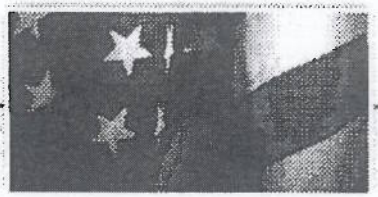


# Red Team

## Discussion document

***Confidential and Proprietary — Pre-decisional Information***

# Red Team overview, objectives, and approach

**The Red Team is:**

- An independent team charged with "pressure testing" existing trajectory of the federal marketplaces
- Not a backwards looking effort or audit

| Objectives | Approach |
|---|---|
| 1 Develop a picture of the planned consumer experience over the first year | Identify consumer paths; review and modify vignettes |
| 2 Identify risks and threats to that picture | Define stages of the journey and risks to each stage |
| 3 Identify current and possible additional risk mitigation options | Identify mitigation steps taken and other options to consider |

The working group determined that extending the go-live date should not be part of the analysis and therefore worked with a boundary condition of Oct 1 as the launch date.

# Overview of the Red Team sources of insight

- **Reviewed 200+ documents and artifacts**, including operational designs and reports, implementation plans, workload forecasts, contract-related documents, and management reports and schedules
- **Interviewed ~40 people** across 6 CMS/HHS Offices, Centers, and FFRDC and Federal partner agencies
- **Participated in select meetings and working sessions**, including weekly operations meetings and OIS working sessions

Per the scope of the review, the Red Team did not include outside interviews (e.g., issuers, states) nor access to operating work products (e.g., SOPs, computer code, or programs)

# Implementing the health insurance marketplaces is a unique challenge in magnitude and complexity

**Establishing all new infrastructure and different business arrangements with new customers to CMS where sellers require education and buyers require sustained education and outreach**

## Example influencers and partner agencies

**Interacting, aligning, and integrating multiple very large organizations with potentially different definitions of success**

## Buyers and sellers

Consumers

Employers

Issuers

## Federally facilitated marketplace

**Channels:**

Website

Call-center

Mail

**Infrastructure:**

Data exchange

Plan mgmt

Identity mgmt

Privacy & security

Manual processing

Call center operations

## State marketplaces

State managed marketplaces

State partnership marketplaces

State departments of insurance

## Assistors

Navigators

Brokers/ agents

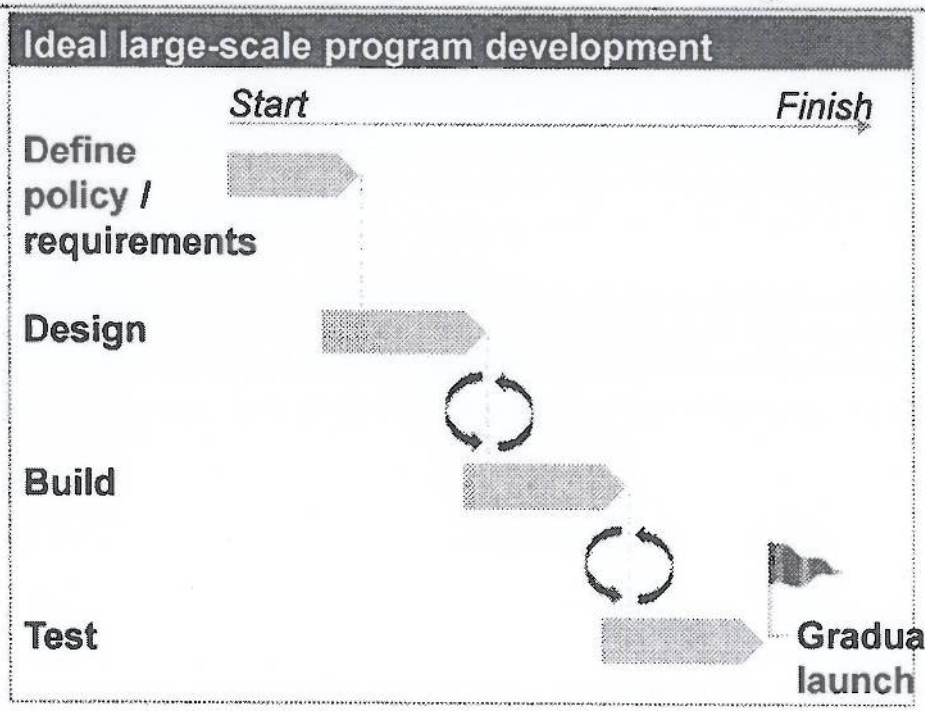
Certified counselors

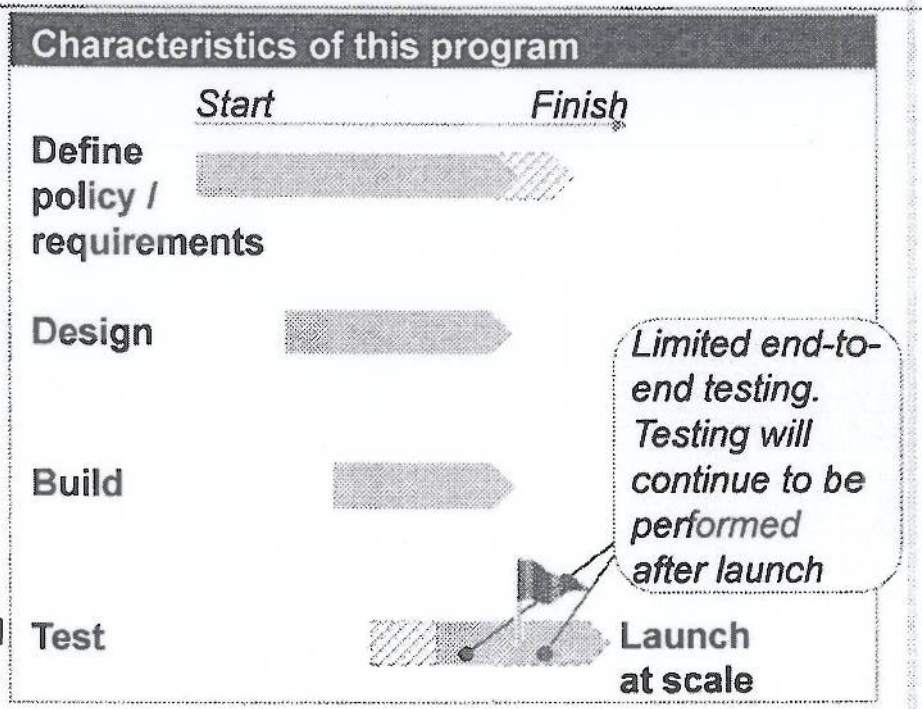
**Educating and certifying assistors for enrollment**

**Launching at scale from day one in all 50 states**

**Supporting a complex and flexible state marketplace and partnership model**

# Programs of this type ideally have a sequential planning, design, and implementation process with significant testing and revision




**Description of ideal situation:**

- Clear articulation of requirements & success metrics
- Minimized dependency on third parties
- Sequential requirements, design, build, and testing
- Iteration and revision between phases
- End-to-end integrated operations and IT testing
- Limited initial launch

**Current situation:**

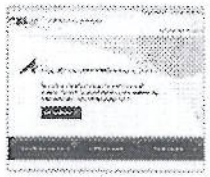
- Evolving requirements
- Multiple definitions of success
- Significant dependency on external parties/ contractors
- Parallel "stacking" of all phases
- Insufficient time and scope of end-to-end testing
- Launch at full volume

**CMS has been working to mitigate challenges resulting from program characteristics**

# Example: Fully automated

Hypothetical consumer profile: Mike

- Mike is married with a two year old son, lives in Maine, and wants to enroll his family in insurance
- He works at an engineering company with 30 employees that does not offer employer sponsored coverage and his household income is $49,000 (~250% of FPL)
- Mike has worked for the same company for 3 years and his household income has not changed significantly in that period

| | Consumer experience | Approximate time required |
|---|---|---|
| | Mike contacts an insurance agent to enroll in coverage; the agent begins an application online on Mike's behalf | 30 mins |
| | Mike satisfies ID verification, residency status check, and income verification | 5 mins |
|  | The application web site indicates Mike's subsidy amount | Real time |

| | Consumer experience | Approximate time required |
|---|---|---|
| | **The broker helps Mike select a plan and enroll**; Mike makes an initial payment to issuer | 30 minutes |
| | **Total elapsed time for Mike to enroll** | **<1 day** |
| | Mike receives a letter from the insurance company indicating his date of initial coverage | Goal: 1 – 2 weeks |

# Example: Manual (high complexity)

Hypothetical consumer profile: Charles

- Charles is single male making $15,500 (~135% of FPL) working part-time as a handyman
- He recently left the military and no longer has insurance coverage through TRICARE
- Charles lives in Texas and would like to apply for insurance through the marketplace
- He has very little income budgeted for health care and wants to be sure he receives the full amount of subsidy for which he qualifies

| Consumer experience | Approximate time required |
|---|---|
| Charles completes a paper application | 1 hour |
| He receives a letter indicating he may qualify for Medicaid; his information is sent to the Texas Medicaid program | 3-4 weeks |
| Charles receives notification that upon state review, he does not meet state-specific Medicaid requirements, which he forwards to the FFM | 3-4 weeks |
| Due to a system lag, he receives notification that he is ineligible to buy on the FFM because he appears to have TRICARE[1] coverage | 1 month |

| Consumer experience | Approximate time required |
|---|---|
| He calls the call center to challenge the notification and is asked to send documentation that he no longer has coverage | Real time |
| The FFM confirms his eligibility and makes a final subsidy determination | 3-4 weeks |
| **Call center operator helps Charles enroll** in a plan and he makes initial payment | Real time |
| **Total elapsed time for Charles to enroll** | **13 – 16 weeks** |
| Charles receives a letter from the insurance company indicating his date of initial coverage | Goal: 1 – 2 weeks |

1 TRICARE real-time checks may not be available on Day 1

# Complexities of the marketplace and its implementation drive four primary experiences for consumers enrolling on FFM

ESTIMATES

| | Largely automated | | Largely manual | |
|---|---|---|---|---|
| | Fully automated | Automated w/ minimal manual intervention | Manual (low complexity) | Manual (high complexity) |
| **Description** | ▪ Single interaction/ instant response for eligibility, shop, and enroll | ▪ Automated enrollment with manual follow-up to verify information | ▪ 2+ interactions with supplemental document(s) needed | ▪ Complex manual processing or challenges and appeals |
| **Anticipated time to enrollment** | ▪ Same day | ▪ Same day<br>▪ Document submission required to extend enrollment > 90 days | ▪ < 30 days | ▪ 30+ days |
| **Assumed volume** | ▪ 15% or less | ▪ 25% or less | 60% or more | |

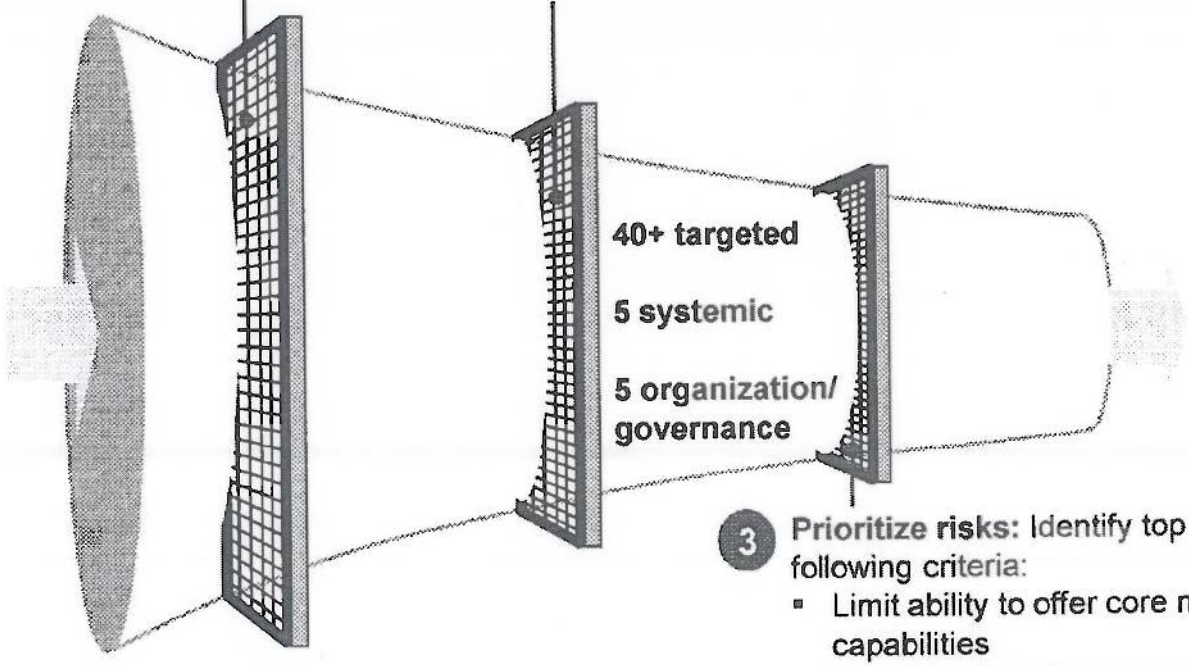
Note: Volume assumptions based on CBO estimates with adjustment for FFM share, resulting in 5M enrollees in individual market and 1.2M enrollees in SHOP. Volume numbers do not include expected Medicaid enrollees or exemptions. See appendix for methodology.

# Risk prioritization approach

1 **Baseline expectations:** Refine risks in the context of expectations for planned consumer experience

2 **Classify risks:** Classify risks as either targeting a specific component of the consumer journey, systemic/cross cutting, or organizational/governance in nature

**Initial set of risks generated from:**
- ~200 artifacts reviewed
- 40+ interviews conducted




**13 most critical risks**

3 **Prioritize risks:** Identify top risks against the following criteria:
- Limit ability to offer core marketplace capabilities
- Significantly reduce consumer participation or experience
- Absence of key cross-cutting enablers

# Most critical risks to marketplace implementation efforts—
## *Core marketplace functionality / Experience and participation*

| | Risk | Root cause drivers |
|---|---|---|
| Core marketplace functionality | A Marketplaces unavailable with system failure | ▪ Data Hub / FEPS are single points of failure<br>▪ Limited end-to-end testing prior to launch |
| | B Long manual processing times | ▪ Potentially undersized contractor eligibility support team<br>▪ Potential protest of June 1st contract<br>▪ Higher than expected manual processing volumes |
| | C Failure to resolve post-launch issues rapidly | ▪ Compressed testing window and volume uncertainty<br>▪ Inter- and intra-agency response teams not yet in place |
| | D No viable marketplace in large-volume SBM states | ▪ Large-volume SBM states (i.e., NY, CA) too big to fail<br>▪ High risk of federal IT/Ops resource overload if pivot needed |
| | E Plans not approved and loaded in selected markets | ▪ Lack of time/resources for State DOI's<br>▪ SBM pivots may miss 4/30 data load deadline<br>▪ Issuers may not design and offer plans |
| Experience/Participation | F Lack of inter-agency consensus on verification standards results in unexpected tax debt to consumer and unrecoverable excess federal subsidies in 2015 | ▪ No inter-agency consensus on verification standards<br>▪ Subsidies calculated with less accurate income<br>▪ Accepting business risks to meet deadlines |
| | G Inaccurate or incomplete financial management systems | ▪ Financial management system release in December<br>▪ Limited testing time and resources prior to launch<br>▪ Due to focus on enrollment, limited focus on financial management |
| | H No call center enrollment channel or long waits | ▪ Call center tools linked to enrollment IT systems<br>▪ Minimal integration/testing time prior to 10/1 launch<br>▪ Significant risk of higher call volumes |

# Most critical risks to marketplace implementation efforts—*Cross-cutting enablers*

| Risk | Root cause drivers |
|---|---|
| I Fast, targeted, locked-down decisions are needed for implementation effort | ▪ Matrix management and consensus decision making<br>▪ No clear roles, responsibilities and processes for making change<br>▪ No single empowered decision-making authority<br>▪ Lack of a "shared definition of success" |
| J Indecision about Version 1.0 requirements in select areas | ▪ Less than 180 calendar days – design still presumed to be open<br>▪ Drives development churn and compressed timelines<br>▪ Materially higher risk of system instability |
| K Lack of end-to-end operational view of interdependencies | ▪ Operational interdependencies among groups<br>▪ No end-to-end business process view across agencies or fully within agency<br>▪ Difficult to identify/address critical integration gaps |
| L No critical path transparency (inter- and intra-agency) | ▪ Lack of transparency and alignment on critical issues<br>▪ Critical path drives coordination of end-to-end efforts<br>▪ Lack of visibility into critical milestones across agencies<br>▪ Staff still engaged in program design |
| M Budget uncertainty and timing prevents execution of plan | ▪ Many functions are contractor dependent<br>▪ Core contracts not awarded due to budget<br>▪ Hampers ability to hire/resource critical path activities |

# Options that could be implemented to help mitigate key risks

| Mitigation type | Mitigation options |
|---|---|
| 1 ***Align on initial release and transition to solving for stability*** | ▪ Prioritize and lock down scope for "version 1.0"<br>▪ Conduct fully integrated end-to-end test of version 1.0<br>▪ Continue to enhance plan to develop an "operations command center" and response team |
| 2 ***Take tactical actions in targeted areas*** | ▪ Determine readiness of SBM implementations<br>▪ Mitigate risks related to Call Center and Eligibility support contracts<br>▪ Define broker/agent and issuer direct enrollment model<br>▪ Manage demand through targeted outreach<br>▪ Accelerate decision-making on using IRS tax data for verification of income |
| 3 ***Streamline decision making process and manage critical path*** | ▪ Name a single implementation leader (COO/DCOO) and implement associated governance process to:<br>– Manage critical path<br>– Create transparency on critical issues<br>▪ Finalize budget and release funds |

Implementing these mitigation options does not guarantee success

CMS

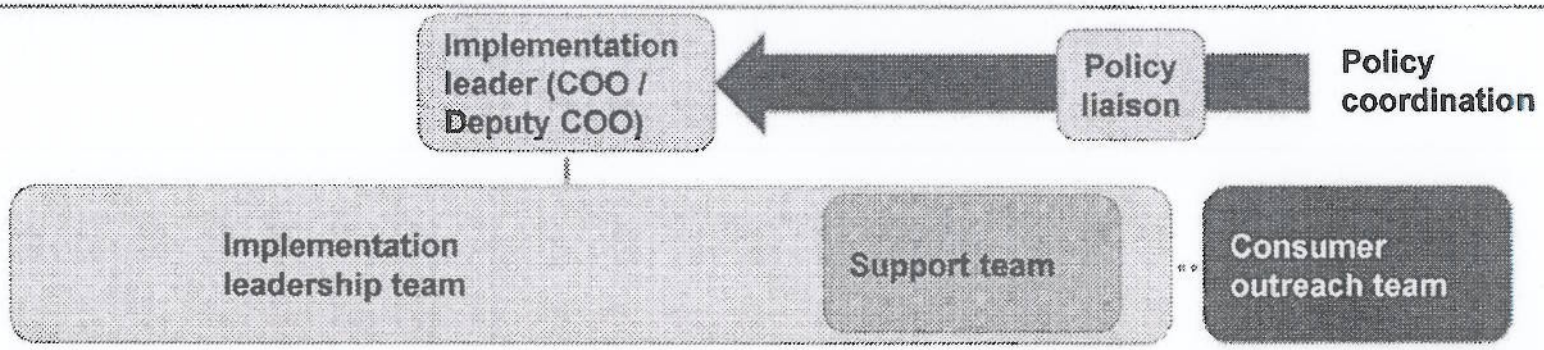
# 1 Top areas where requirements need to be defined and "locked down" by April 30

| Decision | Description |
|---|---|
| ID proofing (IRS)[1] | ▪ Requiring AGI as a shared secret will likely increase the amount of time needed to complete an application for enrollment but will provide IRS with more confidence in a user's identity when returning federal tax information |
| Household consent (IRS)[1] | ▪ Current taxpayer privacy rules require identity verification for each tax return that is retrieved to construct the household income and family size |
| Marketplace operating models | ▪ Determine how each marketplace operating model should function (i.e., SBM and different flavors of partnership models, e.g., Utah) with specific description of business rules for each marketplace variation |
| Issuer direct enrollment | ▪ Define entire end-to-end business flow (registration, authentication, handoffs of information, types of data, SLAs) by which issuers will direct enroll consumers into plans and |
| Agent / broker enrollment | ▪ Define process by which agents and brokers can enroll consumers<br>▪ Agent/broker training and certification (for safeguarding Federal Tax Information) need to be developed and implemented |
| Financial management | ▪ All financials system management processes and calculations need to be defined including: APTC and CSR aggregations across exchanges, internal accounting systems, monthly receipt and reconciliation of enrollment reports, collection of marketplace fees, and payment of APTC and CSR |

CMS

1 ID proofing and household consent need to be finalized by April 12

# 3 An implementation leadership team and a consumer outreach team could drive implementation progress




**Responsibilities**

- **Expedite decisions** on critical path and Version 1.0
  - If consensus cannot be reached, the leader will decide or escalate
- **Regulate issues affecting IT and Ops build**
  - Reduce number of governance bodies to one
  - All decisions impacting build must flow through this team
- **Report directly** to the Administrator and Secretary
- **Brief White House** on implementation progress
- **Requests from policy staff** must flow through the policy liaison

- **Track project status** from all stakeholders
- **Create an integrated managerial view** across key milestones
- **Surface risks** to facilitate resolution
- **Provide analytic capability** to support rapid decision-making

- **Coordinate** with the implementation leadership team
- **Drive consumer outreach**
- **Coordinate outreach efforts** across CMS, HHS, the White House and partner organizations

**Membership**

- 1 representative each (CMS Administrator to select):
  - CCIIO
  - CMCS
  - CMCHO
  - OC (same as Call Center)
  - OIS
  - SSA
  - IRS

- 3-4 dedicated FTEs
- Additional support as needed

- Sr. Advisor to the Administrator
- OC Director
- 1 representative each:
  - Call centers
  - Regional offices
  - CCIIO
- Others TBD

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# CMS needs specific support from HHS and the White House to successfully operationalize the marketplaces

| Critical action | Deadline |
|---|---|
| 1. Agree to lock down open requirements by 4/30[1] and shift all other new requirements or changes to existing requirements into version 2.0 | ▪ Mon, 4/8 |
| 2. Implement new governance process to support effective operational execution | ▪ Fri, 4/12 |
| 3. Determine desired demand strategy | ▪ Fri, 4/12 |
| 4. Align on shared metrics for success | ▪ Fri, 4/12 |
| 5. Lock down all funding sources for year 1 operations | ▪ Mon, 4/15 |
| Distribute funds as early as possible to match contracting schedule | ▪ Ongoing |
| 6. Communicate pivot plan to SBM states | ▪ Mon, 4/21 |

CMS

1 ID proofing and household consent need to be finalized with IRS by April 12

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