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{ MANAGED CARE OUTLOOK }

Take steps to prepare for insurance exchanges

Transaction efficiency needed

BY ERIC GROSSMAN

Health insurance exchanges, not unlike the ones already operating in Massachusetts and Utah, are expected to play an increasing role in individual and micro-group insurance distribution. These exchanges will not exist in a vacuum; they will touch every part of the healthcare system and require substantial changes to the way payers do business.

Begin taking specific steps today (“no regret investments”) to prepare for the risks and opportunities exchanges will create. These investments will enable payers to improve customer service, enhance decision-making and reduce administrative and care costs, no matter the result of reform legislation over the next few years. The three areas of focus are:

1. Sales and service transaction efficiency. With potentially tens of millions of Americans accessing insurance through exchanges, health plans will need to operate more quickly and efficiently to service this fast-paced and high-volume market segment.

2. Applied business intelligence. After healthcare reform is enacted, insurance will be more retail-oriented and no longer medically underwritten. Payers will have to rely on more robust decision support to better understand their customers’ buying behavior, lifestyle preferences and medical history and to foster strong and profitable customer relationships.

3. Constituent engagement. In this new retail marketplace, competition will be fierce. Payers must differentiate themselves

through systems and business processes that better engage and retain brokers, federal and state governments.

Begin with seven “no regret” investments now. These are not “no risk” investments; however, without these investments, payers may find themselves unable to compete for and profit from the expanding and sizable individual and micro-group market.

SALES AND SERVICE TRANSACTION EFFICIENCY

With the large influx of new individual and micro-group customers accessing insurance through health insurance exchanges, payers must focus on transactional efficiency if they are to remain profitable and competitive. Importantly, various reform proposals include taxing health plans and setting minimum medical expense ratios; therefore, plans must reduce administrative costs:

1. Quote-to-card process. Payers should create a single, integrated system that can automatically carry the customer from enrollment at the exchange, to ID card generation, and to post-sale service. Because customers likely will expect instantaneous answers when using the Web-based exchange, the old way of doing business—including full medical underwriting and lengthy case installation windows—will not provide competitive advantages or profitable outcomes. Payers should invest in multi-payer architectures that integrate case installation and policy administration.

2. Eligibility determination. To ensure proper pairing of the low-income consumer and a subsidized insurance plan, payers will need to develop multi-directional eligibility determination utilizing the exchange. Payers must ensure that the information they receive is accurate and they will need to get clarification quickly and efficiently.

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For example, payers should develop interfaces with payroll companies to provide for real-time wage and tax determinations.

3. Care management integration. Given that most reform efforts call for all risk to be treated equally and requires guaranteed issue for pre-existing conditions, payers must leverage key enrollment cycle data (e.g., health risk assessments) earlier and more effectively. Members who are predisposed to certain conditions or who have pre-existing chronic diseases must be routed immediately to appropriate care management programs. Payers are advised to develop processes that enable them to immediately recognize high-risk enrollees and divert them to appropriate care management programs.

APPLIED BUSINESS INTELLIGENCE

Working within the exchange framework—with more competition, more enrollment, and more unseen risk—intensifies the need to provide and receive decision support. Health insurance exchanges will give payers instant feedback, letting them know which offerings are enticing customers, which are not, and what needs to change:

1. Decision-support tools. In an exchange, consumers will be given multiple health plan options coupled with extensive information, but few consumers will have sufficient expertise to choose the best option. At the same time, benefits are becoming more complex. For example, value-based benefits plans or high-deductible health plans offer increased options for lowering costs, but these plans may be

confusing to consumers who are new to the marketplace. That is why decision support will be vital. Payers must offer benefit-modeling tools that will work within the exchange infrastructure and help consumers choose the best insurance plan for their needs.

2. Customer segmentation. Soon, policies could prohibit insurance companies from rejecting applicants. Nor will payers be allowed to charge higher premiums based on pre-existing conditions or certain demographic information. Because premiums will be regulated and largely the same for all customers within a geographic region, payers should develop tools with which to segment, within the bounds of the law, new exchange customers. These tools will include health risk assessments, personal health records and, importantly, behavioral analytics that can determine the best health plan for each consumer.

3. Product performance. To remain competitive, payers participating in health insurance exchanges will require access to real-time product performance reporting capabilities. These will provide payers' product development units with critical business intelligence regarding the specific products that customers are buying. Today, most health plans have visibility only into which of their proprietary products are sold; they do not have real visibility into what business is lost and why. Payers that leverage this information to quickly respond to market demands, and design and offer new plans—such as consumer-directed health plans, value-based benefit plans, wellness programs, integrated health savings account use, and more—will be able to capture, retain and enhance market share.

CONSTITUENT ENGAGEMENT

Within the framework of the health insurance exchange, 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. However, the constituents will change. No longer will brokers, individuals and employers be the sole constituents. Payers probably will find that they have expanded relationships with state governments and the federal government, and that these new constituents have new rules and different needs.

States are likely to be major players in the world of exchanges, regardless of how exchanges are organized. Payers should design systems that accommodate state governments' unique requirements, including standard enrollment applications, state commission payments, complicated billing and eligibility systems, and numerous reporting requirements. In addition, the federal government will play a role in the exchange operation and payers should prepare now to support reporting requirements. Finally, brokers will continue play a critical role in attracting good risk and explaining complex benefits to consumers. Payers should look to offer value-added services and products that can help brokers grow their business.

The future of the American healthcare system is in flux, but the future of payers is not: They will remain the primary purveyors of health insurance. In fact, their role may expand drastically as more people enter the individual and small group market. **MHE**

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