

MANAGED CARE

OUTLOOK

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There's Gold in Exchanges — Here's How to Stake Your Claim

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Call them health insurance exchanges (HIEs) or call them American Health Benefit Exchanges (AHBEs), Small Business Health Options Program (SHOP) exchanges, or gateways — the one thing we know for sure is that they are going to be a major player in the distribution system for individual and small-group health insurance. Of course, just as consumers can opt in or opt out of exchanges, payers will make the same choice — but be aware that you likely will pay a hefty price for opting out of this heavily financed cornerstone of national health care reform.

If you choose to stake your claim in exchanges, there are material technology and process investments you need to make to compete and succeed in individual and small-group markets.

The Good, the Bad, the Ugly

Make no mistake: State-based exchanges will change the face of health care. As of January 2014, payers can expect:

- **The Good:** About 24 million Americans will enter the health care market through exchanges, placing an estimated \$55 billion to \$60 billion in annual premium revenue up for grabs.
- **The Bad:** Exchanges are competitive marketplaces where payers will have to differentiate themselves based on brand, price, customer service, and more — all while cutting costs and increasing efficiencies.
- **The Ugly:** The individual and small-group markets used to be highly profitable. Now, in a new system with ground rules dictated by government, profits likely will drop significantly, especially for those payers most resistant to change.

What Can We Learn from Massachusetts and Utah?

State-based exchanges aren't new. They have been used in two states for several years, and the experiences in Utah and Massachusetts can and should be evaluated for insight into what to expect in 2014.

The Massachusetts Commonwealth Connector was created as a key element of the state's health care reform plan in 2007. It allows state residents to enter a single Internet portal where they can research insurance plans, get instantaneous determination of eligibility for state subsidies, and purchase insurance. Utah also established an exchange, the Utah Health Exchange — a site that allows individuals and small-business employees to compare and buy defined contribution health plans in much the way that consumers shop online for airline tickets and hotels.

Political and other differences between states make it likely that, as with Massachusetts and Utah, all 50 states eventually will administer, maintain, and run their exchanges in different ways. Utah, for instance, operates a fiscally conservative, market-driven model in which just two full-time employees historically have managed the connector and leveraged the distribution infrastructure of health plans.

In Massachusetts, a high-cost infrastructure replicates health plan capabilities, including customer service, billing, quoting, and enrollment. For payers, such state-by-state differences likely will affect several areas, including the amount of unsubsidized business they are likely to receive.

A related lesson of Massachusetts' connector is that payers need to retain their current sales automation capabilities because many consumers are likely to opt out of exchanges. In Massachusetts, for instance, of

400,000 newly insured residents, 100,000 went into Medicaid, 200,000 entered the exchange (170,000 with subsidies and 30,000 without subsidies), and 100,000 purchased unsubsidized commercial insurance using established distribution channels.

According to the U.S. Census, roughly 35 percent of all U.S. households will not be eligible for premium subsidies from Health & Human Services and will continue to purchase insurance through traditional channels. Clearly, payers should prepare to serve the many customers who eschew exchanges.

Three Steps to Prepare for Exchanges

According to the Congressional Budget Office, 24 million Americans will go shopping between 2014 and 2017. They will enter their state-run exchanges and look around for the best value in health insurance. The payers they choose — and the payers that will turn the biggest profits on each customer — will have integrated systems in place to take advantage of the influx of customers.

Below, we outline three of the most important areas in which payers should focus their preparations for this influx.

Sales and Service Transaction Efficiency

With high volume and tighter profit margins, payers will need to be as efficient as possible in the distribution of health insurance. In the online marketplace, transactions will be measured in hours, if not minutes, and customers will be easily attracted to alternatives if their customer experience is below expectation.

Especially with the individual and small-group medical loss ratio (MLR) set at 80 percent, plans will need to lower their administrative costs significantly, including making core system updates, to incorporate federal subsidies as a new payment source. In addition, payers will need to segment exchange enrollees and triage high-risk cases early to appropriate care management programs, given that underwriting based on pre-existing conditions has been disallowed. Value-based insurance designs will prove an additional, highly effective way to differentiate and segment risk.

Applied Business Intelligence

Working within the exchange framework — with more competition, more enrollments, and more unseen risk — will intensify the need to provide and receive decision support. Payers will need to offer benefit-modeling tools to help customers select the best health plan for their needs. At the same time, payers will want real-time product performance reporting capabilities so they

know which customers are attracted to which products.

Constituent Engagement

Within the framework of health insurance exchanges, the goal of constituent engagement will remain the same as it is today: to create an efficient dialogue between the constituent and the payer as well as among the constituents themselves. The constituents, however, will change. No longer will brokers, individuals, and employers be the sole constituents.

Payers will work with states far more extensively than they do today and will need to design systems that accommodate state requirements. In addition, federal-level involvement and reporting requirements will be inevitable, given Washington's financial commitment to fund exchanges and operate a fall-back exchange in the event a state opts out or does not meet federal guidelines.

“Not houses finely roofed or the stones of walls well builded, nay nor canals and dockyards make the city, but men able to use their opportunity,” declared Alcaeus, a sixth-century Greek lyric poet. Health insurance exchanges present great opportunity for the men and women who lead health care payer organizations. They have only to seize it. ■

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