

Creating a Strong Foundation upon which to Build Value in the Marketplace

Insurance Exchanges

Reducing costs of healthcare and extending access to affordable insurance coverage to millions of uninsured and underinsured were the catalysts behind passage of the Patient Protection and Affordable Care Act of 2010 (PPACA). How well the sweeping changes to the insurance marketplace ushered in by this historic legislation achieves those outcomes hinges on the success of several key mandates, one of the most far-reaching being the establishment of American Health Benefit Exchanges by 2014.

Successful Exchanges

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Established by states to stimulate competition within the insurance market, these exchanges will offer a choice of health plans, establish common rules on insurance offerings and pricing and educate consumers on the various options available to them through the exchanges. Open to qualified individuals and employers, the Congressional Budget Office (CBO) projects that 24 million people – plus an additional 5 million whose employers allow them to choose among plans within the exchanges – will purchase coverage through the exchanges.¹

The theory is that exchanges can help the insurance market comply with consumer protections and compete more cost-effectively by providing guidance and improved coordination. As a result, more individuals will be able to obtain coverage. Exchange advocates say they can address key issues such as underinsurance, discrimination, soaring costs, inadequate risk spreading, poor subsidies delivery and difficulties facilitating and ensuring enrollment.

Researchers with the Urban Institute note: “An exchange is not a panacea for all that ails the U.S. health care system, but, carefully designed, it can be a vehicle that facilitates and monitors the movement of the system toward achievement of

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many national health care reform goals. Without an exchange, a patchwork of new agencies and new roles for existing agencies would be required to achieve reform objectives, and in doing so, uniformity and efficiency of administration of the necessary tasks would be compromised.”²

For states, the challenge is designing exchanges that achieve the goals of the PPACA. Doing so requires an in-depth understanding of complex exchange requirements and identifying the model that is most appropriate for their unique market needs. The model must balance the need to realize improvements in the issues plaguing the U.S. healthcare system – costs, chronic disease, misalignment of funding with risks and economic distortions in supply and demand – with the market churn, fundamental landscape changes, payer imperatives and other unprecedented challenges facing the carriers that will participate in exchanges.

In other words, successful exchanges will need to implement an integrated healthcare value strategy that fosters innovation in addressing risk segmentation, payment models, provider collaboration and consumer engagement.³

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Administrative and Budgetary Challenges for States

Implementing successful exchanges requires specific skill sets and domain expertise as well as the ability to deploy and leverage an array of technology and communication tools. Upping the level of difficulty are administrative complexities and budget constraints that will likely plague most, if not all, states as they work to design and deploy effective exchanges.

In terms of administrative complexity, there remain many unanswered questions and definitions have yet to be applied to many of the requirements exchanges must meet. What is known is that they are required to:

- Certify eligibility of health plans, including evaluating premium increases
- Disclose, in plain language, claims payment policies and practices, data enrollment, denials, rating practices, cost-sharing and out-of-network payment information, and enrollee and participant rights, as well as periodic financial disclosures

- Operate a toll-free telephone assistance hotline
- Maintain a website where enrollees can obtain standardized comparative plan information
- Assign a rating to each plan based on the relative quality and price of benefits
- Utilize a uniform enrollment form and a standardized format for presenting plan options
- Inform people about eligibility requirements for and coordinate enrollment procedures with Medicaid, CHIP or other state/local public programs
- Provide an electronic calculator to determine actual cost of coverage after any premium tax credits and/or cost-sharing reductions are applied
- Grant certifications for individuals who are exempt from the individual responsibility penalty
- Establish a grant program for promotion of public education on exchanges⁴

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Meeting these requirements will necessitate sizable investments in a technical infrastructure to facilitate the timely sharing and/or release of information between plans, exchanges and consumers. This same infrastructure must also be capable of managing huge volumes of complex transactions in order to keep administrative costs low, which subsequently translates into lower costs for enrollees.

Further, the capability must be in place to enable carriers to provide online applications and automated enrollment for consumers wishing to purchase coverage through the exchange. This includes the ability to determine eligibility for subsidies, calculate any resulting discounts or credits and perform direct billing to plan holders or payroll deductions to employers/employees.

In fact, administering subsidies is a challenge all its own, in particular the need to collect information about an individual's ability to pay. This requires providing a means by which individuals can document or attest to recent changes in their

ability to pay. To accomplish this, states should consider centralizing the subsidy determination and the process by which subsidy payments are made to carriers into the exchange, a one-stop shop approach that also streamlines the process for consumers.⁵

All of these activities must take place at a time when many states are in the midst of a fiscal crisis, leading to budgetary issues that could threaten their ability to meet the January 2014 date for exchanges to be operational. After that date, the federal government would step in and run the exchange on the state's behalf.

Already, states like New York have gone on record that they cannot afford to establish exchanges without significant outside funding.⁶ That is despite encouragement from the Heritage Foundation to not allow the federal government to take over exchanges, even if what the states are able to accomplish falls short of expected requirements. The theory is that if existing state solutions are popular enough, the decision to challenge them will be too risky.⁷

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Consumer and Carrier Engagement Challenges

State challenges don't stop at complex administration and budget constraints. The exchange model that is ultimately deployed must also address the challenges of two primary stakeholders within the exchange: 1) consumers who will purchase plans through new web-based marketplaces; and 2) carriers that will offer and administer plans.

A significant challenge is successfully engaging consumers in the exchange process. It is a highly complex task, as evidenced by the fact that millions of Americans are eligible for, but not enrolled in, Medicaid coverage – a clear indication of how difficult it will be for states to enroll consumers even after the individual mandate takes effect.

However, doing so is critical because attracting a large and diverse risk pool will determine whether an exchange is sustainable. Equally important will be attracting a significant share of the unsubsidized individual and small group market.⁹ Part of

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this is designing and deploying a comprehensive education program that provides in-depth information on what the exchange is, the plans and benefits offered, eligibility and other details that will help drive consumer interest.

Notes the Robert Wood Johnson Foundation: “Many health policy experts... believe that consumers are key to retooling our health care system. The expectation is that when armed with the right information, we will demand high-quality services, choose treatment options wisely and become active participants and self-managers of our own health and health care.”

“...Yet for all the lip service we give to choice, we often gloss over how it functions in the real world. Pinning down how our choices work when it comes to health plans, providers and treatments, and to what degree we exercise them is a complicated matter. Many patients say they are bewildered by the system’s complexity, and intimidated by its medical and legal jargon. They often face obstacles to obtaining meaningful information about quality or cost. As a practical matter, choice is often limited by the arcane details of insurance coverage—or the inability to get coverage at all. It is also obscured by a system which insulates patients from the true cost of what they consume.”¹⁰

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Carriers are already challenged with retooling critical business processes and revamping product portfolios, sales models and distribution channels to comply with PPACA mandates ranging from minimum medical loss ratios (MLR) to guaranteed issue and preexisting condition coverage to elimination of lifetime maximums. Participation in exchanges brings with it an entirely new and different set of challenges, many of which can be traced back to lessons learned from past participation in Community Health Purchasing Alliances and other purchasing pools and cooperatives.

For example, past experiences have left many carriers reluctant to hand administrative functions like premium collection and enrollment over to pool or cooperative administrators due to concerns over accuracy, loss of control, liability, loss of revenues and functions and loss of control over aspects of the relationship

that directly impacts finances. There is also a significant fear of adverse selection when participating in exchanges that take control of marketing, eligibility, rating and enrollment away from the carrier. This is particularly true when multiple plans are offered or when risk distribution is uncertain.⁸

Thus, it is imperative that states take steps to instill confidence that any administrative functions handed off to the exchange will be handled appropriately and in a manner that does not negatively impact carrier operations or increase liabilities.

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Partnering for Success

In order to build the foundation for effective and sustainable exchanges, states must be able to leverage significant domain, technology and business process expertise. Doing so ensures that the exchange model and supporting technical infrastructure adequately address regulatory mandates as well as the needs of the carriers and consumers in the most cost-effective and expedient manner.

That latter point is crucial. Though exchanges need not be operational until January 2014, states must have a detailed business plan in place and undergo a readiness review by January 2013.¹¹ Further, the complexity of the process demands a methodical approach to avoid any unexpected delays or problems down the road.

By partnering with HealthPlan Services (HPS), a leading provider of acquisition, administration and retention solutions and services to the insurance marketplace, states can leverage the agility, operational efficiency and technical capacity necessary to deliver innovative exchange solutions that overcome obstacles, drive growth and facilitate long-term sustainability. HPS provides a comprehensive suite of services and end-to-end expertise that enables it to meet unique business and infrastructure needs and build solutions that provide measurable results.

HPS has the domain knowledge and business process expertise necessary to provide guidance on structuring the exchange and meeting the various administration requirements. This includes developing the policies and processes necessary for

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sustainability, a requirement for all exchanges by 2015 when federal subsidies are no longer available to offset operational expenses.

For example, by leveraging HPS's advances in automation and support technologies, states can offer **paperless billing and payment**. They can consolidate premiums for multiple products and carriers onto a single electronic bill that can be easily reconciled, adjusted and paid via a self-service portal. This alone has the potential to deliver a one percent savings on administrative costs.¹²

HPS delivers programs that align all functional areas, maximize personal touch points and assess product set and membership demographics.

Another key benefit of partnering with HPS is its **highly effective approach to retention**. HPS delivers programs that align all functional areas, maximize personal touch points and assess product set and membership demographics. These programs address the root causes of customer dissatisfaction, provide market intelligence, and add to the base of data for use in the predictive modeling necessary to offset the historic causes of member lapse rates.

HPS retention programs are unique in that they engage in a multi-touch, customer-focused process that provides a 360-degree view of the client and business, from on-boarding to renewal. They also leverage customer analytics and real-time data to identify trends, pinpoint issues that could trigger termination and develop programs that can be measured around improving retention for at-risk members.¹³

States can also leverage HPS's expertise to address another key challenge: **engaging and educating consumers**. The firm has proven experience educating and informing consumers and enrollees about plan benefits. This includes the ability to design and deploy highly targeted marketing outreach programs that will arm consumers with the knowledge they need to make an educated decision regarding exchange participation.

HPS has the domain knowledge and business process expertise necessary to provide guidance on structuring the exchange and meeting the various administration requirements. This includes developing the policies and processes necessary for sustainability,

Finally, HPS offers the expertise necessary to develop, deploy and manage consumer- and carrier-facing web portals that meet federal requirements. These portals provide consumers and plan members with 24/7 customer support and access to the information they need to understand their options and benefits. This includes plan, rate and eligibility information, subsidy/tax credit calculations, automated online enrollment and even financial reporting.

The ultimate goal is to bring together the proper exchange model, engage and empower key stakeholders, and achieve sustainability.

Conclusion

Regardless of the strategies deployed, the ultimate goal is to bring together the proper exchange model, engage and empower key stakeholders, and identify the means by which to generate the revenues necessary to achieve sustainability.

This can best be accomplished by partnering with HPS. Doing so enables states to leverage the domain knowledge and business and technical expertise required to build an exchange that is compliant and appropriate for the targeted population.

It also ensures that the exchange is capable of attracting – and retaining – the critical mass of carriers and consumers necessary to provide enough market value to generate the revenues necessary for long-term growth and sustainability.

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About HealthPlan Services

HealthPlan Services (HPS), a Water Street Healthcare Partners affiliate, is the largest independent provider of service and technology solutions to the insurance and managed care industry. Since 1970, HPS has offered customized administration and distribution services to insurers of individual group, voluntary and association plans, as well as providing valuable solutions to thousands of brokers and agents that sell into this market. HPS proprietary, scalable technology provides innovative consumer-facing solutions that are turnkey self-service tools for our insurance carriers and distribution partners. HPS offers an ever-expanding array of services to a diverse and growing client base, and administers products that include Medical (PPO, HMO, indemnity, consumer-driven), Dental, Vision, Life, Disability, Long Term Care, Limited Medical, Medicare Supplement and Medicare Part D, as well as various other ancillary insurance. HPS is committed to providing extraordinary service to its customers.

Learn More About HealthPlan Services

Visit us on the web at healthplan.com, or email us at solutions@healthplan.com.

HPS At-a-Glance

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Year Founded: 1970

Employees: More than 700

Current Customers: 30 Health and voluntary insurance carriers
and industry associations

Members Served: 1.4 million nationwide

Inforce Premiums: More than \$1.3 billion

Distributing Agents: 100,000

Services

Sales, Distribution & Member Retention

Benefit/Billing Administrative Services

Claims Processing

Customer Services

Professional Services

Software & Technology

- 1 Kaiser Family Foundation. "Explaining Health Care Reform: Questions about Health Insurance Exchanges." Focus on Health Reform website. April 2010. Available at: <http://www.kff.org/healthreform/upload/7908-02.pdf>.
- 2 Blumberg IJ, Pollitz, K. "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals." Urban Institute and Robert Wood Johnson Foundation. April 2009.
- 3 Agrawal, V. "Operating in a post-reform environment: Underlying Trends and Implications for Payors." McKinsey & Company. Presentation; Washington, DC. Sept. 30, 2010.
- 4 Kaiser Family Foundation. April 2010.
- 5 Blumberg and Pollitz. April 2009.
- 6 Author Unknown. "NY to feds: We're too broke to create health insurance exchange." Crain's Health Pulse. Oct. 7, 2010. Available at: <http://www.craigslist.com/article/20101007/PULSE/101009903>
- 7 Pecquet J. "Experts: Decisions by states on healthcare offer insight into 2012." The Hill. May 8, 2010. Available at: <http://thehill.com/homenews/administration/96781-experts-the-decisions-by-states-on-health-coverage-offers-insight-into-2012>
- 8 Curtis R., Neuschler E. "What Health Insurance Exchanges or Choice Pools Can and Can't Do About Risks and Costs" Institute for Health Policy Solutions. Revised May 2009.
- 9 Carey B. "Health Insurance Exchanges and Health Reform." Robert Wood Johnson Foundation. Health Insurance News. March 14, 2010. Available at: <http://ehealthinsurance.com/blog/health-insurance-exchanges-and-health-reform/>
- 10 Robert Wood Johnson Foundation Website. "Spotlight on Consumer Choice." Health Policy. December 2010. Available at: <http://www.rwjf.org/healthpolicy/product.jsp?id=51409>
- 11 Ghahremani K. "Presentation to the House Select Committee on Federal Legislation." Texas Health and Human Services Commission. Oct. 7, 2010.
- 12 Troutman, Jeffrey W.; Lisi, Diana; and Mayerick, Barbara C. "E-Payment Cures for Healthcare." Presentation to PAYMENTS 2010. April 26, 2010. Available at: <https://admin.nacha.org/userfiles/File/Healthcare%20Resource/Epayments%20Cures%20for%20Healthcare.pdf>
- 13 McLauchlin J. "Retaining Customers: It's Not Just About the Renewal." The Marketer. Volume 17, Number 1, 2010.

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