



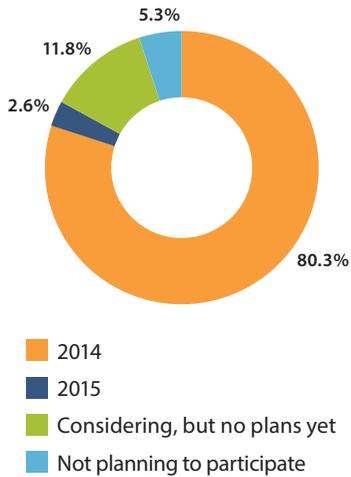
**Special
Report**

**HIX Insights from the 2013
Healthcare Mandate Summit**

**The Promise, Peril and Payoff of
Health Insurance Exchanges**

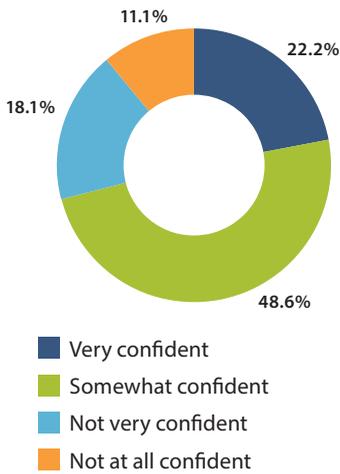
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When is your organization planning to participate in an HIX?



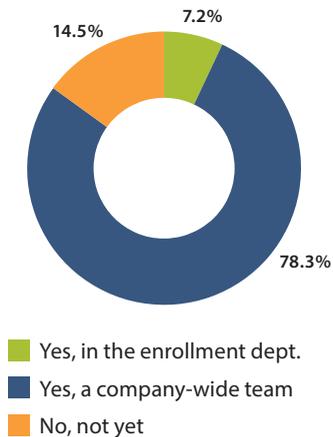
Sample size:76

If planning to participate in 2014, how confident are you that your organization will be ready?



Sample size:72

Has your organization established an HIX Project Team?



Sample size:69

Executive Summary

Later this year, roughly 12 million Americans will begin purchasing health insurance through online marketplaces¹ known as Health Insurance Exchanges, or HIXs.² A pillar of the Patient Protection and Affordable Care Act (ACA), HIXs represent a sea change in the healthcare payment and delivery model, and each state has the option of running their own insurance exchange or relying on the federal exchange instead. Regardless, all HIXs must be able to accept enrollments on October 1, 2013, with coverage beginning January 1, 2014.³

While HIXs present immense opportunity to healthcare consumers and health insurers alike, this new marketplace also carries risk. The unprecedented level of collaboration required and the sheer operational complexity of participating on several state-run exchanges give concern to health insurers. That was the finding of a survey of more than 125 healthcare executives attending the 2013 Healthcare Mandate Summit in Austin, Texas February 4–6, 2013.

Key Finding: HIXs Hold Both Promise and Peril

- 95% of respondents plan to participate in an HIX, and 80% will do so in 2014
- 70% are skeptical that the state and/or federal HIXs will be ready to launch by the October 1, 2013 deadline
- 93% say state exchanges should share more information with—and take more feedback from—health insurers
- 75% are very concerned with being able to reconcile premium, enrollment and payment records received from HIXs
- 88% are concerned about potential disruption to existing IT enrollment infrastructure and processes

The study found that while roughly 95 percent of respondents are planning to participate in an HIX, they have reservations about how HIXs will be implemented and run. Although the majority of healthcare executives attending the Summit were confident their organizations would be ready to participate on an exchange by the October 1, 2013 deadline, they were still skeptical that the exchanges themselves would be ready on time. This doubt further carried over into questions about the reality of day-to-day operations after the exchanges are up and running.

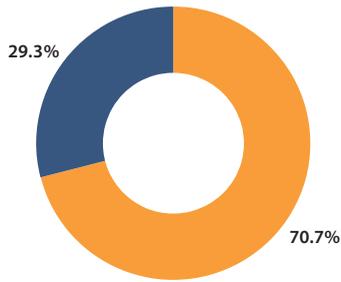
Other insights from the survey:

- Health insurers recognize the HIX opportunity and are taking preparations very seriously, with a high majority planning to be on an exchange in 2014
- There is an urgent, immediate need for more information sharing and collaboration among health insurers and the HIXs they plan to join
- Health insurers are far more concerned about the ongoing challenges of operating on an exchange than the process of actually joining one

Insight #1: Health insurers are taking the HIX opportunity seriously

One goal of the ACA is to ensure that all Americans have health insurance. For the healthcare consumer, the benefits of health insurance are obvious. For health insurers, there's an opportunity as well. The 12 million people projected to buy insurance via an HIX in 2014 will pay

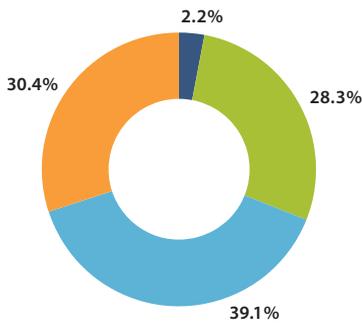
Do you believe the states and/or the Federal government will be ready on October 1, 2013, to launch the new HIXs?



■ Yes
■ No

Sample size:82

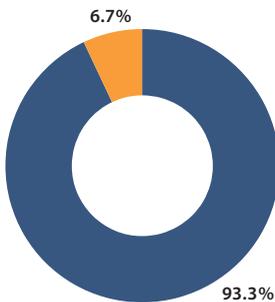
For the HIXs you're working with, rate the quality of information they are providing to help you successfully integrate.



■ Excellent
■ Good
■ Poor
■ Very poor

Sample size:46

Would you prefer that HIXs get more input from you on how to define and operate enrollment processes?



■ Yes
■ No

Sample size:60

approximately \$60 billion in premiums. And by 2019, those figures will grow to 28 million consumers paying nearly \$200 billion in premiums.⁴ Clearly, the HIX potential is immense.

Health insurers well recognize the implications. When asked about their plans, 95 percent stated their intention to participate in an HIX, and of those, more than 80 percent said they would be on an exchange in 2014.

Those pushing hard to participate in 2014 are likely doing so to avoid waiting an entire year until the next health plan qualification period. Besides losing a year's worth of premiums, any health insurer not participating in 2014 will miss out on one of the largest open enrollments in history. They risk being unable to entice a consumer away from the qualified health plan they purchased on the HIX in 2014.

It goes beyond revenue, however. As the healthcare industry moves toward a more consumer-centric model, perception and satisfaction take on increasing importance. In a recent PwC Health Research Institute consumer survey, 34 percent of respondents reported they would have a less favorable impression of a health insurance company that chose to forego participating in their state's exchange. This is likely due to the perceived value of an HIX to consumers: 37 percent of respondents to the same survey believed HIXs will make it easier for them to find and purchase a competitive health plan.⁵

Many Summit attendees are ramping up their HIX implementation efforts to ensure they are ready to meet the October 1, 2013 deadline. Approximately 78 percent have created a company-wide project team, rather than relegating HIX implementation to the enrollment department. This could indicate health insurers are committed to investing enough resources to successfully manage an initiative with far-reaching implications for their operations.

When asked about meeting the deadline, 48 percent reported being "somewhat confident," and 22 percent said they were "very confident" that their organization will be ready.

A note of caution: while health insurers are making a significant investment to ensure their readiness for HIXs, it's worth remembering that complex business process changes inevitably encounter challenges and setbacks. And in the case of HIXs, health insurers may be underestimating the complexity and scale of enrollments coming from the HIX. In other words, they don't yet know what they don't know. While confidence is generally a positive indicator, it may also suggest that health insurers have not fully recognized the risks involved.

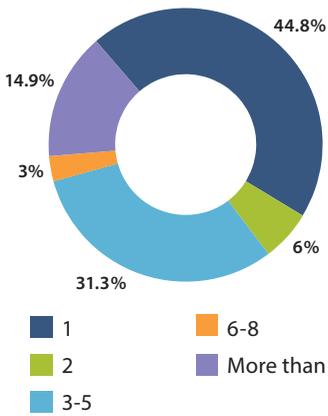
Insight #2: There is an urgent need for better collaboration among health insurers and HIXs

Although the ACA is a federal mandate, states are in the driver's seat for determining exactly how their exchanges will be run. For example, according to the guidelines released by the federal government late last year, states will manage risk pools, develop their own rate review programs, define open enrollment periods and play a major role in certifying qualified health plans.⁶

With this flexibility comes responsibility: involving stakeholders, determining technology platforms, communicating progress and meeting deadlines. Respondents to the Healthcare Mandate Summit survey were not optimistic that states will be ready to launch their respective HIXs on October 1, 2013. Roughly 71 percent did not believe the state and federal government exchanges would be ready.

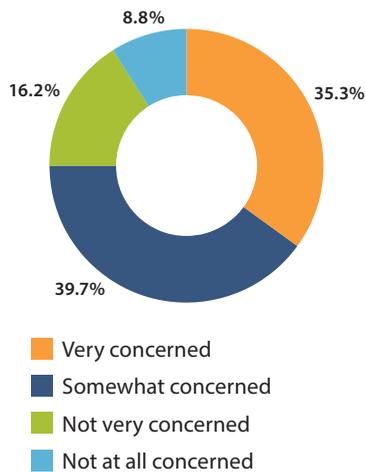
States have big challenges in that many need to overhaul their existing IT systems to comply with all aspects of the ACA and create interfaces among the Medicaid, HIX and CHIP (children's health insurance program) systems at the same time they are developing their HIX infrastructure. Even if they choose not to run their own exchange, many states must complete significant system upgrades.⁷

In how many HIXs does your organization plan to participate?



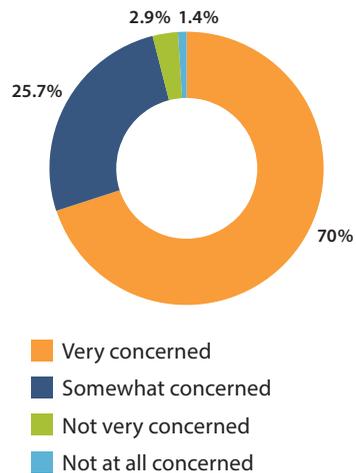
Sample size:67

How concerned is your organization with the need to support multiple HIX formats?



Sample size:68

How concerned is your organization that these formats many change over time?



Sample size:70

As with any major business or technology project, transparency is key. Insurers need early access to technical specifications for exchange EDI transactions, as well as the processes for use of these transactions, such as how to reconcile enrollment discrepancies. Unfortunately, most of the healthcare professionals reported a lack of good information coming from the state exchanges they have targeted for participation. Just over 69 percent felt the quality of information provided to them from their targeted exchanges is “poor” (39 percent) or “very poor” (30 percent).

Even more striking was the preference for two-way communication. Given their overall expertise in enrollment, claims management and payment processing—not to mention the number of mandates health insurers have faced over the last 15 to 20 years (HIPAA, ICD-10, etc.)—most survey respondents felt they have at least a few lessons to share with the state HIX planning and implementation teams.

In fact, 93 percent of respondents expressed a strong desire for exchanges to solicit input from health insurers on how to define and operate their enrollment processes. The good news is that some state HIX teams are doing exactly that. In their presentation at the Healthcare Mandate Summit, representatives from the Colorado and Washington HIXs emphasized the need for ongoing communication and collaboration with health insurers. Both HIXs have developed strong partnerships with health insurers in their respective states, via stakeholder workgroups and a comprehensive series of public meetings.

Colorado and Washington aren’t alone in their efforts. In its 2012 Health Plan Industry Pulse, the Managed Care Executive Group (MCEG) surveyed 120 health plan executives representing more than 75 healthcare organizations nationwide. Just over half (54 percent) reported being “actively involved” in helping their state develop its HIX.⁸

Insight #3: Health insurers are more concerned with the challenges of operating with an exchange, rather than getting on the exchange to begin with

Of course, the October 1, 2013 deadline is merely a starting point. The real challenge for health insurers comes with operating on the exchanges they have joined. For larger health insurers in multiple states, the challenge will grow exponentially relative to the number of exchanges on which they participate. Just over 31 percent of Summit survey respondents indicated they plan to participate in 3-5 exchanges.

As noted, each state has considerable leeway in determining how it will run its exchange, and health insurers face the daunting task of supporting multiple exchange formats.

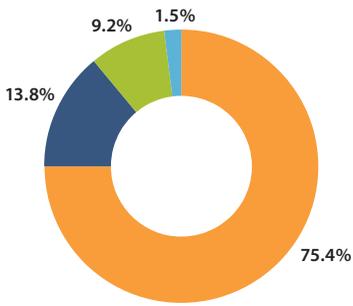
When asked how concerned they were about supporting multiple formats from different exchanges, 75 percent said they were either “somewhat concerned” (39.7 percent) or “very concerned” (35.3 percent).

And the formats may keep changing. With less than a year remaining before October 1, 2013, those HIXs scrambling to meet the deadline will likely be making significant changes in the months and years to follow. Even HIXs well positioned to meet the deadline may have multiple fixes and process changes as the industry accustoms itself to the scale and typical growing pains of an all-new enrollment and healthcare payment model.

In fact, a full 96 percent of survey respondents expressed concern that formats would continue to change over time.

Health insurers already face similar challenges today, due to custom or hard-coded enrollment

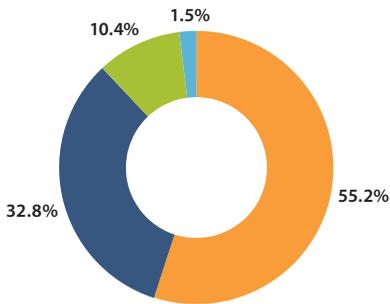
How concerned is your organization with being able to reconcile premium, enrollment and payment records received from the HIX?



- Very concerned
- Somewhat concerned
- Not very concerned
- Not at all concerned

Sample size:65

How concerned is your organization that HIX-based enrollment will disrupt your existing IT enrollment infrastructure and applications?



- Very concerned
- Somewhat concerned
- Not very concerned
- Not at all concerned

Sample size:67

systems. These systems will be even harder to manage with numerous constantly changing formats with HIXs.

As health insurers consider their HIX implementation strategy, they should take a long-term view and recognize that investing early in a flexible and scalable HIX-related enrollment system will likely pay big dividends later on.

Beyond format changes and inflexible systems, many health insurers are realizing that managing membership on an HIX is more than just an EDI challenge. Adhering to appropriate transaction formats and complying with rules are important. For example, in the HIX model, even a simple address change can affect the tax credit amount an individual receives, which means health insurers may have to adjust how they process information updates from individuals they serve via the HIX.

However, a far bigger issue is managing and reconciling health plan member records with the state HIX's membership database. When asked how concerned they were about reconciliation, 89 percent of respondents said they were either "somewhat concerned" (13.8 percent) or "very concerned" (75.4 percent).

Finally, adding an entirely new line of business almost always disrupts operations. Even though health insurers anticipate positive results from participating in one or more HIXs, they also realize they need to consider potential disruption to processes and IT systems supporting enrollment.

More than 88 percent of Summit survey respondents expressed some concern over possible disruption, with 32.8 percent saying they were "somewhat concerned" and 55.2 percent saying they were "very concerned."

Conclusion

Based on the survey results, it is clear that most healthcare professionals recognize both the promise and peril of HIXs. HIXs present a new model reflecting the healthcare industry's inexorable shift toward more consumer-focused payment and care delivery. In this new model, consumers can shop for and compare plans, much the same way they would a car.

The revenue potential is tremendous for those health insurers that compete effectively in these online marketplaces. On this new playing field of standardized benefits, established tiers of coverage and guaranteed issue of health insurance for all, each health insurer will need to decide its basis for competition. Will it be the low-cost option, or will it compete more on service and level of benefits? All of these questions will eventually be answered, but in the meantime, there are significant concerns about the timing, infrastructure and operational challenges surrounding the launch deadline of October 1, 2013.

While most health insurers have confidence in their own ability to be ready, there is a distinct lack of trust that the HIXs will be ready as well. State HIX organizers would do well to dramatically increase the level of communication, cooperation and outright collaboration with health insurers in their region. Not only will it engender mutual feelings of trust, but they may just learn something from the health insurers while they are at it.

Once the HIXs have launched, the real work begins. Consumers used to impeccable service and no downtime from their online retailing experiences will expect the same from their online HIX experience: smooth claims handling, no lost premium payments and fully reconciled records between their health insurer and the HIX. Delivering on that expectation will be difficult. But for those health insurers that successfully navigate the HIX launch process and remain flexible enough to accommodate the inevitable changes as HIXs evolve, the payoff will be considerable.

Notes on Methodology

The survey was conducted among healthcare payer and provider attendees of the 2013 Healthcare Mandate Summit, an industry conference hosted by Edifecs, Inc. that took place February 4-6, 2013 in Austin, Texas. The results are from a survey of more than 125 senior healthcare professionals—each of whom self-selected which questions they chose to answer, and this accounts for the variation in sample size by question. All respondents are actively involved in their organization’s compliance initiatives and carry significant responsibility for ensuring compliance with government mandates. Attendees represented a wide range of healthcare organizations, including commercial health insurers (68%), healthcare providers (11%), government entities and agencies (9%), and other healthcare industry organizations (12%).

This survey is not based on a probability sample, and therefore, no estimate of theoretical sampling error can be calculated. All decimals in this report are rounded to the nearest percentage point. This may result in certain numerical totals adding up to slightly more or slightly less than 100 percent.

The estimates and opinions expressed in this report are based on the survey results only, and the results do not purport to represent all entities or professionals in the healthcare industry.

Edifecs is making the results of this survey publicly available as a service to the healthcare industry. Excerpts from this report (including charts) may be used for editorial purposes without prior permission from Edifecs, provided:

- Edifecs is acknowledged as the source of the content
- Charts are displayed with only minor edits or changes
- A link to the full report is included:
http://www.edifecs.com/downloads/2013SummitSpecialReport_HIXs.pdf

Citations

- 1 CBO, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” July 2012.
- 2 “Health Insurance Exchange” is the original term for online insurance marketplaces created by the ACA. Although other terms are now being used (such as “Health Benefit Exchange” among others), this paper uses only the original term.
- 3 Estimates for the Insurance Coverage Provisions of the Affordable Care Act, July 2012.
- 4 PwC Health Research Institute. “Top Health Industry Issues of 2012; Insurance Exchanges: Health Plans Learn to Compete in a New Marketplace,” November 2011.
- 5 Ibid.
- 6 Department of Health and Human Services, “Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,” <http://www.dol.gov/ebsa/pdf/essentialhealthproposedregulation.pdf>. Accessed February 2013.
- 7 Michael Tutty and Jay Himmelstein, “Establishing the Technology Infrastructure for Health Insurance Exchanges Under the Affordable Care Act: Initial Observations from the “Early Innovator” and Advanced Implementation States”, University of Massachusetts, Medical School, National Academy of Social Insurance, and Robert Wood Johnson Foundation, September 2012; http://commed.umassmed.edu/sites/commed.umassmed.edu/files/NASI%20HIX%20Paper%20Sept%202012_Final.pdf.
- 8 Managed Care Executive Group and HTMS, “The Health Plan Industry Pulse – Moving Forward: Payers Weigh in on Priorities for 2013 and Beyond,” <http://www.htms.com/pdfs/HTMS1040020.pdf>. Accessed February 2013.