NEW MEMBERS, NEW CHALLENGES: GETTING READY FOR HEALTH EXCHANGES

Summary

Infosys Public Services conducted a panel discussion on challenges and opportunities in onboarding to Public Exchanges with experts from Connecticut Health Insurance Exchange, D.C. Chartered Health Plan, Infosys Public Services, Microsoft, Connecture, and Benaissance. The purpose of the session was to share real-world insights and demonstrate how an ecosystem of organizations from the state, healthplan, and technology side need to come together facilitated by a systems integrator with Exchange expertise to address challenges related to Exchange implementation and onboarding. This needs to be accomplished within the tight timelines and evolving requirements of the Affordable Care Act mandates. Here we cover the people, process, technology aspects, and how these come together for successful Exchange implementation.

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People

By people, we are talking about the uninsured and small business health option program (SHOP) enrollees that the Public Exchanges and participating healthplans will be serving. It is easy to lose sight of the people you are trying to serve with the focus on deadlines, Exchange platform implementation, and healthplan onboarding. Most of these members are new to insurance and have limited experience with routine healthcare. They will need help in navigating the system. Outreach will also be essential to create awareness of what an Exchange has to offer and how people can benefit from it. Technology is helpful but leveraging traditional community organizations and resources is important during this launch period.

Efficiency

Public Exchanges and healthplans need to be efficient about the way they use technology to stand up and onboard to Exchange platforms. Exchanges do not need to build every single function from the ground up. They should be leveraging existing commercial off the shelf (COTS) solutions as well as functions that already exist in other state agencies and in participating healthplans. In addition, states need to consider collaboration with other states to share Exchange functions using a common platform. The technology to support this is available today. Healthplans tend to focus on remediating existing systems as the best way to be ready for Exchange participation. In reality, a better approach is to integrate commercial off the shelf (COTS) and Software as a Service (SaaS) point solutions in areas like financial and plan management into the overall compliance strategy.

Involvement

The requirements for Exchange participation are a moving target. Healthplans need to have dedicated staff tracking requirements around Exchange integration, plan design and actuarial equivalency, data collection and reporting, testing, etc. Healthplans and Exchanges need to communicate regularly to make sure that they are in synch with the requirements.

Panelists

Peter Van Loon, Chief Operating Officer, Connecticut Health Insurance Exchange (Access Health CT)

Maynard McAlpin, Principal, Mokxa Technologies. Former President and Chief Executive Officer D.C. Chartered Health Plan

Parminder Sethi, Principal, Mokxa Technologies. Former Chief Information Officer/Chief Operating Officer D.C. Chartered Health Plan

Brian Patt, Head of Exchanges, Infosys Public Services

Brian Russon, Industry Market Development Director – Health and Human Services, Microsoft

Ryan Howells, Vice President – Government Programs, Connecture

Mark Waterstraat, Co-Founder and Chief Strategy Officer, Benaissance

Panel Discussion

Moderator: What are the major milestones between now and October 1, 2013 [for implementing Exchanges]?

Peter: One of the major milestones is that the technology milestones aren't the full answer – we've got significant technology implementation going on the shopping experience, incorporation of the plans, payment, enrollment; but, what we're learning is – serving the people is even more critical. We have to put the people and process together to make that happen. We must reach out to them and then inform them about how healthcare works and how insurance works so that they can be knowledgeable purchasers of what we do. So in that respect, our milestones are technological, but the real milestones for us are engaging our people and that milestone is tomorrow!

Moderator: How are managed Medicaid organizations planning to fit on the Public Exchanges that will be set up?

Maynard: I think the biggest challenge is how eligibility gets managed. The more difficult challenge for [Medicaid

organizations] will be, as we begin to onboard other plans and our members get to select – do they make a wrong selection? Actually, we see these Exchanges as a great opportunity for us, in terms of the ability to go commercial, by targeting bronze-level plan members. Many of these members will be similar to those we serve today, so our difficulty would be in being able to keep track of these members to ensure that no member is left behind.

Moderator: How [does] an organization like Infosys work with the state and payers for successful Exchange implementation?

Brian Patt: We actually started our Exchange practice before March of 2010. We have a couple of decades of payer experience, so [initially] our Exchange was payer-centric with features to lower

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> – Brain Patt

risk, address adverse selection, and help individuals and small business health option program (SHOP) enrollees refine their plan selection by pulling in health records. We worked very closely with our own payer organization to see what they were hearing from clients. What are going to be the challenges? Then, we augmented our original platform with partners to provide key solution components. It's one thing to get up the system when there are grants, but the real challenge is when you have to be self-sustained, so we have to find a way to improve healthcare delivery – everything that we design is built around that [principle].

Moderator: When people talk about Exchanges, things like commercial off the shelf (COTS) and cloud keep coming up, what is Microsoft's plan for embracing this?

Brian Russon: We have been around health and human services for 25 years and building connected health platforms for states, commercial off the shelf (COTS)-based solutions for insurance Exchanges is one of those platforms. The premise is to enable multi-agency insight. Insurance Exchanges for us are a natural extension of our strategy to connect health and human services. It gives us the ability to push our commercial off the shelf (COTS) solutions [and] cloud services down into the arenas of multi-state shared processes and programs. For example, modified adjusted gross income (MAGI) calculation is done in all 50 states – so how do we take a process that's done in all 50 states and put that in a shared services model across multiple states and allow some deviations in cost? I am not a big fan of building 50 different Exchanges – what works is sharing multiple processes across multiple states and then sharing the costs. How do we build multi-state collaboration opportunities? Commercial off the shelf (COTS)-based [and] cloud-based solutions and deploy those technologies to allow states to share a lot of information.

Moderator: Parminder, we heard about how the technology will be implemented and used. What is your perspective as a consumer of that technology? What changes do CIOs and COOs need to make whether it is on Medicaid eligibility or cloud? How are you preparing your organization for that?

Parminder: In the District, we are lucky that we already have eligibility managed up to 133% of the Federal poverty level; and, the District pioneered a program where they took people up to 200% poverty levels. So we won't see a lot of operational changes coming to us [in the District]. However, I think the one thing that will be very critical is that the days of investing millions of dollars in new technologies are gone. You have to find solutions that are economical not only to implement but to sustain. So the biggest thing for us is that the fat has to be cut out of the system. We are investing in a lot of open source technologies to keep implementation costs low. Also, automating processes end-to-end is where the focus needs to be so that we can compete going forward on the Exchange.

Moderator: Ryan, your organization is working with a couple of states. How are you preparing the payers for successfully onboarding the new plans, especially with the Qualified Health Plan (QHP) component?

Ryan: A Qualified Health Plan (QHP) is a way the healthplan can compete on the Exchange. There are a slew of regulations that are coming out related to how health plans can compete on the Exchanges. The message here is [to] stay up with the regulations. I encourage having a dedicated group of individuals who are focused on that. These data templates that are being asked for may have to be done manually in the first year, and that's going to take a lot of effort. Any time the rates or benefits or product changes in any degree, shape or form, it's going to need to get approved and go through the standard approval process. So, it is important to stay

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up with what is happening. What is going to be helpful in this is the technology to help make that happen and dedicated resources on the healthplan to make sure you are focused on the right things.

Peter: Ryan has made some good points about the opportunity to cover a lot of competing requirements that are evolving and often ambiguous. In Connecticut, we're working on little bit of a different track for two reasons. I am an old finance guy and after starting of 2014 my Exchange has got to be self-sustaining. That means I have to provide value to the people who give me revenue. So everything that we are doing is geared towards being concise operationally. To that end, we are not looking to build any new empires. One of the ways we are doing that is by leveraging our stakeholders – the

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Connecticut Insurance Department and the various infrastructures for handling consumer concerns and complaints. We want to leverage the relationships that the insurance department has had with the carriers and do not want to come up with some new forms or processes. Secondly, I don't want to do stuff that's already been done. We have been fortunate to have a lot of input from our carriers in the state. From the beginning they make the point of what administratively makes sense to them rather than having another entity coming up with new administrative requirements. We have tried to listen and incorporate those suggestions. The other aspect is [that] all the Exchanges are required to reach out to the various stakeholder groups. Don't just sit back and monitor. Get involved. Reach out to your Exchange. Get on to advisory committees and make certain that your concerns are heard.

Moderator: One question that keeps coming up is about the financial transactions and integrity of financial transactions. What type of transactions do you think would be most complex for the plans?

Mark: I had an interesting conversation with a gentleman last night from one of the plans who said what's keeping him up at night is wondering if in February 2014 he can ask where did the money go. Right now there is not a lot of confidence in the approach to financial management and what is going to happen after members buy healthplans. It is critical that the healthplan and the Exchange that you are participating in have a dialog so that everyone understands where exactly the money is going and what they are doing. We are bringing in commercial off the shelf (COTS) solutions where our financial back-end is connected with the Exchange front end. In small business health option program (SHOP), employers review their bills in advance every month, make repairs and changes to their enrolment. We do a posted and adjusted bill in advance every month with current census data, so we are going to ask the healthplans to let us put all these employers on a self-bill model. Trust us to take care of this responsibly for you and be very transparent about how we are going to go about handling that money. We've been doing consolidated premium billing since 1995 [and] have existing technology that does this in

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production every day. The opportunity is to make financial management easier for the healthplans – we can take over all the paper payments, processing the partial payments, and the subsidies and send in a money order every Friday. So, in partnership, I think we can bring great synergies.

Moderator: Finally I think it is all about consumers. Maynard, what challenges do you foresee to the Medicaid plans once we see the consumers coming in through the no wrong door on Exchanges?

Maynard: Member education will be a challenge. At the end of the day, it is not just about technology. What we've found is that we're going to have to be on the streets. We are going to have to be in the community and [that's] the only way you are going to really educate the members. We took customer service into the offices of the major providers and the hospitals. We changed our transportation arrangement and went to a local vendor vs. one of the large national vendors to set up these shuttle buses that run between

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community locations and all the major hospitals. On those buses, we put health educators who talk about benefits and who constantly educate people. It's like a tour bus – someone is there to talk to you about care management and talk to you about benefits. So, it's not going to be just technology-based solutions. It is going to be people on the ground, boots on ground. We have increased our community activities by 40%. We also focus on how to educate members to better access the system and resources available. It is again going to have to be an investment to move a lot of your employees out of the office and into the community.

Moderator: In terms of outlook, Parminder, what role do you see for mobility or social media if at all for educating the consumers?

Parminder: We serve primarily the poorest of the poor in the District and what we found was pretty staggering. About 80% of the households have a smartphone. We launched a pilot program called MHealth where M was not for Mobility but "My". The interesting thing we did was that we created an in-house solution for managing diabetes which was part of Maynard's comprehensive strategy. So technology was the catalyst supported by community events at local churches. There was a local college group giving cooking classes, so we took this opportunity to start teaching people how to eat right. Technology played a smaller part along with community events like this. The results were staggering – the 50 people in the pilot program all became compliant in about six months. We looked at the data to see who was using the Emergency Room the most and for what. HIV was a big issue for us in the District but diabetes and hypertension also cost a lot, so we deployed mobility and social media to create awareness. One of the things that we are pioneering now is what we call a social platform. We are trying to give community activists access to these tools. Many people think that poor people are not looking at Facebook. That's not true. They all are. We need to get these tools in the hands of the community so that they can take care of themselves. Technology by itself is not going to solve the problem. This is a people issue that we are trying to solve.

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Maynard: There is no way the industry can continue to support heavy tech investments. We considered this mobile solution that would cost US$150,000 to US$200,000 to deploy. We achieved similar results for under US$40,000 by taking a completely different approach. We have a team with credible tech experience. What we do is fuse technology and operations to get a complete picture. Part of the reason why Parminder is both COO and CIO is to lower the cost and integrate both perspectives by consolidating management and decision making.

Moderator: On education and outreach Peter, what actions are planned on the Exchange side and how can payers help?

Peter: As Maynard and Parminder said, we are getting down into the community. We started with a traditional TV spot. Town Halls in communities in the state of Connecticut began last week so that we can talk to the people that we are supposed to serve – you realize what opportunity we have to make a change in the way healthcare is delivered. We are doing all the traditional things, but we recognize that we can't depend upon traditional media or even social media. The metaphor that we keep using is boots on the ground. We meet people with different perspectives and we work together. As we go out, we find that even our best ideas are minuscule compared to the ideas that we get from the people on the street. We also need to reach out to non-traditional organizations like faith-based communities. I can't tell you how exciting it is to get the feedback not just from the people on the ground but from the carriers as well. Something is changing and we are all involved in it.

Audience Questions

Audience: Could you address patient engagement in chronic conditions, cloud-based measurement tools and how you are going to be looking at those healthplans that are on your Exchange? How does it all wrap together?

Maynard: Our approach might be a little bit different in the sense that we look at high technology costs as a limiting factor to innovation. We have seen a lot of money spent on thinking that cool technology solves the problem. So, we made a deliberate decision that we will never let our cost exceed a certain level. So from our standpoint we are willing to consider and evaluate all options to find innovative solutions. But more importantly, we think about it from end-to-end, and then we think about all the non-technical things that have to be done. So, for example, we went with the pill dispenser idea. We talked about technology but we actually spent more time talking about the other things that would need to happen if we don't get the person to utilize it. So we spend more time talking about the non-technical aspects of the problem and how to solve those than focusing on the cool technology idea.

Audience: A question for Peter – what has been the biggest ah-hah moment?

Peter: The one that hit me was the fact that we are serving people who were not looking for insurance but looking for healthcare. We need to think about the people we are serving – that they are looking for healthcare, not insurance, not diabetes training, but healthcare. That

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[has] made my job a lot more interesting and intricate.

Brian Patt: Can I add one thing from the technology side real quick – technology to some extent does integrate with this, meaning that when you look across at health and human services (HHS) across the states and payers, historically we have had a vertically integrated supply chain. So with Medicaid, states came with their own set of systems and that is when we ran into that big spend. Now we are trying to enable the paradigm shift – the move from how do I handle this transaction to how do I handle this function. So for example, we put together our platform to support that approach. On the plan management side, Ryan and his team [are] working with National Association of Insurance Commissioners (NAIC) on System for Electronic Rate and Form Filing (SERFF) and are already building the integrations. Microsoft provides the cloud aspect but really the collaboration was key. We are moving from this vertical state by state model to this horizontal integration. That is why everything that we have is extensible so that as new opportunities come in, say new devices, we can put them in place and really reduce the time to see results. By addressing the healthcare issues immediately with the patient, you drive the cost way out of the supply chain.

Ryan: The biggest ah-hah moment for me is around the changing dynamics in the industry. I think what's going to happen here in the next five to ten years is that new models are going to sprout up and they are good models. For those of you who are familiar with the Camden Project that is going on in New Jersey – that's a public-private partnership that is allowing them to go after vulnerable parts of the population and lower healthcare costs for the entire community. The value in the health insurance exchanges over the long term has to do with the ability of healthplans and public entities to come together and deliver care for a common cause to lower the overall cost of healthcare for the entire community. And so, as healthplans embrace those new models and actively reach out to their states and to their

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members, you will see a lot better case management, a lot better cost of care. The health insurance exchange process and the technology is going to enable those conversations to happen. I think the more actively healthplans become engaged in this process and understand these populations and what they need, the better handle they will have on the members they serve.

Audience: One question that I have is do you have any comment on the viability of insurers on the Exchanges? Insurance organizations are all about managing risk. Can you give us some feedback on that?

Mark: In my private life, I sit on the board of hospitals and one of the things we struggle with is – how do we get our Medicaid population to engage with us? All we are doing is providing care, episode by episode at the moment someone walks into the emergency department – that is not an effective and cost-effective way to deliver healthcare. The population that this Exchange is going to bring in has either been in and out of Medicaid or has never been insured at all so we don't even know what their risk parameters look like because they are not even part of the market. How are we going to get them to engage with us both on the provider side and the payer side, and engage in their own healthcare? We need to bring this population in and educate them as much as possible.

Brian Patt: I do think a measurable portion of that risk was mitigated with the upholding of the individual mandate. That downplayed the death spiral that was talked about on all these Exchanges. So that's going to help us. It gets down to the collaboration that you have with the state and how you structure the QHPs. QHPs should be dynamic – not a one-time setup.

Maynard: My opinion is – nobody knows. But it's probably going to be worse than what we have. That may not be a politically correct answer, but we really don't know. What we have found is that at the end of the day, if you don't have sufficient data, you are going to have quite a few surprises. You have heard the word collaboration put out there and I can't stress that enough. We are getting all the stakeholders involved. It really requires a completely different level of transparency, a completely different level of honesty, a completely different level of collaboration. So when you hear me talk about the customer service in the field, their function is not so much services as much as it's to make sure that there is no limitation to access, that there are no administrative issues that cause that person to not be able to access the care. Transportation is not just transportation, transportation is an opportunity to engage the consumer and it is also an access issue. I think we need to get out in the field. As Peter said, you cannot deal with any of these issues or work with these customers if you are not honest about who they are. You can't sit in the suburbs and think you know these customers. You have to walk the streets. You have to interact with these customers. And Peter, as he correctly says, they are not looking for health insurance, they are looking for care and they are looking for people who will actually connect with them. So you have to completely change your model, and in many ways you go back to the roots of community health. It is more of a public health approach.

Peter: Maynard hit all the buttons. I totally agree and reiterate this is not an Exchange or provider or carrier issue – it is a collaborative one, and those collaborations are not necessarily going to go on without more heat than light as you work together. I also find that folks listen to what we are thinking and together we come up with better ideas than what either one of us does alone. Get out, get involved. We don't have all the answers but working together we can come up with a few more than what we have individually. So please be part of the team. I really am glad for the carriers and the technology providers that we are working with in the state. I think we have a model that works, so in your states, reach out to them.

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Key takeaways

The majority of the audience consisted of representatives from healthplans who are considering participating on the Public Exchanges. From the questions to the panel and conversations in the meeting room, important take-aways included:

- Enrollees coming through the Exchanges are unfamiliar with insurance procedures and have limited exposure to routine healthcare. They will need help in terms of enhanced call center technology and staff as well as online tools to support navigators appointed by the Exchanges.
- Staying on top of the reporting requirements will be a major challenge. Healthplans will need to seek out ways to automate as much of this effort as possible.
- Exchange technology is heavily reliant on computers and internet technology, yet many of these new members are more likely to be engaging on smartphones rather than laptops. In the rush to compliance, mobility has been pushed to the back burner. It needs to be moved up in the queue.
- Exchange participation represents a significant shift in the way that plans will pay claims, bill members and employers, file regulatory reports, etc. The timeline for compliance is too short to upgrade existing systems to meet all of these new requirements. Healthplans will need to look to third-party solutions for some of the answers.

For more information, contact askus@infosys.com

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