



A New Management Structure for a New Phase of the Affordable Care Act

By Neera Tanden, Zeke Emanuel, and Topher Spiro | May 17, 2014

President Barack Obama's nomination of Sylvia Mathews Burwell as the next secretary of health and human services presents an opportunity to look afresh at the decision-making processes for implementation of the Affordable Care Act.

More than 8 million Americans have already signed up for private health insurance through the marketplaces created under the Affordable Care Act—exceeding all expectations.¹ A few months ago, no one would have thought this achievement was possible.

The federal marketplace—which sells health plans in 34 states—has come a long way. When it was first launched in October 2013, the federal marketplace was virtually unusable. Its website, HealthCare.gov, was slow, produced error messages, and crashed frequently. For weeks, the website was down an estimated 60 percent of the time.² But a crisis management team led by Jeffrey Zients repaired more than 400 software bugs and significantly upgraded hardware to improve the system's capacity.³

The results were significant:⁴

- Response times have dropped from eight seconds to less than half a second.
- Error rates have dropped from more than 6 percent to less than 0.5 percent.
- The system is up and running more than 99 percent of the time, an increase from 43 percent.
- System capacity can handle more than 1.8 million site visits per day and about 100,000 users at once.⁵
- Error rates for 834 forms—which transmit enrollment information to insurers—have dropped sharply.

These substantial improvements led to a surge in enrollments in January and a wave of enrollments in March.

With the end of open enrollment for the 2014 plan year, attention must now turn to the next phase of implementation. We recommend that the next secretary put in place a new structure that:

- Empowers a single leader accountable for all of implementation, not just the website
- Integrates technology, policy, and business decisions
- Has authority from the White House to coordinate the many federal agencies involved in implementation
- Coordinates seamlessly with states and insurers
- Fosters transparency and accountability

This next phase of implementation will require sustained leadership and a permanent, streamlined management structure.

A shift to long-term tasks

The crisis management led by Jeffrey Zients focused on the front end of the system, which is the part of the system that interacts with consumers. Now that the front end is working reasonably well, longer-term work must focus on improving the consumer experience and building the back end of the system, which is the part of the system that interacts with insurers and states. In addition, the next phase of work must enable more sophisticated consumer transactions. Major tasks that must be completed over the coming months include:

- Building the system to transmit enrollment information to state Medicaid agencies. Hundreds of thousands are waiting for their applications to be transmitted, and hundreds of thousands more applications are still being manually processed.⁶
- Enhancing website functionality so that consumers can make better choices. HealthCare.gov should display estimated total out-of-pocket costs for a plan, allow consumers to search for plans that include a specific provider, and display drug formulary information and costs. When consumers can only compare premiums, they may not find the deal that is best for them.⁷
- Cleaning up the federal database of enrollment information so that a single source of accurate data can be relied upon to pay premium tax credits, change coverage, and re-enroll individuals. Due to the errors in transmitting enrollment information to insurers, insurers have had to manually correct the data, but the federal database still holds the inaccurate data.

- Eliminating the error rate for “orphans”—individuals who submitted an application and selected a plan, but whose enrollment information was never transmitted to insurers. Even an error rate as low as 0.38 percent—as reported by the Centers for Medicare & Medicaid Services, or CMS, in December⁸—translates to thousands of orphans. Some insurers still report higher error rates.
- Building an automated appeals system so that eligibility and enrollment errors can be corrected online. For example, individuals might file an appeal if HealthCare.gov determined they were eligible for Medicaid but the state Medicaid agency determined they were eligible for a private plan.
- Building the automated system to pay premium tax credits to insurers.
- Building the system for the programs—risk adjustment, reinsurance, and risk corridors—that collect payments from insurers and make payments to insurers to stabilize premiums.
- Automating the process for insurers to submit bids to the federal marketplace. If insurers have to submit Excel spreadsheets containing plan information again for 2015, manual loading of the information will likely cause errors in how premiums rates and other information are displayed on the website.
- Enabling online enrollment for small businesses.
- Collecting premium payments from small businesses and workers and forwarding them to plans; this is known as “premium aggregation.”
- Enabling small businesses to offer a choice of insurers and plans; this is known as “employee choice.”
- Transitioning one or more dysfunctional state marketplaces to the federal marketplace.⁹
- Overseeing rescue efforts or substantial improvements for one or more state marketplaces.

In addition to these technological tasks, numerous policy and business decisions must be made for the 2015 plan year—and made in a timely way to ensure enough time for IT testing and implementation. Many of the IT functions described above will require at least six months of testing. Delaying or changing decisions after premium rates and plan information are submitted would likely cause errors and consumer confusion.

Principles of organizational management

In spring 2013, expert management consultants from McKinsey & Company evaluated risks to implementation of the Affordable Care Act, including an assessment of the decision-making processes across federal agencies. McKinsey identified a flawed decision-making structure as an important root cause of risks to successful implementation of the Affordable Care Act.¹⁰ Specifically, McKinsey identified:

- A “matrix management” in which individuals report to more than one manager
- Decision making by consensus
- No clear roles, responsibilities, and processes
- No single empowered decision-making authority
- Lack of transparency on progress

McKinsey recommended a new decision-making process for implementation of the Affordable Care Act in which a single implementation leader reports directly to the secretary of health and human services; there is transparency on progress; and all decisions flow through one consolidated path.

Similarly, other experts have recommended streamlining and simplifying the decision-making processes.¹¹ According to a Harvard Business Review article that applies management concepts to the Affordable Care Act, this first and foremost requires someone who is explicitly accountable for end-to-end implementation. Second, the process must not be insular. The article states that “Complex transformational challenges usually benefit from injections of fresh thinkers, who can change the way things have been done in the past and look for simpler or better alternatives.” Third, the process must embrace transparency to position leaders to respond to problems more effectively: “Nothing amplifies complexity more than a lack of information.”

As a group, state marketplaces were more successful than the federal marketplace, enrolling a greater share of the eligible population.¹² By this metric, the top three performing marketplaces were state-based.

All state marketplaces empower a CEO or executive director who is accountable for managing the marketplace. In addition, 15 state marketplaces established a board to oversee the CEO, generally composed of both public officials and private-sector individuals. Board members include consumers, small-business representatives, IT experts, and in the case of Rhode Island, an e-commerce expert.¹³ This governance structure is certainly not solely sufficient for success—a handful of state marketplaces failed and continue to experience significant problems—but it is a necessary condition for success.

Crisis management of HealthCare.gov

In its “HealthCare.gov Progress and Performance Report,” the U.S. Department of Health and Human Services concluded that “inadequate management oversight and coordination among technical teams prevented real-time decision making and efficient responses to address the issues with the site.”¹⁴ To manage the immediate IT crisis, the president appointed Jeffrey Zients, who was replaced in December by Kurt DelBene, a former Microsoft executive whose appointment could end in June. In addition, CMS appointed IT contractor Optum as the general contractor and systems integrator. Currently, there is a decision-making entity for the website comprised of six individuals—three from CMS and three from Optum.

This crisis management appropriately focused on the website alone and its technical problems. However, it does not address the underlying management problems that were the root cause of the technical problems. There was a failure to plan ahead and enforce a strict timetable to allow for at least six months of system testing, which was caused in part by delays in policymaking and changing requirements. When it was well known that there were serious risks—as far back as spring 2013—a lack of accountability, transparency, and oversight delayed corrective action until late December. It is unclear whether decision-making authority resides with the White House, the Centers for Medicare & Medicaid Services, or the secretary of health and human services.

The federal marketplace—and implementation generally—involves more than a website or IT project. The marketplaces are a business that market health insurance, which requires management of the following functions: call centers, eligibility determinations, premium payments, setting rules for plans, soliciting and processing plan bids, appeals, marketing, and communications. The current crisis management is not set up to carry out all of these functions and activities.

Even under the current crisis management, roles and responsibilities—as well as a plan or schedule for work that remains to be done—are still not transparent.¹⁵ Most importantly, there still is no single leader who is accountable for successful implementation of the Affordable Care Act.

A new management structure

We recommend a new management structure for a new phase of implementation of the Affordable Care Act. This new management structure would include the following three components.

First, it would include a CEO of marketplace health insurance who would oversee the federal marketplace, the state marketplaces, and insurance oversight and regulation—but not Medicare or Medicaid. The CEO would report directly to the president and the secretary of health and human services and be empowered to make all decisions or escalate them to the president and the secretary. The CEO would be the single leader accountable for all of implementation, not just the website. As such, the CEO should have a background in health care issues, as well as private-sector experience, and should be appointed for the remainder of the administration.

Second would be an advisory board composed of the secretary of health and human services—who would serve as the chairperson—the administrator of the Centers for Medicare & Medicaid Services, the commissioner of the Internal Revenue Service, and two private-sector individuals, who must be free from conflicts of interest.

Third, there would be a technical advisory committee composed of representatives from the IT general contractor, the Centers for Medicare & Medicaid Services, the Office of Immigration Statistics, the Social Security Administration, the Internal Revenue Service, state Medicaid agencies, state insurance commissioners, and insurers. This committee would ensure closer coordination between all of these key parties.

One of the first tasks of the CEO and board—in consultation with the technical advisory committee—would be to develop a work plan that prioritizes and schedules the long list of tasks discussed above within specific timeframes. This plan should be made transparent to stakeholders and the general public.

Conclusion

Open enrollment for 2014 ended on March 31, and open enrollment for 2015 does not begin until November—seven months from now. While seven months may seem like a long time, a significant amount of work remains to be done. To optimize the consumer experience, a new management structure for a new phase of implementation of the Affordable Care Act is essential.

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Endnotes

- 1 Congressional Budget Office, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014" (2014), available at <http://www.cbo.gov/publication/45231>.
- 2 U.S. Department of Health and Human Services, *HealthCare.gov Progress and Performance Report* (2013), available at <http://www.hhs.gov/digitalstrategy/sites/digitalstrategy/files/pdf/healthcare.gov-progress-report.pdf>.
- 3 Ibid.
- 4 Julie Bataille, "HealthCare.gov Moving Forward," U.S. Department of Health and Human Services, January 16, 2014, available at <http://www.hhs.gov/digitalstrategy/blog/2014/01/healthcare-gov-moving-forward.html>.
- 5 Julie Bataille, "Open Enrollment Ends March 31—Just 5 Days Left to Apply," U.S. Department of Health and Human Services, March 26, 2014, available at <http://www.hhs.gov/healthcare/facts/blog/2014/03/open-enrollment-ends-march-31.html>.
- 6 Rebecca Adams, "Federal Website Glitches Hinder Medicaid Applicants from Gaining Coverage," *Congressional Quarterly*, March 25, 2014.
- 7 Consumers' Checkbook, "Many Will Waste Thousands Because Health Insurance Marketplaces Don't Give Them the Information They Need to Make Best Plan Choices," PR Newswire, February 13, 2014, available at <http://www.prnewswire.com/news-releases/many-will-waste-thousands-because-health-insurance-exchanges-dont-give-them-the-information-they-need-to-make-best-plan-choices-245367461.html>.
- 8 Julie Bataille, "Missing 834s as Percentage of Enrollment Now Near Zero," U.S. Department of Health and Human Services, December 14, 2013, available at <http://www.hhs.gov/digitalstrategy/blog/2013/12/missing-834s-percentage-now-near-zero.html>.
- 9 Amy Goldstein, "Obama administration prepares to take over Oregon's broken health insurance exchange," *The Washington Post*, April 24, 2014, available at http://www.washingtonpost.com/national/health-science/obama-administration-prepares-to-take-over-oregons-broken-health-insurance-exchange/2014/04/24/ff9aa220-cbc4-11e3-95f7-7ecdde72d2ea_story.html.
- 10 *The Washington Post*, "McKinsey report on problems with HealthCare.gov," November 19, 2013, available at <http://apps.washingtonpost.com/g/page/politics/mckinsey-report-on-problems-with-healthcaregov/601/>.
- 11 Ron Ashkenas and Daniel Dworkin, "How Simplicity Principles Could Fix Obamacare," Harvard Business Review Blog, November 1, 2013, available at <http://blogs.hbr.org/2013/11/how-simplicity-principles-could-fix-obamacare/>.
- 12 Kaiser Family Foundation, "Marketplace Enrollment as a Share of the Potential Marketplace Population," available at <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-marketplace-eligible-population-2/> (last accessed May 2014).
- 13 Analysis by the Center for American Progress.
- 14 U.S. Department of Health and Human Services, *HealthCare.gov Progress and Performance Report*, p. 3.
- 15 Kyle Cheney, "Behind the scenes, much of HealthCare.gov is still under construction," *Politico*, April 25, 2014, available at <http://www.politico.com/story/2014/04/healthcaregov-obamacare-affordable-care-act-106036.html>.