Excluded existing clients*	840,057 (84 percent) *Included new and existing clients*
Exchange – QHP	408,000 (68 percent)	157,511 (16 percent)
Total	**602,000 (100 percent)**	**997,568 (100 percent)**

Sources: 2014 Operational Advanced Planning Document, cost sharing agreement between HBE and HCA, June 2011 Milliman actuarial report and 2014 enrollment reports.

Although CMS and other federal guidance direct states to update these plans promptly when better enrollment information is available, the Exchange and HCA did not do this.

The reimbursement plans for other state exchanges we examined confirm that the Medicaid reimbursements to Washington's Exchange are too low. For example, plans for the exchanges in Kentucky and Vermont include all or most operating costs (such as marketing, facilities and administrative staff), which Washington excludes. These states also use the breakout of Medicaid and QHP enrollment to determine Medicaid's share of these costs. As a potential alternative for some costs, Kentucky and Vermont have also considered ways to determine how much time staff spend on Medicaid-related tasks. Such reimbursement practices would help the Exchange ensure it is fully reimbursed for the Medicaid services it provides for HCA.

Even when the Exchange and HCA had access to other information to split costs accurately, they did not make use of it. For example, in 2014, HCA reimbursed the Exchange for only 6 percent of call center costs, even though about two-thirds of the calls handled came from Medicaid customers. And even though navigators spend almost all their time assisting Medicaid customers, HCA did not reimburse the Exchange for their services because their costs were not included in the reimbursement plan.

When asked why the cost allocations were so inaccurate, Exchange officials told us former staff lacked cost allocation knowledge. They also told us Exchange and state officials wanted to minimize the financial impact on the state in its first years of operation by maximizing its use of the federal establishment grant funds, which do not require the state to match funds as Medicaid does.

The Exchange must work with HCA to seek CMS approval for full Medicaid reimbursement to be financially sustainable

Although HCA and the Exchange updated their reimbursement plan for 2015 to share costs more equitably, the latest plan still does not fully reimburse the Exchange for the Medicaid services it provides. Some costs that benefit both Medicaid and private insurance customers – such as marketing, building rent and security, utilities, insurance, most administrative staff and equipment – are fully paid for by the Exchange, and the reimbursement rates for other costs are still too low. For example, although HCA now reimburses the Exchange for 50 percent of navigator costs, this does not reflect the fact that navigators spend almost 90 percent of their time with Medicaid customers.

CMS officials told us they work with states to correct reimbursement plans retroactively. Although the Exchange and HCA did not update the plan promptly with CMS, doing so now will ensure the Exchange can be fully reimbursed for the Medicaid-related services it provided. Other states acted to update their prior years' reimbursements when their enrollment predictions proved inaccurate. When Connecticut used Medicaid enrollment forecasts in its 2014 reimbursement plan that were later found to be too low, it recalculated and recovered those unpaid reimbursements. Colorado is doing the same to avoid having its QHP customers subsidize Medicaid.

Exchange managers told us they did not know that CMS requires prompt updates under such circumstances. As a likely consequence, HCA and the Exchange update the reimbursement plan just once annually for the next year's cycle, even though their cooperative agreement allows them to do so more often. Officials at the Exchange told us they currently have no agreed-to plans to apply for retroactive repayment with CMS and that doing so would require the state to contribute to past Medicaid-related costs that were subsidized by the Exchange at the time.

If the Medicaid program does not fully reimburse the Exchange, these costs must be borne by private health plan enrollees through higher assessments.

State law allows the Exchange to charge assessments to insurers, which are passed on to plan members, to pay only for those QHP operations that are not covered by other revenue sources. Federal law requires insurers to charge the same premiums for identical plans however they are sold. When HCA does not fully reimburse the Exchange for Medicaid-related services, the Exchange must pay for these services through its carrier assessments. Insurers pass these costs on to customers through higher premiums for plans sold through the Exchange, which may also be sold off the Exchange. Purchasers of private health insurance plans across all incomes are effectively subsidizing Medicaid if HCA does not fully reimburse the Exchange.

Partnership challenges and delays in obtaining reimbursements need to be addressed

To be financially self-sustaining, the Exchange must receive prompt reimbursement for the full cost of the Medicaid-related services it provides. Under past and recent practice, months have elapsed between when the Exchange incurs Medicaid-related costs and when HCA reimburses the Exchange. Since it has no other revenue to cover the shortfall, the Exchange must cover these costs with assessments to avoid late fees owed to vendors. This creates a false impression that the Exchange needs to increase these assessments.

The cooperative agreement between the Exchange and HCA does not require a "true-up," which includes comparing forecasted enrollment and service activities used to split shared costs to actual enrollment and activities. True–ups are a CMS requirement and a leading practice used to verify that the initial splits resulted in complete and accurate reimbursements.

Because CMS approved the cost reimbursement plans used by the Exchange and HCA, the two agencies have not corrected those plans or the resulting incomplete reimbursements. To receive prompt and complete reimbursement:

- The Exchange should insist on mutual adherence to the cooperative agreement with HCA that requires the equitable sharing of all applicable costs between the Exchange and HCA. If the Exchange cannot achieve this mutual adherence, its agreement allows it to pursue arbitration through the Governor's Office.
- HCA and the Exchange must first have a timely CMS-approved cost reimbursement plan in place. Although due to CMS by August 1, 2015, CMS did not receive the 2016 plan approval request until November 2015, delaying its approval until March 2016. Not submitting the plan on time to CMS puts the state at risk of not having federal matching funds to help pay for Medicaid-related services. To avoid this risk, the Legislature now requires HCA to work with the Exchange to submit a cost reimbursement plan to CMS within 60 days of the enactment of the omnibus appropriation act each year.

The Exchange may need to repay some of the federal grant funds it used in calendar years 2014 and 2015, potentially affecting its short-term sustainability.

The Exchange used federal establishment grants to pay for Medicaid-related costs

These grants were used to pay for the estimated $50.8 million in 2014 Medicaid-related costs that HCA should have paid for but did not. The Exchange also used establishment grants to pay for some of the estimated $26.3 million in 2015 Medicaid-related costs that HCA should have paid for but did not. (Costs for both years are included in Exhibit 4, above.)

CMS requires that exchanges only charge non-Medicaid costs to the establishment grants. However, the Exchange's reimbursement plan did not fully capture all Medicaid-related costs that the Health Care Authority should have reimbursed. The Exchange charged all these uncaptured costs to its establishment grants in 2014 and a portion in 2015. Other states have had similar issues. The Department of Health and Human Services' Office of the Inspector General (OIG) found that the Medicaid agencies in Maryland and Nevada similarly did not fully reimburse their exchanges. The OIG found that both states improperly allocated Medicaid costs to their establishment grants, and recommended repayment of those costs. Because the Exchange also used federal establishment grants to pay its costs and did not receive full reimbursement from HCA, it is at risk of needing to pay back some of its federal grants. Although the Exchange has an independent CPA firm that audits its federal grant expenditures to ensure that costs are allowable, this issue was not identified.

The Exchange should seek clear assurance that it is not at risk of having inappropriately charged other operating costs to federal grants after January 1, 2015

Separate from the cost reimbursement issues identified above, the Exchange may also be required to reimburse the federal government for other unallowable costs that were more recently charged to its federal establishment grants. According to federal law, state exchanges may not use these grants for operational costs beginning January 1, 2015. The OIG raised concerns about the Exchange's plans to charge $10 million in operating costs to establishment grants between July 1 and December 31, 2015. Some of these funds are likely included in the $26.3 million total. These grant-funded costs included call center and navigator costs for ongoing special enrollments, printing, postage and bank fees. We identified other grant-funded charges that appeared to be for 2015 operating expenses, such as rent and utilities.

Although the Exchange received approval from CMS to charge these costs to its federal grants, this approval conflicts with earlier CMS guidance and federal law. This earlier guidance specified that federal grants may not be used for ongoing operations after January 1, 2015. This guidance identifies examples of unallowable costs, including rent, telecommunications, utilities and ongoing call center operations. And while CMS approved the Exchange's request for additional grant funding for operating expenses for calendar year 2015, the OIG notified CMS that Washington was at risk of inappropriately using federal establishment grant funds for operating expenses.

The Exchange is working to identify potential adjustments to what it has charged these grants. Once it has finalized these adjustments, the Exchange should work with CMS and the OIG to determine whether it must reimburse the federal government for any unallowable costs. As we discuss later in the report, the Exchange does not have a working reserve. As a result, it may not have funds that could help it repay CMS for any identified unallowable costs. Therefore, depending on the amount, reimbursing these costs could challenge its immediate financial self-sustainability, particularly if HCA does not reimburse it for the Medicaid-related costs discussed previously.

The Exchange is taking other steps to contain operating costs, contributing to financial sustainability

In 2015, the Exchange took several steps to lower its operating costs. In addition to working with HCA to make improvements to the CMS-approved cost reimbursement plan to more fully recover Medicaid-related costs, it has:

- Made changes to its IT practices, including reducing its dependence on its primary IT contractor.
- Implemented payroll compensation policies to control pay increases.
- Turned over the billing and collection of premiums to insurance companies to reduce bank fees and call center costs.
- Begun other efforts to control call center costs.

The Exchange has taken steps to lower its IT costs

When the Exchange was established in 2011, its primary IT expenditure was for the development and production of the Internet-based Healthplanfinder, which was entirely funded with federal grant dollars. In 2014, the Exchange began to incur and pay system maintenance and operating costs totaling more than $12 million annually, with the vast majority consisting of payments to Deloitte Consulting, the Exchange's primary IT consultant, for ongoing maintenance services. Once the website was launched and its operations began, the Exchange embarked on steps to reduce IT operating costs:

- **Renegotiating its primary IT contract with Deloitte** – The Exchange has extended the contract once and it did not agree to rate increases when it did so. It plans to renegotiate the contract to obtain better pricing for some services upon its expiration in December 2016. For example, it is working with Deloitte to identify locations where system maintenance services can be provided more cost-effectively.
- **Reducing technical dependence on Deloitte** – The Exchange had to follow a costly, time-consuming process to make even simple changes to its website or system-generated correspondence because it depends on Deloitte to make system code changes. To eliminate this dependency and process, the Exchange has been developing change management tools so it can update its website and correspondence directly. Additionally, it recently hired a Chief Information Officer with extensive knowledge of Deloitte systems. This should help the Exchange reduce its reliance on Deloitte in other areas.
- **Managing some subcontracts and licenses directly and using state government resources to save money where possible** – Previously, Deloitte managed multiple subcontracts and software licenses. The Exchange is assuming management of some of these, and is renegotiating costs and terms to reflect its actual needs. Although savings have been small, the Exchange has used state master contracts to reduce its costs. For example, the Exchange reported it has purchased Adobe, SAS and other products through the state, saving about $200,000 over three years. The Exchange is also exploring opportunities with Washington Technology Solutions (WaTech), the state's centralized IT agency, to purchase IT services at a lower cost. Because WaTech does not support the Oracle platform used by the Exchange, it is unlikely the Exchange can use its services to lower costs at this time.

In the infancy of the Affordable Care Act (ACA), state-run exchanges sought opportunities to partner with other states to provide services at lower costs. We determined that sharing IT services is not a simple matter. For example, Washington's exchange is integrated with its Medicaid system. Since some Medicaid requirements are state-specific, Washington's system has different needs than other states. This assessment is common among state-run exchanges, but the Exchange is still open to any future opportunities.

We found Healthplanfinder's IT maintenance and operations costs compare well with other states

We attempted to compare the Exchange's IT operating costs to those of other state exchanges, but proprietary information restrictions and differing state exchange structures made it difficult to find detailed or reliable information. To compensate for this, we compared costs four ways to assess whether the Exchange's IT operating costs were reasonable. We examined:

- System operating costs as a percentage of system development costs
- The original financial proposals submitted by other firms to build and maintain the system
- IT operating costs as a percentage of the total exchange budgets
- Contracted hourly rates for maintenance and operations of other states

Health Management Associates, an independent, national research and consulting firm specializing in publicly-financed health care, published a report that said the ongoing maintenance and operations costs of an IT system are reasonable if they fall within 15 percent to 25 percent of the original system development costs. To assess the Exchange against this benchmark, we first compared its ongoing IT costs to Deloitte's original proposal to build Healthplanfinder: operational costs were 19 percent of the proposed development costs, within the benchmark.

Exhibit 7 shows that the Exchange's ongoing costs were comparable to estimates submitted to the Exchange by other firms, and appeared reasonable compared to the actual costs of two other state-exchanges, one of which also used Deloitte to build its IT system. We did not use the actual system development costs for Healthplanfinder in our comparisons because they were significantly higher than the original proposal and would not have been comparable to other states that did not see similar cost over-runs.

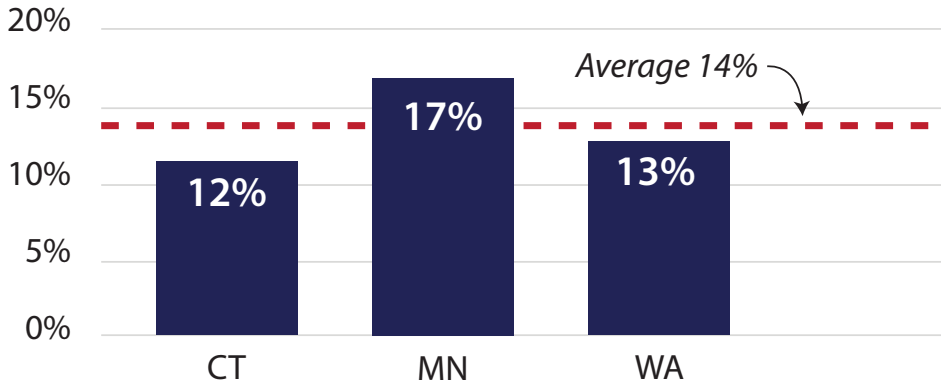
Exhibit 7 – Deloitte's proposed maintenance and operations costs for Healthplanfinder were similar to those proposed by other firms and those of other state exchanges

	Washington Deloitte	Washington Firm 1	Washington Firm 2	Connecticut (Deloitte)	Vermont (CGI)
Original development costs	$46.3 million	$67.4 million	$47.8 million	$42.5 million	$45.6million
Recurring Annual operational costs	8.6 million	11.7 million	9.97 million	8.9 million	10.7 million
Ongoing as a percent of development	19%	17%	21%	21%	23%

Source: HBE proposals for HBE integrated System and CT and VT financial reports.

As a third measure, we compared the Exchange's IT operating expenditures as a percentage of its total budget to two other states: Connecticut and Minnesota. **Exhibit 8** shows Washington's rate of 13 percent appeared reasonable compared to those of the other states.

Exhibit 8 – The Exchange's ongoing IT maintenance and operating costs are comparable to other states



Source: Financial reports from Connecticut, Minnesota and Washington.

As a final measure, we compared Washington's contracted hourly rates for system-related maintenance and operations to those of three other states. After adjusting for regional differences, we found that Washington's average rate ($135 an hour) was lower than the three other states we reviewed, which ranged from $136 to $183 an hour.

Based on these four comparisons, we consider the Exchange's IT operating costs reasonable.

The Exchange has taken steps to control compensation costs

Employee wages and compensation packages are often a significant operational expense for any enterprise, private or public. How and when employees receive promotions, pay raises, or bonus payments should be codified in policies that managers can reliably follow. When we examined the compensation practices at the Exchange from 2013 through 2015, we found it did not have policies in place to govern raises, bonuses or promotions. However, Exchange managers told us these were put in place in 2015.

Between 2013 and 2015, the Exchange gave its employees pay increases that significantly exceeded two benchmarks commonly used to control costs – the Consumer Price Index and the Employment Cost Index published by the U.S. Department of Labor – as well as the average cost of living increase for state employees in Washington. In that three-year period, each of these three benchmarks rose less than 3 percent annually.

We reviewed payroll records for 125 employees who received pay increases during 2013 through 2015: more than half received average annual increases that exceeded all three benchmarks. Exchange managers told us that these raises were due to rapid promotions and a desire to place employees into positions that better suited their talents. **Exhibit 9** shows the distribution of raises during this three-year period.

Exhibit 9 – Over three years, nearly half of employees received wage increases of 3% or less, but some earned considerably more

Average annual payroll increase, 2013 through August 2015

Annual raise amount	Less than 3%	3% to 9.9%	10% to 19.9%	20% to 39.9%	More than 40%	Total
Number of employees	58	38	21	7	1	125
Percent of employees	46%	30%	17%	6%	1%	100%

Note: *Percentages are affected by rounding.*

Source: HBE payroll reports.

The Exchange budgeted $611,000 for wage increases in the 2015-2017 biennium, allowing most staff to receive a 3 percent cost-of-living adjustment.

The Exchange also paid employees bonuses in its first years of operation. From August 2013 through January 2015, 21 employees received 25 bonuses ranging from $800 to $10,000 for a total of $52,000. Four employees received more than one bonus, with the highest totaling $15,000; most were $3,000 or less. Managers told us they no longer provide bonuses as part of compensation, which we confirmed.

Executive management salaries are comparable to other state-based exchanges

We compared the salaries of executive management at the Exchange to similar positions in other state exchanges. Although we attempted to compare Washington's salaries to all state-based exchanges, we were able to obtain payroll information for only 11 states. Because specific salary data was limited, we restricted our comparison to salaries for seven executive management positions. After adjusting for regional differences, the Exchange's executive management salaries for 2015 fell in the upper range of salaries — most similar to those of Colorado, while Connecticut was the highest in most cases. Some of these comparisons are shown in **Appendix D**.

The Exchange discontinued its role in billing and collecting insurance premiums, reducing its bank fees and call center costs

During its first two open enrollment periods, the Exchange billed and collected customer payments for insurance premiums, which it passed through to insurance companies. Although it did this to make it easier for customers to enroll and pay for insurance in one place, system issues delayed some payments to insurers. Affected customers were unable to use their insurance even though they had paid their premiums. The Exchange's solution was to remove this function from Healthplanfinder and have customers pay their insurers directly.

The Exchange spent about $4.5 million to make the necessary system changes and expected to save about $10 million during state fiscal years 2016 and 2017. Our estimate is about $900,000 less, or $9.1 million. The Exchange's estimate was higher largely because it was based on bank fees paid by 330,000 anticipated

QHP enrollees, which significantly exceeded the 152,500 and 192,500 people who actually enrolled during the last two enrollment periods. This means the bank fees the Exchange avoided paying are less than half of what it estimated. Our estimate also considers the reduction in call volume that has occurred since customers now call insurance companies directly when they have payment-related questions, rather than calling the Exchange.

Although call center costs are reasonable, to further reduce them, the Exchange restructured the teams that resolve help tickets

The Exchange contracts with Faneuil, Inc., for all call center services. The main call center is located in Spokane, with overflow calls routed automatically to sites in Virginia and Florida. In fiscal year 2015, the Exchange paid its call center vendor Faneuil $18.1 million for call center services. Call center spending is driven by the number of calls and the duration of calls.

Washington's call center costs are reasonable compared to other states

When considered in relation to enrollment-related activity (including Medicaid eligibility determinations and health plan selections), Washington's call center costs compare favorably to other states. Of the eight states for which we obtained reliable FY 2015 data, only Idaho had a better ratio of call center expenditures to enrollment-related activity than Washington.

We attempted to obtain information from all state exchanges, but were limited by each exchange's responsiveness. We made limited comparisons with other state exchanges, based on the available information.

Four exchange call centers – Connecticut, Kentucky, Maryland and Minnesota – provide services most comparable to Washington, based on similar working relationships with their Medicaid programs. Compared to these four states, Washington:

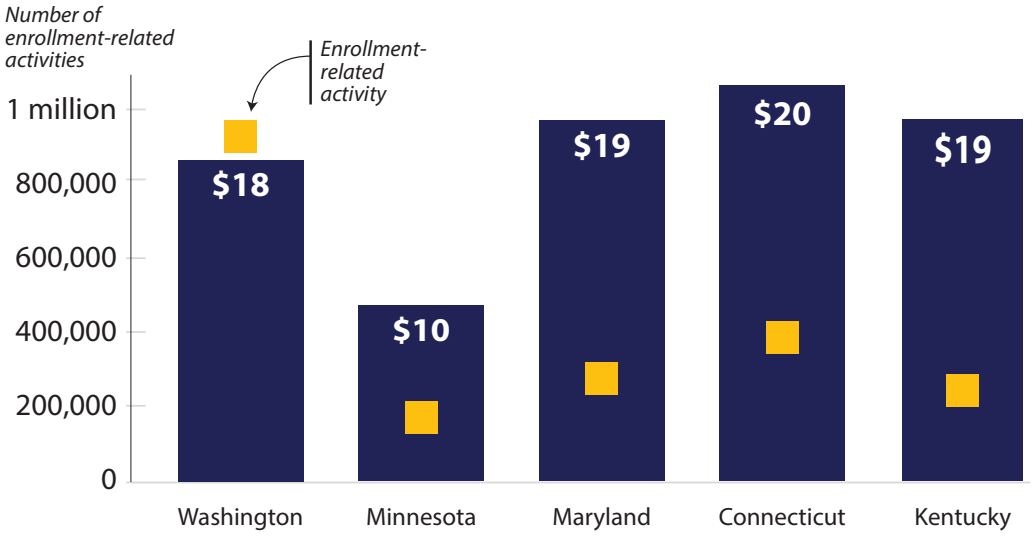
- Spent about the same on its call center as Maryland and Kentucky, but handled more than three times the enrollment-related activity
- Spent almost twice as much on its call center as Minnesota, but handled more than five times the enrollment-related activity

Exhibit 10 contrasts the five states' enrollment-related activity and call center spending (adjusted by region).

Exhibit 10 – Call center expenditures compared to enrollment-related activity

Dollar amounts in millions for FY 2015, adjusted by region.

Squares represent total enrollment-related activity, 11/15/14-2/15/15.



Source: Auditor prepared based on CMS reports and state exchange expenditures.

Washington's hourly rate is reasonable compared to other states. During 2015, Washington paid Faneuil $26.18 on average for each hour worked by call center staff, which included wages and benefits as well as overhead costs. For this comparison, we used data from California, Minnesota, New York and Rhode Island. We found the lowest hourly contracted rate for call center staff was $23.75 and the highest was $34.30. Hourly call center rates are shown in **Exhibit 11**.

Exhibit 11 – Washington's call center rate compared to other state-based exchanges

	Rate includes administrative and overhead costs			Rate does not include administrative and overhead costs	
	Washington	California	Minnesota	New York	Rhode Island
Hourly rate for call center staff	$26.18	$23.75	$25.50	$24.09-$29.92	$34.30
Rate adjusted for regional differences	$26.18	$21.83	$26.96	$21.56-$26.78	$36.08

Source: Vendor invoices and contracts obtained from the Exchange and other state exchanges.

When regional costs of living are considered, Washington's hourly rate is still reasonable compared to other states. Idaho and Nevada pay lower hourly rates, but to state employees or nonprofit navigator organizations.

Some states pay by minute of call time, instead of paying by the hour. We found that Washington's call center costs are also reasonable compared to other states on a per-minute basis. Because call center staff perform some tasks while they are off the phone, dividing or multiplying by 60 does not yield accurate comparisons between per-minute and hourly rates. We were able to calculate a per-minute rate for Washington to compare it with states that pay by the minute: the results of these calculations are shown in **Appendix E**.

Reorganizing the teams that resolve tickets has helped reduce call center costs

According to Exchange management, when the online enrollment systems opened for business in late 2013, call center staff frequently encountered unanticipated questions they could not resolve on their own. When this happened, they created help tickets to track the problems that were referred to Exchange staff for resolution. Delays in resolving tickets can prompt worried customers to call repeatedly, especially if they cannot obtain insurance until the problem is resolved. In response, the Exchange created desk manuals for call center staff so they could address issues immediately instead of creating tickets to fix later.

The process of resolving problem tickets was, however, inefficient and cumbersome. The Exchange was organized into teams that worked with customers and teams that dealt with insurers, passing tickets back and forth until they were resolved. To help resolve tickets more quickly, the Exchange recently reorganized the teams so they can work with both customers and insurers to more quickly resolve each issue.

Washington's hourly rate varies depending on the number of call center staff used by Faneuil: more during open enrollment periods, fewer in the summer. For example, Washington pays $27 an hour if there are 200 staff, but only $25.54 an hour if there are 320. During 2015 Washington paid $26.18 an hour on average.

These changes to the call center's operations, combined with the Exchange's decision to stop billing and collecting insurance premiums, have helped reduce both the number and duration of calls. Compared to November and December 2014, the number of calls in November and December 2015 dropped by 27 percent while the average call duration dropped by 22 percent.

Washington's call center budget reductions mirror trends in other states

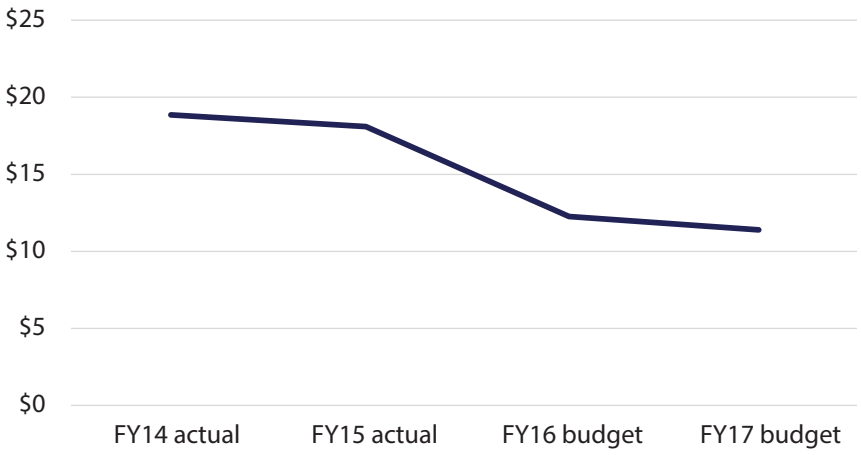
With reduced call volume, Washington's call center costs are declining from $18.1 million in fiscal year 2015 to a planned reduction of $12.3 million budgeted for fiscal year 2016, as illustrated in **Exhibit 12**.

Exchanges should reasonably expect to receive fewer calls as they correct website and other operational problems. Washington's reduction in its call center services budget is in line with other comparable states, as illustrated in **Exhibit 13**.

A notable exception to this trend is Kentucky, which started off with far fewer technical problems than other state-based exchanges. These technical problems contributed to higher initial call volume in these other states. The Kentucky exchange also agreed to pay its call center vendor annual rate increases. We believe these factors may partly explain why Kentucky has not seen the same cost reductions that other states have experienced.

Exhibit 12 – The Exchange plans to reduce call center costs

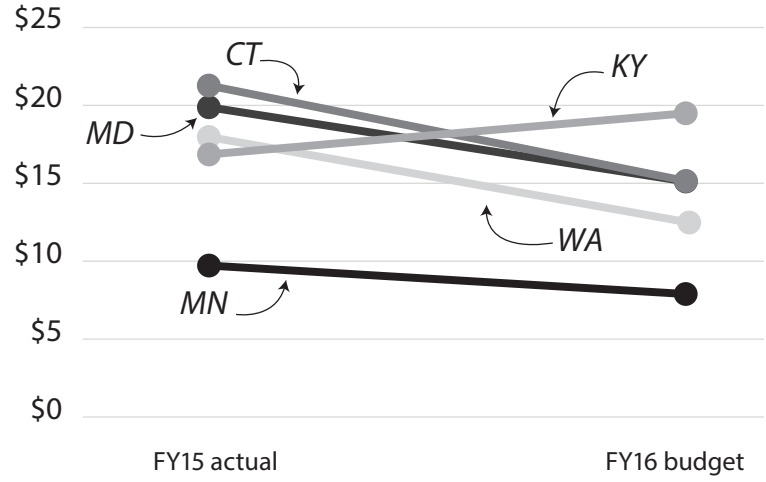
Dollars in millions



Source: Exchange officials, the Exchange's financial system, and call center invoices.

Exhibit 13 – Many states are budgeting less for call centers

Dollars in millions



Source: Exchange officials, the Exchange's financial system, call center invoices, and board presentations.

The Exchange can take steps to further reduce call-center costs

While Washington's call center costs compare favorably with other states, we identified opportunities to further reduce them. Some of these may require initial funding or staff time to realize.

Encourage more customers to work directly with insurance brokers instead of using the Exchange's call center to lower costs

Both navigators and insurance brokers can provide in-person assistance to customers, but only brokers may recommend a specific insurance plan. Historically, insurance companies have compensated brokers for their services through commissions; they do not receive compensation for helping with Medicaid enrollment. By contrast, the Exchange pays for the services provided by both navigators and the call center.

Brokers told us the Exchange could reduce call center costs by better advertising the role and availability of brokers, and encouraging customers to use their services instead of contacting the call center.

The Exchange told us it has taken several steps to partner with brokers (noted in the sidebar), but there is still room for improvement. According to an independent customer survey conducted during September 2015, only 13 percent of QHP enrollees in Washington purchased coverage through a broker. By contrast, during one or more of the three open enrollments, brokers assisted more than 40 percent of QHP enrollees in California, Colorado and Kentucky.

Other state exchanges are exploring ways to further partner with brokers. For example, Maryland's exchange ran a small pilot program in the fall of 2015 in which call center staff transferred the calls of customers seeking health plan advice to licensed brokers. Maryland's exchange reports the 25 brokers participating in the pilot responded to almost 3,200 calls and spent more than 970 hours talking to customers. Assuming these hours would have otherwise been provided by call center staff, this represents approximately $15,000 in savings just from the pilot (calculated using the average hourly rate that Washington paid Faneuil during 2015). As nearly a third of the Exchange's calls and its $12.3 million in annual costs are solely QHP-related, if the Exchange could shift just 10 percent of these calls to brokers, the resulting annual savings may total about $400,000.

While these ideas are promising, there are challenges that must be addressed:

- Limitations in Healthplanfinder mean the Exchange cannot track the enrollment channel customers use, and must rely on surveys to determine the percentage of enrollments completed by brokers.
- Washington's state budget establishes minimum spending on navigators and outreach, so the Exchange does not have the flexibility needed to explore the most cost-effective use of navigators and how much it spends on them.
- Beginning in November 2015, about half of the 11 insurance companies selling health plans through the Exchange eliminated or significantly reduced commissions paid for policies in an effort to lower their operating costs as they evaluate the profitability of selling these policies. California may address this barrier by requiring insurance companies to pay commissions on plans sold on its exchange.

The Exchange told us it has taken steps to partner with brokers

November 2015 – To help resolve issues more timely and reduce call center volume, brokers serving large numbers of customers were allowed to receive technical assistance from navigator organizations that have more system access to Healthplanfinder.

February 2016 – Agents within brokerage firms were permitted to serve each other's customers without having to contact the call center and have the account unlocked. Navigators can now refer clients to brokers, with brokers receiving credit for enrolling these clients into qualified health plans.

July 2016 – Healthplanfinder will allow an automatic partnership when brokers create new applications to reduce the manual process for brokers. Previously, people who enrolled in a plan had to take four different steps to name the broker who helped them: if they missed one, the broker was not recognized as a customer's broker and may have missed commissions.

- In Washington, brokers represent specific insurance companies instead of all plans sold on the Exchange, which means they may not give impartial advice to customers. Minnesota addresses this barrier by requiring brokers working with MNsure to represent all insurance companies offering plans in the assigned region.

Limit call center contract price increases to the consumer price index

The Exchange can also achieve cost savings by limiting its contract increases to the Consumer Price Index, which is often used to limit rate increases. Between late 2013 and early 2015, the Exchange increased some call center costs by 12 percent while the index increased just 1.1 percent. If the Exchange had limited contract price increases to the Consumer Price Index, it would have saved the Exchange and the Medicaid program a combined $387,000.

Provide call center staff additional tools to potentially reduce call time and repeat calls

Exchange managers told us they want to implement a searchable knowledge library to deliver information to staff more quickly. Currently information is located in multiple documents that staff must take time to search. Managers also told us they want to add tools that allow call center staff to troubleshoot customers' issues, for example, when consumers need to provide additional information because their applications do not match existing records or other trusted data sources. Furthermore, brokers and navigators have indicated customers received inconsistent or incorrect information from the call center during the months before the third open enrollment, which led to increased calls seeking clarification. By providing call center staff additional tools, the Exchange will likely not only reduce the length of calls, but also increase consistency among call center staff and help them resolve issues the first time customers call, which will reduce repeat calls and lower overall call center costs.

Reduce the number of calls by improving correspondence sent to customers

Brokers and navigators told us that both Medicaid and health plan customers are confused by the duplicative letters they receive, and end up calling the Exchange to understand what actions they must take. HCA officials told us they are establishing a workgroup that includes both Medicaid customers and legal advocates to simplify this correspondence. If the workgroup is successful in clarifying the correspondence, customers will not need to contact the call center or navigators to understand what they must do. The Exchange should consider a similar effort for its QHP customers.

Collect better information on why customers call to identify improvements likely to reduce call center volume

In the summer of 2015, Deloitte analyzed 200 calls and conducted focus groups and surveys with call center staff to identify key reasons for customer calls. Also, call center supervisors meet weekly to discuss call trends and emerging issues. However, call center staff do not systematically track the reasons for customer calls. The Exchange has reports that tally the menu selections that customers make while navigating the call center's phone system, but these reports may not accurately reflect the issues that drive most calls because customers may not follow the prompts as intended. For example, the fourth-most common category selected in 2015 was "other."

To accurately identify what drives call volume, the Exchange will need to collect better data. For example, the Exchange uses commercial software to track issues faced by customers. This software generates reports showing how frequently different issues occur across eight different categories. However, call center management told us they do not receive these reports. Another way to collect data about problems is to have call center staff ask for and record the reason for a customer's call as part of closing the call.

Improve the clarity and quality of information on Healthplanfinder to help minimize calls and reduce costs

The Exchange's 2015 customer survey of 8,000 people revealed 86 percent of survey respondents who enrolled in a health insurance plan used Healthplanfinder as an information source, but only 66 percent of all respondents used it to self-enroll. And fewer than half of all respondents who enrolled through Healthplanfinder said it was available when they needed it, that it was easy to find information quickly, and that it made it easy to understand how health insurance works. At least 32 percent of those who used Healthplanfinder as an information source and enrolled in a QHP said they also needed to contact the call center.

Challenges customers reported with Healthplanfinder during 2015 included:

- **The website was unavailable** – According to a different survey conducted by CMS in 2015, 39 percent of respondents said they could not get information they needed because the website was not working correctly.
- **The website was confusing** – Respondents to both surveys reported confusion on how to apply for and renew their coverage, and what they needed to do after enrollment. Only 38 percent of respondents to the CMS survey said it was "always easy" to understand the website.

  A separate small scale usability study published by the American Institutes for Research in June 2015 produced similar results (see sidebar). Ten customers with the demographic characteristics of people eligible to receive assistance through the Exchange struggled to complete several tasks on the Healthplanfinder website.
- **Applications for insurance were hard to edit** – Making even minor revisions, such as changing a telephone number or email address, was difficult and required contacting the call center. Both brokers and navigators believe this is a much-needed improvement. When combined with questions about enrollment, editing applications contributed to nearly 7 percent of calls during 2015.

Customers in the American Institutes for Research usability study struggled to:

- Understand what it meant to apply for tax credits
- Notice error messages or locate the source of the error
- Read and answer correctly the question about whether or not they were employed
- Set the intended relationships between family members
- Recognize they had not been enrolled in a plan but were only being informed of eligibility status

The Exchange continues to improve Healthplanfinder. Exchange management told us they had fewer unplanned website outages during their last open enrollment period (November 2015 – January 2016) compared to previous open enrollments. Also, upgrades scheduled for the summer of 2016 should enable Exchange employees to edit website content. See scheduled upgrades at **Appendix F**. During our audit, any updates to the text of Healthplanfinder required changes to the system coding that was written by website developers. Once staff can edit content on Healthplanfinder, the Exchange can also add tools and explanations to help customers more easily enroll in coverage. These upgrades should also reduce the number of errors customers make when enrolling through Healthplanfinder, which increases call center volume (see sidebar).

Improving Healthplanfinder could also increase QHP enrollment

Healthplanfinder improvements may also help with enrollment. Respondents to the 2015 customer survey included almost 1,000 individuals who started an application but ultimately did not enroll. More than half of this group did not have health insurance from another source. When asked why they did not enroll, 26 percent of respondents cited technical difficulties with the website, poor experience with Healthplanfinder or poor customer service. One broker suggested that adding an overall description of the application and enrollment process would make it easier for potential QHP enrollees to navigate Healthplanfinder. This could reduce the frustration that was described in the consumer survey and could increase QHP enrollment.

Partnering with California could reduce the hourly rate the Exchange pays to its call center vendor, but leasing the federal IT platform would increase costs.

Not all aspects of a state-based health benefit exchange are suitable for partnerships with other states or the federal government. We learned this as we considered whether partnering with other states to reduce IT costs by sharing services is possible. However, we did find opportunities within the call center that could benefit Washington's exchange.

Partnering with California for a lower hourly call center rate merits exploration

California's health benefit exchange, Covered California, uses state employees to handle most call volume, but it also contracts with Faneuil, Inc., to handle its overflow calls during open enrollment. Covered California pays Faneuil $23.75 an hour for staff in the overflow center. During 2015, Washington paid Faneuil on average $26.18 an hour. Covered California managers told us they could see potential benefits in a partnership with the Exchange. If the Exchange partnered with Covered California and obtained the same rate, it could save between $756,000 and $1.3 million annually, depending on call volume. These savings would be shared by the Exchange and the Medicaid program.

Furthermore, the Exchange's contract with Faneuil guarantees it will receive the same or better prices as any other customer with similar requirements and qualifications. If the Exchange is unable to establish a partnership with Covered California, it may be able to use this contract clause to negotiate a better rate with Faneuil.

More than 7 percent of calls were prompted by error codes in 2015

Errors made by customers while enrolling on Healthplanfinder also increase call volume. For example, if a customer starts an application in Healthplanfinder, encounters a problem and decides to start a new application, the system generates an error code that may take many calls to unravel. The Exchange could prevent customers from starting additional applications by telling them what to do up front if they encounter a problem.

Leasing the federal IT platform is not currently cost-effective

The legislation requiring this audit directed the State Auditor to assess whether partnering with the federal exchange could lower operating costs for Washington's Exchange. Under the ACA, states can operate a state-based exchange that uses the federal Healthcare.gov IT platform, relying on it for eligibility determination, enrollment and support for customers purchasing QHPs. However, the state remains responsible for outreach and other Act requirements. To evaluate this option, we considered the experience of other states that chose leasing in light of new fee proposals from CMS.

A proposed user fee could increase costs for those state-based exchanges leasing the federal Healthcare.gov platform

Until now, state-based exchanges of Hawaii, Oregon, Nevada and New Mexico have not been charged any fees to lease the federal IT platform. In the fall of 2015, CMS proposed imposing a 3 percent leasing fee, based on QHP premiums, that would be in addition to any taxes or fees the state exchanges charge insurers to support their other operations, such as customer outreach and plan management. Some exchanges that have leased the federal platform for free have expressed concern about the proposed fee.

For example, Oregon's Department of Consumer and Business Services estimates that if it passed the fee along to people insured through its exchange, it would mean $13 million a year in higher premiums. As a result, Oregon is considering buying a proven IT system from another state-based exchange. Similarly, Nevada estimates the 3 percent fee would add more than $7 million to the premium fees it already charges customers. In a statement to the Washington Post, the Director for Nevada's exchange described the 3 percent federal fee as "excessive."

As shown in **Exhibit 14**, while leasing the federal platform would allow the Exchange to reduce its own IT, call center and staffing costs, the lease fee would still add more than $13 million in spending to the Exchange's budget. We noted that other state exchanges that lease the federal platform maintain a smaller staff, a smaller call center and maintain a more limited system. For the purposes of our calculations, we assume these costs are entirely avoidable. However, some portion of these costs would continue, and for this reason, the net costs shown are likely understated. Our calculations assume HCA is fully reimbursing the Exchange for the Medicaid services it provides.

Exhibit 14 – Leasing the federal platform would increase the Exchange's current costs by at least $13 million

Annual costs (or savings)

	Annual cost	Notes
Leasing costs	**$23.8 million**	
Less maximum avoided costs		
IT Maintenance and operations	($1.0 million)	Includes contracted maintenance, license fees, security, and operations.
IT Release and development	($2.6 million)	Includes compliance and regulatory costs and the annual Qualified Health Plan Update.
Call center	($4.5 million)	Other federally-facilitated state-based exchanges have call center costs, so actual savings would be lower.
Staffing costs	($2.7 million)	
Net cost/(Benefit)	**$13 million**	**The cost is much higher than the savings.**

Source: Auditor calculation using Exchange financial data.

Furthermore, leasing the federal IT platform would increase the state's Medicaid program costs, because HCA would be left having to pay the full cost to manage the interfaced systems that handle the state's Medicaid eligibility determinations and enrollment. Although too expensive at this time, the Exchange should continue to evaluate the cost of leasing the federal IT platform in the future.

The Exchange can seek ways to increase enrollment in qualified health plans and enrollment-driven revenue

Just over half of the Exchange's operating budget of $110 million for the 2015 – 2017 biennium comes from two sources: the 2 percent tax on premiums for QHPs sold on the Exchange and the assessments on insurers. Although the Exchange will no longer be as reliant on health plan enrollment when the state and the federal Medicaid program fully reimburse the Exchange for services received, increasing enrollment improves the Exchange's financial sustainability. In 2016, the Exchange expects to collect an average of $182 in taxes and assessments for each person enrolled in a QHP.

The Exchange can potentially increase health plan enrollment by improving clarity around its automatic re-enrollment process, expanding broker-assisted enrollment, and highlighting the help that is available to customers on its website.

The Exchange could increase revenue with better information about automatic renewal

Although Washington's approach to automatic renewal is similar to other state exchanges, it has a lower retention rate. According to a six-state study conducted by the Urban Institute, exchanges in California, Kentucky and Washington automatically renew health plan holders and update their subsidy rates when it is time to renew coverage. However, during the second year of enrollment, California and Kentucky reported retention rates over 90 percent; Washington's rate was only 80 percent.

Washington's lower retention rate may result from customer confusion about the renewal process. The Urban Institute noted that insurers describe Washington's communication around automatic renewal as "well-intentioned but perhaps confusing." For example, Washington customers received one set of notices from insurers and separate notices from the Exchange. Other exchanges in the study worked together with the carriers to ensure consistency.

Both brokers and navigators agreed that Washington's process is confusing, and even experienced navigators told us they do not understand parts of Washington's renewal process. The 2015 customer survey revealed that only 43 percent of respondents with QHP plans said they received clear instructions on how to renew.

Also, the Urban Institute found that Washington was unique among the study states in that a comparatively high 20 percent of QHP plan holders did not give the Exchange on-going consent to access income information. Customers in Washington may be more reluctant to provide on-going approval, compared to customers in the other states, due to the way the Exchange's website describes how income will be verified. In addition, during the second year of enrollment, Washington experienced more technical problems with its renewal process than other states in the study. As a consequence, some plan holders who thought they had been automatically renewed had to re-enroll or they were inadvertently dropped. The Exchange may be able to increase retention and enrollment by clarifying its message around automatic renewals.

The Exchange could enlist brokers to help encourage health plan enrollment

According to national information reported by the Urban Institute and the 2015 customer survey, insurance agents and brokers were identified as customers' most helpful information source. In its pilot program, Minnesota's MNsure exchange partners with broker agencies that serve customers at in-person enrollment centers. The six broker agencies participating in the pilot program's first year enrolled 14 times more people in QHPs than they did in the previous year when they did not participate in the program. The Exchange wants to expand broker-assisted enrollment in Washington, and devising a program like Minnesota's could increase enrollment and reduce call center costs.

Better information about subsidies for health insurance could draw new customers to the Exchange

The ACA has been widely publicized, but people considering health insurance may not know that a family of four may earn about $97,000 annually and still qualify for financial assistance.

Many exchanges provide tables, graphics and calculators to tell users about the income levels that qualify for subsidies to lower their premiums. For example, the Maryland Health Connection has a table on its homepage (illustrated in **Exhibit 15**). While Healthplanfinder allows customers to anonymously browse plans and see estimates of potential subsidies, the initial homepage does not highlight the income levels that qualify for assistance.

Exhibit 15 – Maryland Health Connection highlights incomes qualifying for assistance

If your household size is this:	You may be eligible for Medicaid if your income* is less than approximately:	You may be eligible for reduced premiums and/or lower insurance costs if your income is less than approximately:
		For Plans in 2016
1	$16,349	$47,080
2	$22,108	$63,720
3	$27,821	$80,360
4	$33,534	$97,000
5	$39,247	$113,640
6	$44,960	$130,280
7	$50,687	$146,920
8	$56,428	$163,560

**Income eligibility levels for pregnant women and families with children are higher.*

Source: Maryland State Department of Health and Mental Hygiene, Medicaid Planning Administration.

In addition to the subsidies that lower premiums, cost-sharing reduction plans lower the costs of deductibles and co-pays. Customers qualify for these plans based on income. For example, a family of four earning less than $60,750 a year can qualify for subsidies to lower their premiums and additional federal assistance to lower deductibles and co-pays. Many exchanges highlight the benefits of these plans. For example, GetInsured (a private exchange that provides the platform for state-based exchanges in California, Idaho, Mississippi and New Mexico) has a Questions & Answers section and an interactive graphic to show how the plans work.

Healthplanfinder has information about cost-sharing reduction plans, but the Exchange could better highlight the benefits through bold explanatory messages on the website. Currently, Washington ranks 41st out of 49 states in the percentage of health plan purchasers who also use a cost-sharing reduction plan. If customers better understood the income levels that qualify for assistance and the benefits of these plans, they would more likely enroll in coverage.

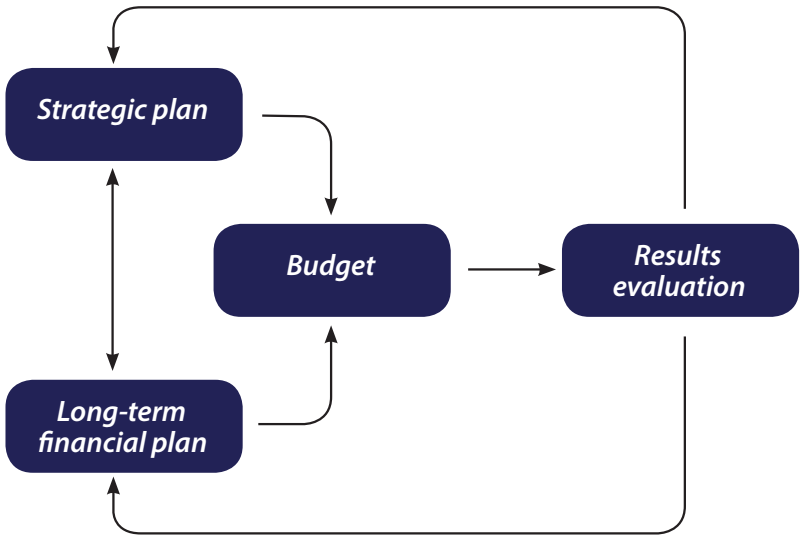
Sustainability will require a long-term financial plan and attention to financial management over the next three years

Washington's exchange was slower than others to focus on sustainability. Although it has a strategic plan, it lacks a long-term financial plan and has only recently started to address other aspects of sound financial management.

Washington state law (RCW 43.71) requires the Exchange to establish a method to ensure it is financially self-sustaining. Long-term financial planning provides this method by combining financial forecasting with strategic investment and expenditures. Forecasts are used to gain insight into future financial capacity so that operational strategies can be developed to achieve long-term sustainability in light of an agency's long-term financial challenges and capital needs, such as IT investments. Such planning promotes long-range perspectives (five or more years) on an organization's financial direction. **Exhibit 16** shows this integration at a high level.

Exhibit 16 – A Comprehensive Planning Framework

How Strategic Planning and Budgeting are Integrated



Source: Protect Your Community with Financial Planning, Written by the Government Finance Officers' Association, Published by Public Management in 2007.

Although the Exchange established a strategic plan in September 2015, it lacks a long-term financial plan, in particular how and when it will pay for future IT investments. Such a financial plan must acknowledge the significantly lower enrollment that is now forecasted and its effect on revenue, spending capacity and sustainability. The Exchange's managers acknowledge they were slow to start such planning, telling us they were focused on addressing the IT problems related to billing and collecting premiums, and on working through its budget uncertainties during the long legislative session in 2015. The high enrollment forecasts from 2012 perhaps contributed to a sense that the Exchange's near-term finances were secure, and long-term planning was not urgently needed.

Other financial management tools are essential if the Exchange is to manage to a goal of sustainability

Plan how to respond to fluctuations in enrollment-driven revenue

A 2012 report to the Legislature from a consulting firm that works with many state exchanges noted higher plan enrollment positively affects sustainability because most of an exchange's costs are fixed. Higher enrollment therefore results in significantly lower per-member costs.

Many states have seen their QHP enrollment stagnate or come in lower than expected. Similarly, Washington's enrollment in QHPs fell short of initial calendar year-end forecasts: 280,000 predicted for 2014, 343,000 for 2015, and 407,500 for 2016. For example, as of March 2016, actual enrollment totaled only 192,000. Although a 2015 forecast shows that plan enrollment will increase modestly over the next four years, these forecasts are never certain. A recent California State Auditor's report recommended that Covered California's financial planning identify the contracts it could quickly eliminate and other actions it could take if enrollment-driven revenues were lower than expected.

Factor in IT investments

To manage its sustainability, the Exchange must establish a long-term financial plan that focuses not only on operating costs, but on needed IT investments. The timing and extent of planned IT investments is affected by the amount of insurer assessments and capital reserves that are established to pay for them. Such reserves are typically part of a long-term financial plan.

Appendix F provides a list of needed IT investments that have been identified by the Exchange. Because the Exchange lacks a long-term financial plan and a capital reserve, the Exchange risks unnecessarily deferring those investments that would help increase its health plan enrollments or pursuing others too quickly at the expense of its sustainability. Similarly, the Exchange's strategic plan does not require periodic consideration of the federal exchange.

Ensure the Audit Committee plays its role in meeting self-sustainability compliance requirements

The Audit Committee, consisting of a select number of board members, is responsible for ensuring the Exchange meets all state and federal laws. However, the committee does not review the Exchange's compliance with the self-sufficiency requirement. Exchange officials told us the Operations Committee oversees the strategies and solutions that are necessary to achieve self-sufficiency. However, because the Audit Committee must still fulfill its Charter, it should obtain ongoing assurances from the Operations Committee that the Exchange is self-sufficient.

Establish a policy concerning the amount of working reserves and its effect on the carrier assessments it charges

Enrollment-driven revenues at state-based exchanges are expected to be inversely related to a strengthening economy, when more people have employer-provided health insurance. When the economy is weak, fewer people have coverage, and more will need to turn to the exchange to purchase their insurance. Maintaining a working reserve of funds enables exchanges to more easily manage their sustainability during these ups and downs. Connecticut's plans call for on-hand reserves that are sufficient to pay for nine months of operations; California plans for reserves of up to six months.

A working reserve would also help the Exchange weather delays in obtaining reimbursements from HCA for Medicaid enrollees and other unanticipated challenges. The Exchange plans to work with OFM and the Legislature to establish a reserve – not only for IT investments but also to ensure stable operations during transitional economic times.

In pursuit of self-sustainable operations, some exchanges decided not to bill and collect insurance premiums while Washington did

As of late 2014, Washington was one of only four state-based exchanges that billed and collected insurance premiums on behalf of insurance companies (premium aggregation). Although it was never required to provide this service, the Exchange originally pursued it to provide an easier enrollment experience. Early on, Connecticut's strategic planning focused heavily on financial sustainability. Considered two of the best run exchanges in the country, Connecticut and Kentucky decided to do fewer functions well. Both states decided against premium aggregation and both had comparatively seamless startups. The Exchange's decision to pursue premium aggregation, the subsequent problems that resulted, and its later effort to remove it, distracted it from focusing on sustainability.

The Exchange is addressing some financial management weaknesses that made it more difficult to monitor its costs and self-sustainability, but one remains

Recently, the Exchange experienced difficulty preparing financial reports and reconciling its accounts. These difficulties delayed its ability to obtain complete and timely cost reimbursements from the Health Care Authority and to provide us with the financial information we needed for the audit. One consultant noted these types of reporting weaknesses were attributable to the accounting system's limited functionality. Its 2015 strategic plan and 2016 budget request both identify the Exchange's plans to upgrade its accounting system.

Although charges were small, we identified instances in which the Exchange paid Deloitte for work that was performed before it was contractually approved. A consultant hired by the Exchange identified similar instances and others where the Exchange agreed to work orders that exceeded the contract cap before it was amended. Insisting that all work is contractually authorized before it is performed and that work orders do not exceed contract caps helps control costs and avoid vendor disputes. Through 2015, the Exchange had a procurement officer but lacked a contracts manager. During this time, contract authorities were unclear. To address these matters, management told us it has developed contracting policies that specify lines of authority and a spreadsheet that tracks contract caps so they are not exceeded. It also hired a contracts manager in February 2016.

Based on OFM instructions, the Exchange accounts for both carrier assessments and premium taxes in a single account that is maintained by the State Treasurer. The Exchange uses the funds in this account to pay for its QHP related operations, and to pay for some of the state's match on the Medicaid reimbursements it receives.

This accounting arrangement is problematic. Unlike premium taxes, which can be spent on eligibility services for both Medicaid and QHPs, the Exchange's carrier assessments can only be spent on servicing QHPs. These assessments may only be used to pay for QHP related operations. But because the two funding sources are comingled in one account, the Exchange cannot ensure its carrier assessments are used only for their statutorily intended purpose. This accounting arrangement creates one more problem. Unless separate accounts are established, if the legislature ever decides to transfer these funds as part of a future budgeting process, it cannot distinguish the carrier assessments from the premium taxes.

Recommendations

We recommend the Exchange:

1. **Work with the Health Care Authority (HCA) to ensure it is fully reimbursed for the Medicaid services it provides by doing the following:**
   a) Insist on mutual adherence to the cooperative agreement with HCA, which requires the equitable sharing of all applicable costs between the Exchange and HCA.
   b) Work with HCA to seek payment from the state and the federal Medicaid program for past unreimbursed services the Exchange provided.
   c) Work with CMS to determine if it must repay federal grant funds that were used to pay for these unreimbursed Medicaid services.
   d) Work with HCA to submit a corrected cost reimbursement plan to CMS so the Exchange is fully reimbursed for the future services it provides to Medicaid clients on behalf of HCA.
   e) Consistent with the Dispute Section of its cooperative agreement, pursue arbitration through the Governor's office if a fair and equitable cost reimbursement plan cannot be readily achieved.
   f) Work with HCA to more quickly establish future cost reimbursement plans and to obtain timely reimbursements.
   g) Retain system-generated QHP enrollment figures to better support the recovery of Medicaid related costs incurred on behalf of HCA.
   h) Ensure the following are reported in its financial statements:
      - Receivables related to the unpaid reimbursements for Medicaid-related costs incurred by the Exchange.
      - Obligations to the federal government, if any, for those establishment grant funds that were used for Medicaid services and the Exchange's operating costs after January 1, 2015.
2. **Reduce call center costs and increase enrollment and resulting revenues by doing the following:**
   a) Partner with California to obtain the same low hourly rates or use the contract's best pricing guarantee to negotiate a better rate.
   b) Ensure all call center contract costs are capped to the CPI or other third-party inflation sources.
   c) Pursue cost-effective Healthplanfinder and website improvements to achieve reduced call volume and increased enrollment.
   d) Collect additional information to better identify the key issues that customers call about, so issues can be avoided and call center calls can be reduced.
   e) Develop a searchable knowledge library to help staff assist customers faster.
   f) Plain-talk all boiler-plate correspondence to QHP customers to reduce the number of calls.
   g) Explore ways to use brokers more to improve customer service, reduce call center costs, and increase enrollment.

h) Track how customers enroll in plans, such as through brokers, navigators, the website, etc. to measure progress towards cost containment through increased self-enrollment and broker-assisted enrollment.
i) Highlight the income levels that qualify for subsidies and Cost-Sharing Reduction plans on Healthplanfinder's homepage, and advertise the benefits of Cost-Sharing Reduction plans throughout the application process.
j) Clarify and improve information on automatic renewal to increase QHP enrollment.

3. **Improve long-term financial planning and other financial management practices by doing the following:**
   a) Create a long-term financial plan that will help the Exchange better manage its sustainability. Share this plan with the Legislature and HCA so it is factored into the appropriation and cost allocation process.
   b) Add self-sustainability to the Audit Committee's charter since it is a legal requirement the Exchange must meet.
   c) Require periodic considerations of moving to the federal exchange and the criteria it will use in making those assessments.
   d) Work with CMS to resolve the Inspector General's concern that unallowable operational costs may have been charged to federal grants. If they identify unallowable costs, the Exchange should work with CMS to reimburse the federal government.
   e) Work with OFM and the State Treasurer to establish one account for premium taxes and another for carrier assessments. Afterwards, make sure that carrier assessments are only used for QHP-related purposes.

We recommend the Legislature:

4. **Consider the following as part of the appropriation process:**
   a) Eliminating any requirement that the Exchange spend minimum amounts on navigators and outreach.
   b) The Exchange's need to obtain full reimbursement for all Medicaid-related costs.
   c) The Exchange's long-term financial plan, its planned list of IT investments, its need for both working and capital reserves, and how sweeping those reserves adversely affects planning.

Agency Response

STATE OF WASHINGTON

June 24, 2016

Honorable Troy Kelley
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor Kelley:

Thank you for the opportunity to review the State Auditor's Office (SAO) performance audit report, "Costs and Sustainability at the Washington Health Benefit Exchange."

While not audited for this report, the Health Care Authority (HCA) is a key partner of the Health Benefit Exchange (HBE). HBE has been a national leader in expanding health coverage to Washington state residents. HBE funding and expenditure information, both state and federal, has been regularly shared with the Legislature and the public.

HCA and HBE have worked closely with the federal Centers for Medicare and Medicaid Services (CMS) to ensure compliance with all requirements for the use of federal funds. We are pleased the SAO did not find any inappropriate or questionable expenditures. Rather, the findings address whether the correct share of costs was allocated to Medicaid and other federal grants.

States have many options for developing cost-allocation plans for Medicaid reimbursements. The methodology must be approved by CMS, and only costs documented in the plan can be reimbursed. HCA and HBE worked together to develop a cost-allocation plan that would best serve Washingtonians. That plan, and subsequent annual updates, were approved by CMS. To date, CMS has not questioned the appropriateness of costs charged to its federal grants.

SAO's methodology is different from the methodology CMS approved for our state. Under the approved CMS methodology, more federal grant funding is used for CMS-approved expenditures. If the methodology proposed by the SAO were implemented, $90 million would retroactively shift to Medicaid. This would require up to $44.6 million in General Fund-State funds as match for federal fund expenditures. Because we have CMS approval for the current methodology, we are uncertain whether costs incurred under the approved plan will or should be allocated differently.

We appreciate the input about the effects of different methodologies, and will consider it and other information when updating the next cost-allocation plan.

Sincerely,

Dorothy Frost Teeter, Director
Health Care Authority

David Schumacher, Director
Office of Financial Management

cc: David Postman, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Miguel Pérez-Gibson, Executive Director of Legislative Affairs, Office of the Governor
Matt Steuerwalt, Executive Director of Policy, Office of the Governor
Tracy Guerin, Deputy Director, Office of Financial Management
Wendy Korthuis-Smith, Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
MaryAnne Lindeblad, State Medicaid Director, Health Care Authority
Pam MacEwan, Chief Executive Officer, Washington Health Benefit Exchange

June 24, 2016

Honorable Troy Kelley
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021
Washington State Auditor's Office

Dear Auditor Kelly:

Pursuant to RCW 43.71.080 (8), the State Auditor's Office (SAO) has spent the last year conducting a performance review of the Washington Health Benefit Exchange's (Exchange) operating costs.

We appreciate the due diligence done on the part of the SAO and appreciate the agency's commitment of both time and resources to ensure a thorough examination of operating costs, fiscal responsibility and the Exchange's efforts to become sustainable.

Since its inception, the Exchange has helped improve access, increase competition and lower cost trends in the individual health insurance market. As of today, one in four Washington residents obtain their health coverage through *Washington Healthplanfinder*, providing a marketplace for hundreds of new insurance products, creating more competition, and bringing affordability to thousands of families – many for the first time. Residents have accessed over $900 million in subsidies to help pay for premiums and over $150 million to reduce out-of-pocket costs. And through its outreach and enrollment efforts, the Exchange has not only reached and enrolled more than 169,000 Qualified Health Plan (QHP) but also added close to 600,000 newly eligible Medicaid enrollees – 250% over the forecasted target.

The state auditor's office found that the Exchange's largest cost areas – IT maintenance and operations, call center expenses and wages, are reasonable and compare well with other states. Furthermore, the report found that the idea of the state leasing of the federal marketplace IT platform is not cost effective, increasing the Exchange's overall operating expenses.

We concur with these findings as they corroborate findings seen by the Exchange from internal and external audits and reviews and such reports conducted nationally.

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To that end, the Exchange also concurs with state auditor's findings regarding additional actions and opportunities – the majority that are already underway – that would help the Exchange reduce costs, increase enrollment and achieve financial sustainability. These include:

- Assessing operational dependencies and adjustment contractual arrangements in the areas of both information technology and call center operations.
- Increasing enrollment in Qualified Health Plans through web site improvements for both new and renewing customers as well as exploring ways to use brokers to improve customer service and increase enrollment
- Working with the Washington State Health Care Authority (HCA) to revise the current cost reimbursement plan to better reflect the Exchange-related activities performed on behalf of HCA's Medicaid program.
- Establishing long-term financial management practices and procedures to ensure the adequate capturing, accounting and spending of state dollars, including planning for a working and capital reserve.

It is important to note that the Exchange remains fully supportive and is committed to working with HCA on a revised cost allocation plan that represent both fair and full reimbursement for Medicaid activity. We recognize that the efficacy of that allocation arrangement – and its subsequent approval by the Centers for Medicare and Medicaid Services (CMS) – is critical to our organization's sustainability.

However, the Exchange does not see a need to revisit previous decisions associated with cost reimbursement for Medicaid-related services for purposes of reclassifying expenditures.

The initial cost reimbursement as agreed upon by HCA and the Exchange was equitable based on the best information available at that time and the corresponding work undertaken to identify costs and services. The identified expenditures and supporting methodology served as the framework for the required advanced planning document (APD). This advanced planning document was submitted for review and authorization with CMS granting approval of the agreed upon cost allocation and reimbursement methodology. Several times, the APD was updated to recognize changes in enrollment.

It is important to note that the Exchange's three legislatively appropriated funding sources – (1) the 2% premium tax paid for plans sold in the Exchange; (2) the carrier assessment paid for plans sold in the Exchange, and; (3) the cost paid by HCA for Medicaid-related services provided by the Exchange – have all been and continue to be used in a legally and fiscally appropriate manner.

Moving forward the Exchange is fully committed to establishing an ongoing process that identifies and defines equitable reimbursement for its Medicaid activities. This is reflected today in the continued work being done with HCA to reach agreement on updates to the appropriate cost allocation methodologies; enforcing the HCA/Exchange cooperative agreement to guarantee the timely submission of any updates to CMS, and; encouraging discussion of future cost reimbursement, enabling the timely capturing of dollars for both organizations and the state.

Attached please find an accompanying document that provides responses in detail to the specific findings found in the report. Again, we appreciate the work by the state auditor's office and look forward to further discussions on this report with our board, members of the legislature, our many stakeholders and partners as well as the public at large.

Sincerely,

Pam MacEwan
Chief Executive Officer
Washington Health Benefit Exchange

Enclosure: SAO Matrix

cc: David Postman, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Miguel Perez-Gibson, Executive Director of Legislative Affairs, Office of the Governor
Matt Steuerwalt, Executive Director of Policy, Office of the Governor
Robert Crittenden, Senior Policy Advisor, Office of the Governor
Wendy Korthuis-Smith, Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
David Schumacher, Director, Office of Financial Management
Tracy Guerin, Deputy Director, Office of Financial Management
Richard Pannkuk, Senior Budget Assistant, Office of Financial Management
Dorothy Teeter, Director, Health Care Authority
MaryAnne Lindeblad, State Medicaid Director, Health Care Authority
Ron Sims, Chair, Washington Health Benefit Exchange Board

Rec	Description	Status	Action Steps	Lead Agency	Due Date	Notes
1	**Work with HCA to assure it is fully reimbursed for the Medicaid services it provides by doing the following:**					
1a	Insist on mutual adherence to the cooperative agreement with HCA, which requires the equitable sharing of all applicable costs between the Exchange and HCA	In progress	HBE and HCA are currently renegotiating their Agreement, including Schedules A-1 and A-2, to improve cost allocation and implement section 213(3)(g)(iv) of the 2016 supplemental budget.	HBE/ HCA	8/1/2016	
1b	Work with HCA to seek payment from the state and the federal Medicaid program for past unreimbursed services the Exchange provided.	Not Planned		HBE		The Exchange submitted and received funding for services provided for Medicaid in accordance with a CMS approved cost allocation plan. CMS has not issued a disallowance or taken other action to invalidate or require revision of the previously approved plans.
1c	Work with CMS to determine if it must repay federal grant funds that were used to pay for these unreimbursed Medicaid services.	Not Planned		HBE		The Exchange submitted and received funding for services provided for Medicaid in accordance with a CMS approved cost allocation plan. As recently as this month, CCIIO indicated no intention to seek repayment of grant funds or disallowance of costs.
1d	Work with HCA to submit a corrected cost reimbursement plan to CMS so the Exchange is fully reimbursed for the future services it provides to Medicaid clients on behalf of HCA.	In progress	HBE continues to work with HCA to submit a new-advanced planning document (APD) to CMS in August for Federal Fiscal Year 2017. The APD requests full reimbursement for all Exchange operational costs provided on behalf of Medicaid clients, as directed by section 213(3)(g)(iv) of the 2016 supplemental budget.	HBE / HCA	10/1/2016	
1f	Work with HCA to more quickly establish future cost	In progress	HBE and HCA are currently renegotiating their existing operating agreement, including	HBE / HCA	8/1/2016	

Rec	Description	Status	Action Steps	Lead Agency	Due Date	Notes
	reimbursement plans and to obtain timely reimbursements.		Schedules A-1 and A-2, to improve cost allocation and implement section 213(3)(g)(iv) of the 2016 supplemental budget, which requires the timely submission of APDs by HCA.			
1g	Retain system-generated QHP enrollment figures to better support the recovery of Medicaid related costs incurred on behalf of HCA.	Not planned	See note- action will only be taken as needed.			The Exchange will receive Medicaid reimbursement based on its CMS approved plan. The percentage of QHP to Medicaid enrollment does not change significantly from year to year. An update will be submitted to CMS in the event such of such a change.
2.	**Reduce call center costs and increase enrollment and resulting revenues.**					
2a	Partner with California to obtain the same low hourly rates or use the contract's best pricing guarantee to negotiate a better rate.	In progress	The Exchange continues to pursue operational efficiencies. This includes the renegotiating its call center contract; which includes the proposal to utilize the California call center from overflow coverage.	HBE	12/31/2016	
2b	Assure all call center contract costs are capped to the CPI or other third-party inflation sources.	In progress	The Exchange is currently in process of renegotiating its call center contract. CPI or third-party inflation sources continue to inform all financial and contractual discussions.	HBE	12/31/2016	
2c	Pursue cost-effective Healthplanfinder and website improvements to achieve reduced call volume and increased enrollment.	In progress	The Exchange has included system improvements for an enhanced customer experience and improved efficiency of call center operations in releases scheduled for July 2016, September 2016	HBE	06/2017	

Rec	Description	Status	Action Steps	Lead Agency	Due Date	Notes
			and April 2017. These efforts are represented in the three work plan items that follow.			
2d	Collect additional information to better identify the key issues that customers call about, so issues can be avoided and call center calls can be reduced.	In progress	The Exchange will continue the practice of gathering data on calls in order to identify key issues. Daily and monthly reports are currently run that identify issues and issue areas that inform both operations and process improvements.	HBE	06/2017	
2e	Develop a searchable knowledge library to help staff assist customers faster.	In progress	In July, the Exchange will debut content management functionality that will enable more control of existing information and material on Exchange web properties, allowing for a faster, more intuitive search experience.	HBE	06/2017	
2f	Plain-talk all boiler-plate correspondence to QHP customers to reduce the number of calls.	In progress	The Exchange continues to assess and adapt notification language provided to QHP customers to the extent state and federal law allows such modifications. The Exchange is currently conducting a review of all notices with the intent of simplifying existing correspondence.	HBE		
2g	Explore ways to use brokers more to improve customer service, reduce call center costs, and increase enrollment.	In progress	The Exchange will be implementing a pilot program with brokers to identify strategies to increase enrollment, including the use of storefronts/enrollment centers during the open enrollment period.	HBE	6/30/2017	

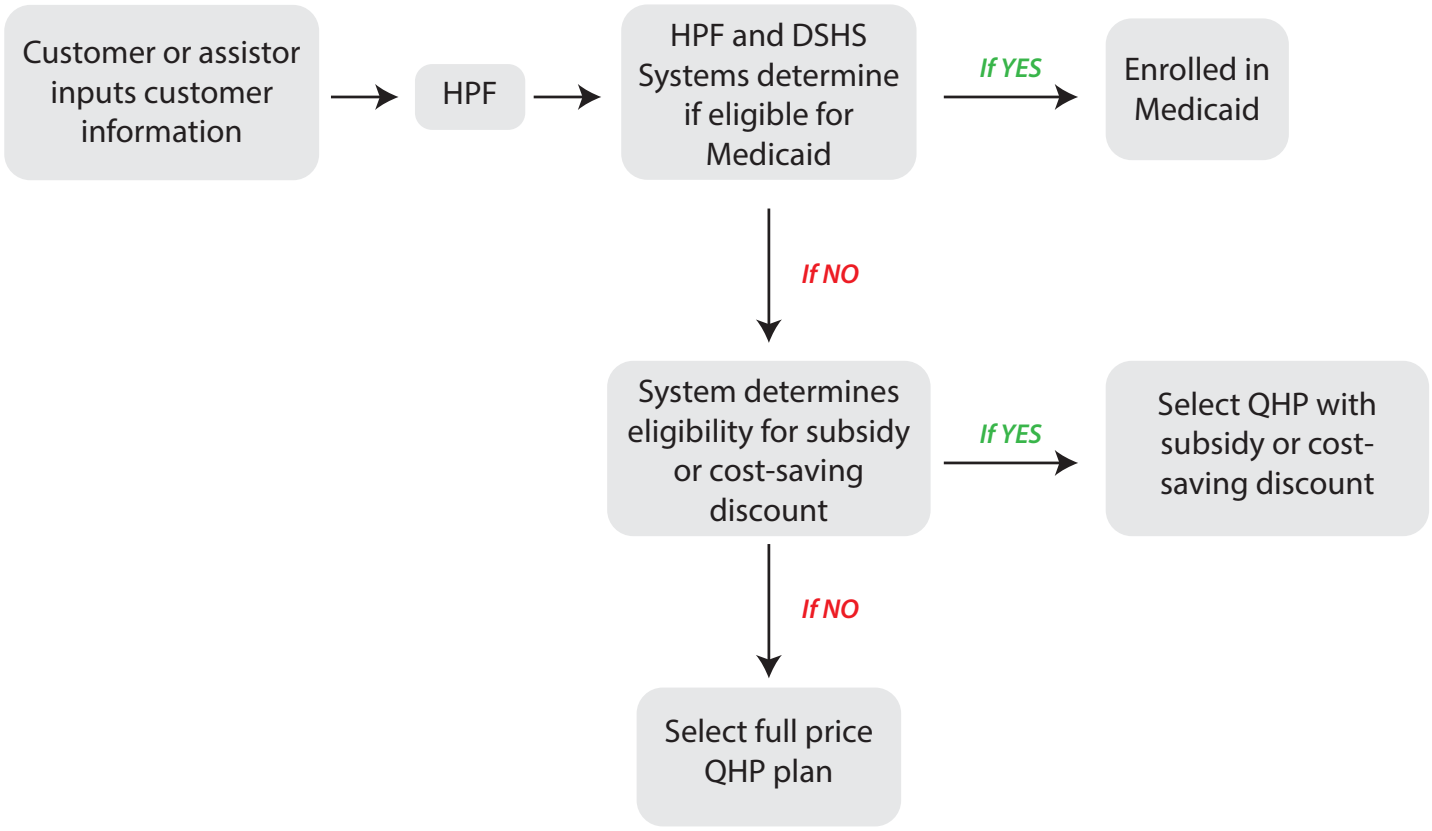
Rec	Description	Status	Action Steps	Lead Agency	Due Date	Notes
2h	Track how customers enroll in plans, such as through brokers, navigators, the website, etc. to measure progress towards cost containment through increased self-enrollment and broker-assisted enrollment.	In Progress	The Exchange is evaluating modifications to the current system that may yield more accurate measurement of customer engagement at the point of purchase, including the documenting of Navigators and brokers interaction during the enrollment process.	HBE	6/30/2017	
2i	Highlight the income levels that qualify for subsidies and Cost-Sharing Reduction plans on Healthplanfinder's homepage, and advertise the benefits of Cost-Sharing Reduction plans throughout the application process.	In progress	The Exchange will continue to highlight the importance of selecting the most appropriate plan by incorporating stronger messaging and decision-making graphics into the 2017 online application process as well as in corresponding outreach and communications plans.	HBE	6/30/2017	
2j	Clarify and improve information on automatic renewal to increase QHP enrollment.	In progress	The Exchange will improve outreach to individuals who have previously declined automatic renewal to encourage them to participate. This may include, but not be limited to, preferred communications vehicles – email, mail, robocall or other.	HBE	12/31/2016	
3.	**Improve strategic planning, long-term financial planning, and other financial management practices**					
3a	Create a long-term financial plan that will help the Exchange better manage its sustainability. Share this plan with the Legislature and HCA so it is	Pending	The Exchange will develop a long-range financial plan including the development of a reserve. This process includes the development of an operational business plan	HBE	12/31/2016	

Rec	Description	Status	Action Steps	Lead Agency	Due Date	Notes
	factored into the appropriation and cost allocation process.		that will be presented to the board for discussion.			
3b	Add self-sustainability to the Audit Committee's charter since it is a legal requirement the Exchange must meet.	Pending	This recommendation will be presented to the Exchange board for its consideration.	HBE	12/31/2016	Currently planning to have this going before the board in July 2016.
3c	Require periodic considerations of moving to the federal exchange and the criteria it will use in making those assessments.	Not planned		HBE		The Exchange will continue to respond to legislative and executive branch questions and analysis regarding the effectiveness and efficiency of the Exchange.
3d	Work with CMS to resolve the Inspector General's concern that unallowable operational costs may have been charged to federal grants. If they identify unallowable costs, the Exchange should work with CMS to reimburse the federal government.	Not planned		HBE		The Exchange has had discussions with CMS who has stated that the Exchange has appropriately used their establishment grants in the all areas audited by the SAO.
3e	Work with OFM and the State Treasurer to establish one account for premium taxes and another for carrier assessments. Afterwards, make sure that carrier assessments are only used for QHP-related purposes.	Pending	The Exchange will modify its chart of accounts to provide greater transparency regarding fund source for expenditures.	HBE		The Exchange does not believe it is necessary to have a separate account since it will have greater transparency in costs and revenues with the new financial system approved by the Legislature.

Appendix A: Healthplanfinder Enrollment Process

Figure 1 shows the decision-making process after customers (or their assistors) first submit information into the Healthplanfinder (HPF) website. The Exchange, together with the DSHS' eligibility system, determines whether these customers qualify for Medicaid. Those who do not qualify for Medicaid are further reviewed to determine whether they qualify for QHP plan subsidies and other assistance.

Figure 1 – Healthplanfinder enrollment process



Note: *Payments are not shown above because the customer pays the insurance carriers directly.*

Source: State Auditor analysis of Healthplanfinder application process.

Appendix B: Methodology

We performed the following audit procedures:

- **To determine whether the Exchange is receiving fair compensation for the Medicaid-related services it provides on behalf of HCA, we:**
  - Reviewed the Exchange's operating costs and interviewed staff to gain an understanding of what services are related to Medicaid.
  - Researched federal guidelines and best practices for Medicaid cost reimbursements at other state-based exchanges. Compared the Exchange's cost reimbursement plan against these federal guidelines, assessed the reasonableness of this plan.
  - Determined if the state and the federal Medicaid program were reimbursing the Exchange for all the Medicaid-related services provided on behalf of HCA.
  - Reviewed a selection of expenditures and determined whether the Exchange was reimbursed according to the CMS-approved reimbursement plan and whether that plan resulted in a fair and accurate reimbursement.
- **To determine whether the Exchange could reduce its IT maintenance and operating costs, we:**
  - Researched whether other states have formed partnerships to lower their IT costs and what efforts the Exchange has made to form such a partnership. We did not review the reasonableness of the Exchange's IT development costs as this was outside the scope of the audit.
  - Reviewed the Exchange's IT maintenance and operating costs, comparing them to industry standards and other state exchanges, and looked for opportunities to lower costs through state master contracts and use of the state data center.
  - Reviewed the Exchange's actions to reduce its maintenance and operations costs and its plans to continue to reduce them.
- **To assess the reasonableness of the Exchange's payroll costs and the possibility to lower them, we:**
  - Reviewed annual salary increases and bonuses, and compared them to the CPI and other benchmarks.
  - Compared executive management salaries to those of other state exchanges.
  - Reviewed the Exchange's compensation policies.
- **To determine whether the Exchange could reduce its call center costs, we:**
  - Obtained call center cost information for other state-based exchanges so we could compare it to Washington's costs. Some states provided us this information directly. For others, we obtained it from audit reports, contracts and reliable online sources.
  - Interviewed the Exchange's management and its call center vendor to determine the actions they are taking to reduce call center costs.
  - Determined how effectively the Exchange identifies and tracks the issues that contribute to more call center volume.
  - Interviewed navigators, brokers and call center management, and reviewed a customer survey and various reports to identify issues that cause increases to call volume.
  - Compared the Exchange's Healthplanfinder website to leading website practices to identify improvements that can make it easier for customers to use so they do not have to call for assistance.
  - Compared call center costs, including hourly and per-minute rates, to those of other state exchanges, taking into consideration regional costs of living.
  - Interviewed management from California's exchange to determine if there is an opportunity to partner with Washington's Exchange to lower call center contract costs.
  - Determined whether the Exchange was using contract provisions that capped future rate increases to the CPI or other industry sources.

- **To determine whether a federal partnership would reduce costs, we:**
  - Interviewed management and reviewed reports from other state-based exchanges that lease the federal IT platform.
  - Reviewed the cost and benefits associated with leasing the federal IT platform to determine whether this would lower the Exchange's operating costs.
- **To determine whether the Exchange could improve its long-term financial sustainability, we:**
  - Interviewed management to understand how they plan for long-term self-sustainability.
  - Compared the Exchange's long-term financial planning practices to best practices and those of other state-based exchanges.
  - Analyzed enrollment and revenue projections, including future budgets and expenditures.
  - Reviewed board committee charters to determine if the Exchange has a mechanism in place to ensure management was complying with future self-sustainability requirements.
  - Reviewed the reasonableness of the Exchange's calculated savings on removing premium aggregation.

Appendix C: Estimated Reimbursements Still Required

The tables below show the amount of Medicaid-related expenses the Health Care Authority should reimburse the Exchange for 2014 through 2016.

Calendar year 2014 estimated reimbursements still required

Cost categories being shared	Total costs	Actual reimbursement	Reimbursement per audit	Additional reimbursement needed[1]
HBE staff (IT)	$981,178	$28,258	$872,214	$843,956
Navigator costs	$4,103,322	$0	$3,780,713	$3,780,713
Call center/customer support	$23,913,234	$1,657,109	$15,540,022	$13,882,913
IT operations/maintenance	$8,922,117	$701,764	$7,955,427	$7,253,663
Subtotals	*$37,919,851*	*$2,387,131*	*$28,148,377*	*$25,761,246*

Cost categories that should also be shared	Total costs	Actual reimbursement	Reimbursement per audit	Additional reimbursement needed
Other HBE staff	$10,725,567	$0	$9,599,383	$9,599,383
Rent and facilities costs	$1,366,066	$0	$1,222,629	$1,222,629
General and administrative	$5,161,734	$0	$4,619,752	$4,619,752
Advertising and other professional services	$10,692,184	$0	$9,569,505	$9,569,505
Subtotals	*$27,945,551*	*$0*	*$25,011,268*	*$25,011,268*
Total CY2014				**$50,772,514**

Calendar year 2015 estimated reimbursements still required

Cost categories being shared	Total costs	Actual reimbursement	Reimbursement per audit	Additional reimbursement needed[1]
HBE staff (IT, call center, correspondence & Navigator)	$1,194,314	$606,300	$1,003,728	$397,428
Navigator costs	$2,652,613	$1,378,633	$2,357,032	$978,399
Call center/customer support	$15,402,740	$9,398,696	$10,446,682	$1,047,987
IT operations/maintenance	$7,212,955	$3,001,794	$6,561,819	$3,560,024
Bank fees	$45,000	$15,632	$40,960	$25,328
Subtotals	*$26,507,623*	*$14,401,055*	*$20,410,221*	*$6,009,166*

Cost categories that should also be shared	Total costs	Actual reimbursement	Reimbursement per audit	Additional reimbursement needed
Other HBE staff	$9,642,299	$0	$8,774,492	$8,774,492
Rent and facilities costs	$1,262,172	$0	$1,148,577	$1,148,577
General and administrative	$4,037,694	$0	$3,674,302	$3,674,302
Advertising and other professional services	$7,400,982	$0	$6,734,893	$6,734,893
Subtotals	*$22,343,147*	*$0*	*$20,332,264*	*$20,332,264*
Total CY2015				**$26,341,429**

Fiscal year 2016 estimated reimbursements still required

Cost categories being shared	Total budgeted costs	Budgeted reimbursement	Reimbursement per audit	Additional reimbursement needed[1]
HBE staff (IT, call center, correspondence & Navigator)	$2,489,192	$1,189,661	$2,122,385	$932,725
Navigator costs	$3,202,000	$1,147,277	$2,881,800	$1,734,523
Call center/customer support	$17,587,058	$10,244,936	$12,110,018	$1,865,081
IT operations/maintenance	$10,776,592	$5,453,085	$9,698,933	$4,245,848
Subtotals	*$34,054,842*	*$18,034,958*	*$26,813,136*	*$8,778,178*

Cost categories that should also be shared	Total budgeted costs	Budgeted reimbursement	Reimbursement per audit	Additional reimbursement needed
Other HBE staff	$8,775,294	$0	$7,897,765	$7,897,765
Rent and facilities costs	$1,293,467	$0	$1,164,120	$1,164,120
General and administrative	$1,437,552	$0	$1,293,797	$1,293,797
Advertising and other professional services	$5,508,533	$0	$4,957,680	$4,957,680
Subtotals	*$17,014,846*	*$0*	*$15,313,362*	*$15,313,362*
Estimated total[2] FY2016				**$24,091,539**

Notes:

[1] Additional Reimbursement Needed includes federal and state match for Medicaid reimbursement.

[2] Because the first six months of FY2016 are the same as the last six months of CY2015, we halved the FY2016 total when estimating the total reimbursement of $89.2 million that should have been paid to the Exchange, in order to avoid duplication.

Source: State Auditor analysis of FFY 2014-2016 Operational Advanced Planning documents, CY 2014-2016 Medicaid reimbursement requests to HCA and the Exchange's 2015-17 biennium budget.

Appendix D: Payroll Cost Comparisons

Figures 2 and **3** below show how CEO and CFO salaries at Washington's Exchange compared to compensation for these same positions at other state exchanges. We used the latest payroll information available for calendar years 2014 and 2015, and adjusted it by regional cost-of-living.

Figure 2 – CEO or Executive Director compensation by state

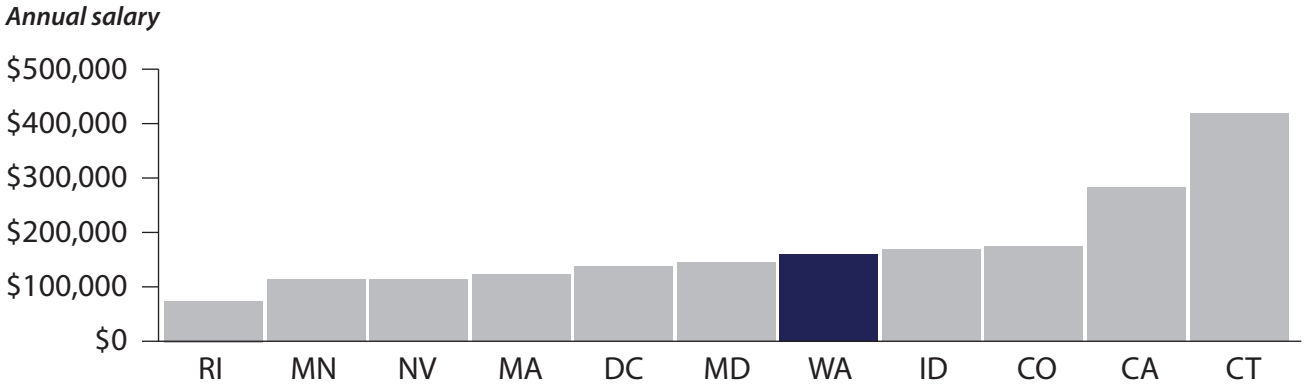
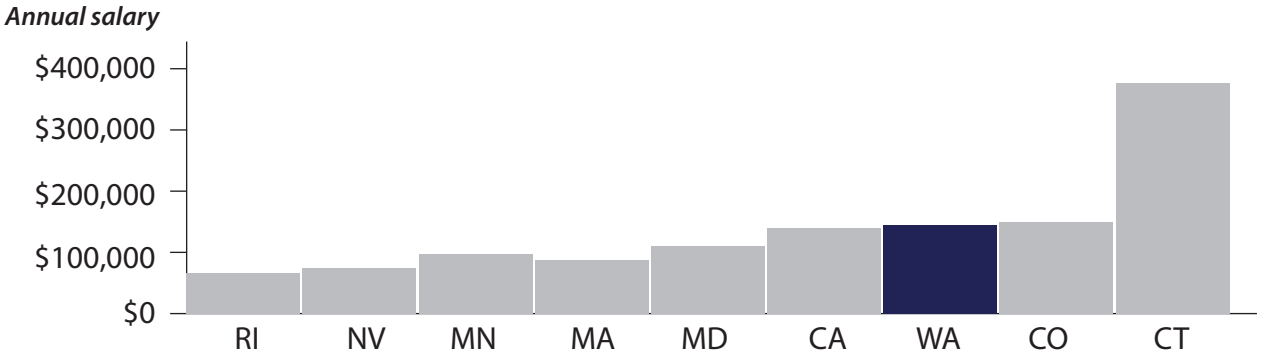


Figure 3 – Chief Financial Officer compensation by state



Sources: Most salary information was obtained from budget and salary information published by the state exchanges above. Other salary information was obtained directly from the CFO or other officials who worked at these exchanges. Some salary information was obtained from newspaper articles.

Appendix E: Call Center Cost Comparisons

Call center costs per minute compared to other states

Figure 4 below shows how Washington's call center costs compare to other states on a per-minute basis. Washington had an average cost of $0.84 per minute in fiscal year 2015. This per-minute cost compares favorably with other states that pay per minute rates to their call center vendors. These per-minute rates ranged from a low of $0.79 per minute to a high of $1.22 per minute.

Figure 4 – How Washington's cost per minute compares to other state exchanges

	Rate includes administrative and overhead costs		Rate does not include administrative and overhead costs	
	Washington	Vermont	Kentucky	Connecticut
Per-minute cost	$.84	$.86	$.79-$.84	$1.22
Per-minute cost adjusted for regional differences	$.84	$.88	$.92-$.97	$1.16

Note: *Because call center staff perform other functions in addition to answering phones, it is not feasible to compare hourly and per-minute rates by simply multiplying or dividing by 60.*

Source: Auditor-prepared exhibit using vendor-reported minutes and cost data from general ledger accounts or from vendor contracts.

Appendix F: The Exchange's Planned IT Investments

The Exchange has identified these future information technology investments, some which are scheduled for release in July 2016. The remaining projects, including the identified capital projects, depend on the Exchange establishing a working and a capital reserve, as well as a long-term financial plan that establishes when these investments will take place and how they will be funded.

Project title	Project description	Implementation date	Estimated cost
Adult Dental (Individual & Anonymous Browsing)	Expanded insurance	July 2016	$2,324,962
Retro SSU 1095 Updates & Regen	Federal requirement	July 2016	$486,896
CMS required - stop collecting info for individuals NOT seeking coverage	Federal requirement	July 2016	$419,751
Admin Service to Split or Merge Person IDs	Operational improvement	July 2016	$370,451
Admin Service to Edit the Application Status	Operational improvement	July 2016	$322,021
Security Documentation Update	Security improvement	July 2016	$298,424
Web Content Management	Operational improvement	July 2016	$258,380
Usability Testing for Adult Dental - 1302	Operational improvement	July 2016	$234,204
Tax Filing Status Validation Updates	Federal requirement	July 2016	$210,061
Prevent multiple people from sharing the same SSN	Operational improvement	July 2016	$207,659
Quality Rating System	Federal requirement	July 2016	$184,641
Store ACES Client ID for all Household Members	Operational improvement	July 2016	$134,684
Storage of Verification Data	Operational improvement	July 2016	$134,003
QA flag results from ES	Operational improvement	July 2016	$133,444
Create automatic partnership for Brokers / Navs	Operational improvement	July 2016	$121,509
Navigator role Changes	Operational improvement	July 2016	$106,668
HCA Correspondence Requests for 2016	Plain talk improvements	July 2016	$106,319
SHOP Checks Only Payments	Operational improvement	July 2016	$99,019
Non-ESI MEC Verification Call w/o SSN Dependency	Operational improvement	July 2016	$92,119
Updates to Income Verification	Federal requirement	July 2016	$82,497
Separate Elig Service Results page into two URLs	Security improvement	July 2016	$78,580
Updates to Trial Eligibility	Operational improvement	July 2016	$66,959
Collect income of all members	Federal requirement	July 2016	$64,065
Enforce a 5-8 digit pin for Privileged User Accounts	Security improvement	July 2016	$59,208
SHOP SSU to change Employer Start Date	Operational improvement	July 2016	$49,052
Authentication Management	Security improvement	July 2016	$39,704
ESA Change Request	Federal requirement	July 2016	Unknown

Project title	Project description	Implementation date	Estimated cost
CSA Elig Updates/Conditional Eligibility Batch Job	Operational improvement/ Capital project	Unknown	$1,025,000
Account Worker Improvements	Operational improvement	Unknown	$562,500
Updates to Verification Process Part 2	Operational improvement	Unknown	$512,500
Customer service improvements, including SHOP	Operational improvement	Unknown	$187,500
Call Center Capability Maturity Assessment	Operational improvement	Unknown	$175,160
Initial payment to carriers	Operational improvement/ Capital project	Unknown	$137,500
FTR alignment	Operational improvement/ Capital project	Unknown	$112,500
AI/AN CSR 02 and 03 when go non affordability route	Federal requirement	Unknown	$100,000
U/I changes	Operational improvement/ Capital project	Unknown	$87,500
1095 changes	Federal requirement/Capital project	Unknown	$82,500
Paymentus Integration with HPF	Operational improvement	Unknown	$75,000
Add language tags to all correspondence	Operational improvement	Unknown	Unknown
Alignment of Edifecs and HPF to reduce manual work by account workers and improve EDI error rate.	Capital project	Unknown	Unknown
Change disenrollment date to EOM	Capital project	Unknown	Unknown
Changing the 23rd cutoff date	Capital project	Unknown	Unknown
Chat	Capital project	Unknown	Unknown
Customer Service Application (CSA) tool enhancement	Capital project	Unknown	Unknown
Customer Service Center training	Capital project	Unknown	Unknown
Data warehouse	Capital project	Unknown	Unknown
EDI-Update HIPPA business validation rules	Capital project	Unknown	Unknown
Federal Service VLP1a	Federal requirement	Unknown	Unknown
Federal Service VLP3	Federal requirement/Capital project	Unknown	Unknown
Fix catastrophic enrollment	Capital project	Unknown	Unknown
Guided customer shopping	Capital project	Unknown	Unknown
Imaging system	Capital project	Unknown	Unknown
Implement customer decision making tool	Capital project	Unknown	Unknown
Implement HPF functionality for better carrier interactions: • Routing of users to carrier site for payment • Lead generation from carrier sites to HPF	Capital project	Unknown	Unknown
Implement next version of Worker Management Tool	Capital project	Unknown	Unknown

Project title	Project description	Implementation date	Estimated cost
Improvements to sponsorship functionality (to decrease manual work for HBE and issues resulting in delayed sponsorship payments	Capital project	Unknown	Unknown
Mobile	Capital project	Unknown	Unknown
Numerous improvements to account work functionality to expedite data clean-up, reduce manual workload, and improve issue resolution time	Capital project	Unknown	Unknown
Password change	Security improvement/Capital project	Unknown	Unknown
Paymentus system implementation	Capital project	Unknown	Unknown
P-ID MDM	Capital project	Unknown	Unknown
Provider directory	Capital project	Unknown	Unknown
Schedule next Edifecs Release/Retain resources	Capital project	Unknown	Unknown
Small team to accelerate clean-up work • Edifecs-Security • Self-service password reset feature, for example, re-include challenge questions. • Fix account creation failures • Reporting DB for Security databases	Capital project	Unknown	Unknown
SSU-Cancel enrollment plan rejection and trigger	Capital project	Unknown	Unknown
Support for correspondence management	Capital project	Unknown	Unknown
Training for 3.2	Capital project	Unknown	Unknown
WMT	Capital project	Unknown	Unknown

Source: Information provided by Exchange officials.