Positioning for continued growth in public exchanges

Expert presenters

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With 4 million people enrolled in public health exchanges as of the end of 2014, most payers competing in federally facilitated marketplaces or state-based exchanges are finally beyond the initial stages of implementation. Payer can now envision taking their plans to a new level where they can deliver more consumer-oriented offerings and engagement approaches, supported by efficient operations, sophisticated data analytics and appropriately estimated risk management models.

Although the industry may not be quite there yet, payers should consider the pathway toward, and the benefits of, the next generation of public exchanges, according to Optum Perspectives panel members speaking at a recent webinar, "Public Exchange 2.0: Positioning for Future Growth." The panel of Optum payer market experts was led by Jeff Lowry, vice president, payer exchange consulting, Optum, and included Mike Nestor, vice president, payer consulting, Optum; Craig Howarth, senior director, payer consulting, Optum; and Kecia Rockoff, director, actuarial consulting, Optum.

Lowry kicked off the panel discussion by sharing that Optum experts, who have been involved with the exchanges since October 2013, have done extensive work across state and federal exchanges in multiple states, serving as general contractors and systems integrators to help plans with enrollment, data centers, payments, financial management and reporting. Excerpts from the panel discussion are highlighted below.

Lowry: What are the operational impacts or considerations that payers have dealt with in the 2014–15 open enrollment periods?

Nestor: The context I will provide is heavily influenced by work on the federal exchanges and healthcare.gov. In terms of process for payers, this year seemed to be a much more stable experience compared to the prior year. There were major improvements across core elements of the system … but more important was the consumer experience and the payer experience. Like any very large enterprise, in the first year the program may not be fully evolved, the second year it is hitting stabilization, and in the third year, the goal is to have a more mature product. This was our second year, similar to other state-based exchanges, so it was a question of stabilization, making the consumer experience more predictable and also refining existing functionality.

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> *— Jeff Lowry*
> *Vice President, Payer Exchange Consulting, Optum*

Unlike the prior year when there were tremendous spikes in enrollment, we had the expected spikes around the key dates at the start and end of open enrollment, so the experience was much more stable and steady. Payers, the marketplace and [the Centers for Medicare and Medicaid Services (CMS)] also focused on data reconciliation. The prior year, everyone was learning, it was all new and there was a lot of new functionality, so there was an opportunity this year to improve the data that was captured during that time period as we collectively learn more. There has been a heavy investment on all sides in improving the quality of the data.

Lowry: What are the financial impacts or considerations that payers have dealt with in the 2014–15 open enrollment periods?

Rockoff: It's a whole new ballgame for the financial and actuarial areas as well. It's very important to understand how data is coming in and what the challenges are with the data, what the most common errors are and what's getting fixed, so you know how to make estimates for the 3Rs [reinsurance, risk corridors, risk adjustment]. … We have to anticipate what those are going to be without really having any data. … As the 2014 experience rating data was coming in, the plans started [analyzing] the data and comparing it to their estimates of the 3Rs to see whether they were close or not, and had to start preparing the data to feed it to their edge servers, which was a big effort. I think most plans have been able to work with CMS and get that data loaded and are getting reports back.

It's very important right now to ensure the data is as accurate as possible, validate the data, see that CMS understands what they've received, and make certain that CMS is using the data that you sent correctly. These are all important for 2015–16. Also, plans are still filing rates with very little data, so you have to keep your finger on all of your estimates and make sure that they're coming in as expected. …

The focus will continue to be on the consumer experience investment and acceleration of application entry, so we can improve the process and the quality of data. The other main focus is around minimizing complexity both for consumers and payers. … We are reaching a point of stability, having learned from the prior years.

Lowry: What are the operational impacts or considerations that payers should be planning for in upcoming enrollment periods?

Howarth: From a state-based exchange standpoint, there are a lot of challenges around the consumer experience. From working with the states you see there is a flow of information from the states out to the payers, which is a new thing in the industry … having the state involved at the onset of that flow means there are some challenges and the immaturity of the model leads to unknowns. … When it comes to consumer experience, how the consumer understands how to enroll and who to call are some of the challenges from both a payer's and the state's perspective.

From a payer standpoint, my answer is two-fold, for those already on state-based exchanges and for payers who may be just starting to get into that world. For those for whom the process is brand new, there is a lack of predictability. Generally, back-end processes are the same, but it's different at the onset of the process. During open enrollment, enrollment is going to increase, so that puts a burden on forecasting and operations to make sure that they are staffed appropriately…

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Also, how can we ensure that the consumer experience — that regular connection with the member — is maximized from an efficiency standpoint? Does the payer have a consistent understanding of how to address general medical questions as well as billing questions? And how does that fit into the overall strategy, given that there are different ways of handling [those encounters]?

States obviously are challenged with how to handle the volume that's coming in, and that has a trickle-down effect to the payers. A payer on multiple state exchanges — which could include up to 26 different states — need to know how each state is affecting its operations. … A payer we worked with [found that] one state's volume was 50 percent above forecast, which caused [unexpected] expense and tremendous stress on the operations.

Data reconciliation also is an issue right now. Are records at the state consistent with those of the payer? The difference between payer and SBM records could result in a lack of funds going back and forth, so plans have to work with the states to make sure that funds and enrollment are correct. … And manual processes are [still] going to exist, so payers have to factor that in.

Lowry: What are the financial impacts or considerations that payers should be planning for in upcoming enrollment periods?

Rockoff: Reconciliation and understanding the manual processes are critical in your planning for 2015, 2016 and 2017. You need to know that the enrollment you think you have matches the enrollment that the state thinks you have, and you need to watch that on a consistent, weekly or monthly basis, depending on what measure you are looking at. … Right now, plans are filing their rates for 2016, yet they won't know what the results of the 3Rs are until the end of this year.

King v. Burwell is a big issue right now and a lot of plans have been asking their states if they can file two sets of rates to account for either outcome in that case. … Another big change coming up is small group expansion. As of 2016, the small group definition is going to expand up to 100, and there are all kinds of risks associated with that. Some of these 'larger-smaller' groups may decide to self-insure. There's new reinsurance that's available to reinsure small populations like that, which may be an incentive for small groups to leave the market and leave the less healthy in the market, which can increase premiums for everyone. …

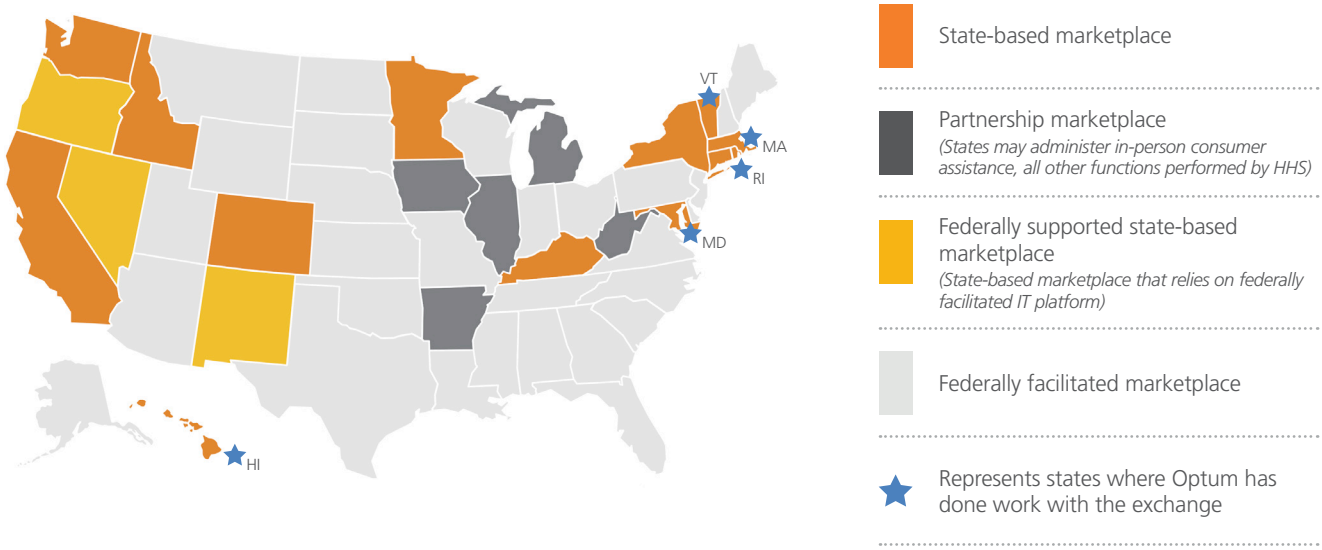
It is important that you understand where you are today as much as you can with your data, so you can be prepared to make estimates and decisions in the future in this continuously changing environment.

Lowry: What should payers be considering to account for any upcoming CMS policy changes (for example, prepping for audits, operational assessments, advanced analytics?

Nestor: A couple of things payers should be reminded of for this year and next year, in terms of open enrollment, is that a change in the enrollment date in 2015 — two weeks early — is a significant amount of time and reduces our collective time to prepare for open enrollment, which means any of our operational processes and case management, advertising and consumer engagement functions all need to have earlier steps to support that earlier date.

Figure 1

Geographic breakdown of exchange marketplaces



Source: State Health Insurance Marketplace Types, 2015, KFF State Health Facts: http://kff.org/health-reform/slide/state-decisions-for-creating-health-insurance-exchanges/

Across the industry, we are also seeing a new focus on consumer retention. So what steps are you taking to ensure retaining your membership, whether through active outreach campaigns or leveraging direct enrollment, where you are keeping a consumer more guided toward your plan and the policies you offer on the exchanges? … Plans also are looking at enhanced functionality. Exchanges will be migrating to more standard functionality moving forward. …

The policy-level premium payment also is going to be critical as we move away from what's been in place over the last 12 months around group payments. I am seeing a move to understand the financial aspects of this, to use more sophisticated ways of analyzing back-end data, to ensure accuracy and to focus on compliance-related activities in our future.

Howarth: In regard to the marketing aspect, state-based exchanges' ability to market is somewhat limited, and essentially comes down to brand and price, so we are really looking at retention rather than acquisition where it pertains to marketing. Over the last few years the marketing of health plans has gone from a membership model to a consumerism model. So how can we be more like the Targets of the world when it comes to marketing on a health care exchange? … The crux of the matter really is this: Are the internal tools and capabilities there to execute on the strategies that are in place?

[When plans engage with members and provide individualized services,] the member may see that brand or that logo and be willing to pay a slightly higher price because the company has many products and services that give the member the experience to support maintaining that relationship.

So does the payer have the expertise and the tools to have a centralized data repository to start analyzing who the new members are, and how it can get risk assessment from both a financial and a marketing standpoint? What conditions are on board? What additional products and services do we as a payer have to offer members? How do we reach out from a one-to-one perspective rather than through mass marketing? Retention becomes even more key than it was previously. We shop based on brand and price instead of based on employer-based enrollment.

How Optum can help

Optum assists our clients in positioning for success across both state-based and federally facilitated marketplaces whether they are entering an exchange for the first time or looking to expand into additional exchanges. With proven methodologies, customizable tools and experienced professionals, including consultants with over 200,000 hours of work directly supporting exchanges, we provide insights in the following areas:

- Market, financial and operational assessments
- Enrollment and payment reconciliation and remediation
- Interplay between exchange and Medicaid enrollment
- Profitability and segmentation analytics
- Marketing and brand strategy
- Consumer insights and segmentation
- Audits and filings

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