Preparing for the Health Insurance Exchanges

HFMA Forums' Virtual Networking Event

February 23, 2012

2:00 – 3:00 pm Central Time

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Agenda

- Overview of the health insurance exchanges
- Key lessons from the Massachusett's exchange
- One CFO's experience with the Massachusett's exchange
- Networking:
  - Identify key questions that healthcare finance leaders should be asking about the exchanges
  - Other questions and remarks
- Closing remarks

An Overview of the Exchanges

February 23, 2012

Jim Landman

Director, Thought Leadership Initiatives

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Basic Definitions

- "A state-based competitive marketplace where individuals and small businesses will be able to purchase affordable private health insurance."
- "A one-stop shop where individuals will get information about their options, be assessed for eligibility for the Exchange, tax credits for private insurance, or programs like the Children's Health Insurance Program, and enrolled in the plan of their choice."

Source: U.S. Department of Health & Human Services Fact Sheet, July 11, 2011, http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011b.html

Main Functions of the Exchanges

- Certifying, recertifying, and decertifying "qualified health plans"
- Assigning ratings to each plan offered through the Exchange on the basis of relative quality and price
- Providing consumer information on qualified health plans in a standardized format
- Creating an electronic calculator to allow consumers to assess the cost of coverage after application of any advance premium tax credits and cost-sharing reductions
- Operating a website and toll-free telephone hotline offering comparative information on qualified health plans and allowing consumers to apply for and purchase coverage, if eligible
- Determining eligibility for the Exchange, tax credits and cost-sharing reductions for private insurance and other public health coverage programs, and facilitating enrollment of eligible individuals in those programs
- Determining exemption from requirements on individuals to carry health insurance and granting approvals to individuals relating to hardship or other exemptions
- Establishing a navigator program to assist consumers in making choices about their healthcare options and accessing their new healthcare coverage

Source: U.S. Department of Health & Human Services Fact Sheet, July 11, 2011, http://www.healthcare.gov/news/factsheets/2011/07/exchanges0711

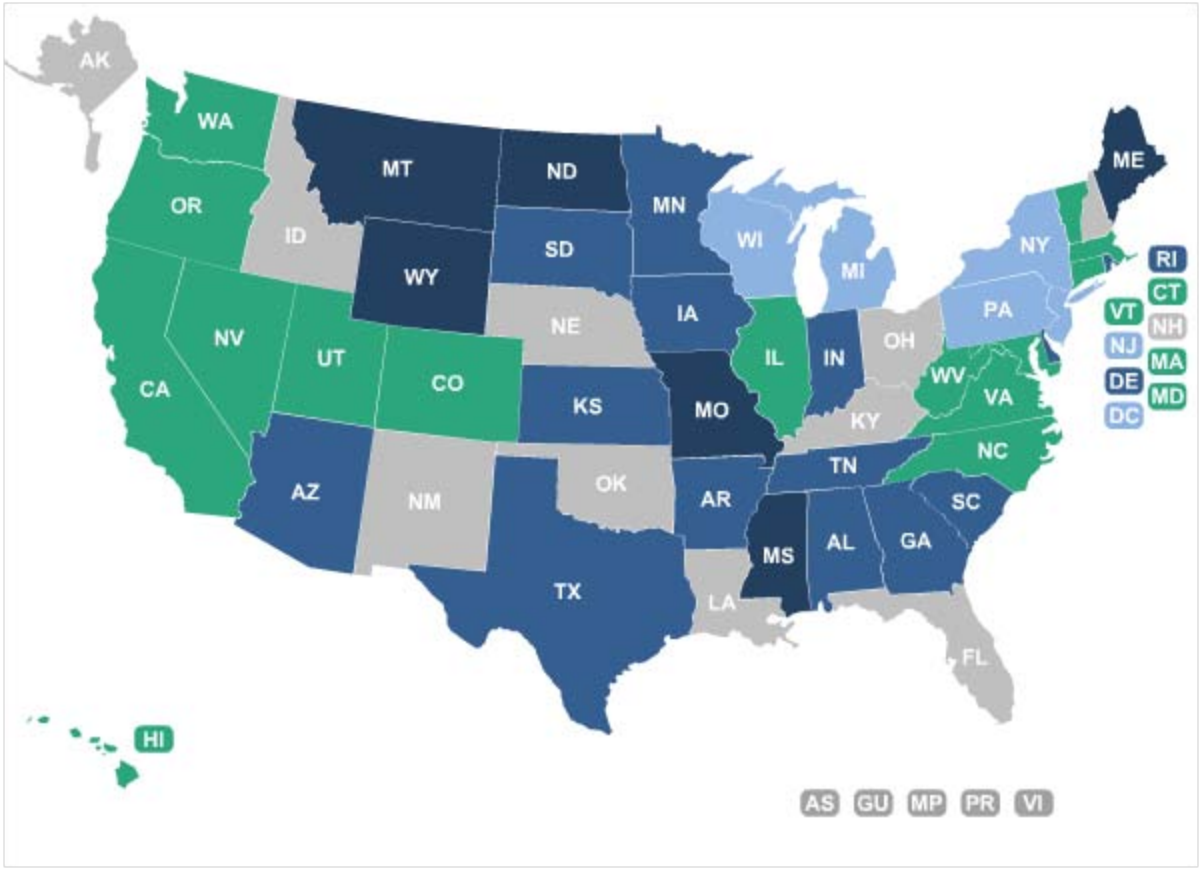
Key Dates

- January 1, 2013: States demonstrate ability to run an exchange by January 1, 2014 (HHS is contemplating "conditional" approval)
- October 1, 2013: Exchanges open for enrollment
- January 1, 2014: Exchanges operational
- January 1, 2015: Exchanges are "self-sustaining"

Possible Models

- Depending on a state's ability/willingness, an exchange may be:
  - Completely state-run
  - Run initially as a state/federal collaboration
  - Federal-run for states with no interest in running their own
- States running their own exchange will choose to be:
  - A "passive" purchaser, certifying any plan that meets minimum criteria, or
  - An "active" purchaser, selecting plans based on additional affordability and quality criteria (California, Connecticut, Massachusetts, and Oregon to date)

State Progress to Date



Source: National Conference of State Legislatures
http://www.ncsl.org/issues-research/health/state-actions-to-implement-the-health-benefit-exch.aspx

Uncertainties

- Definition of “essential health benefits” that health plans on the exchanges must provide
  - Initial guidance outlined in HHS informational bulletin issued December 16, 2011 (http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html)
- Readiness of state and federal governments to meet deadlines
- Supreme Court decision on constitutionality of Affordable Care Act (argued in March, decided by end of June)
- Outcome of 2012 elections

Massachusetts Reform: Lessons Learned

February 23, 2012

Jon Kingsdale & Patrick Holland

Wakely Consulting Group, Inc.

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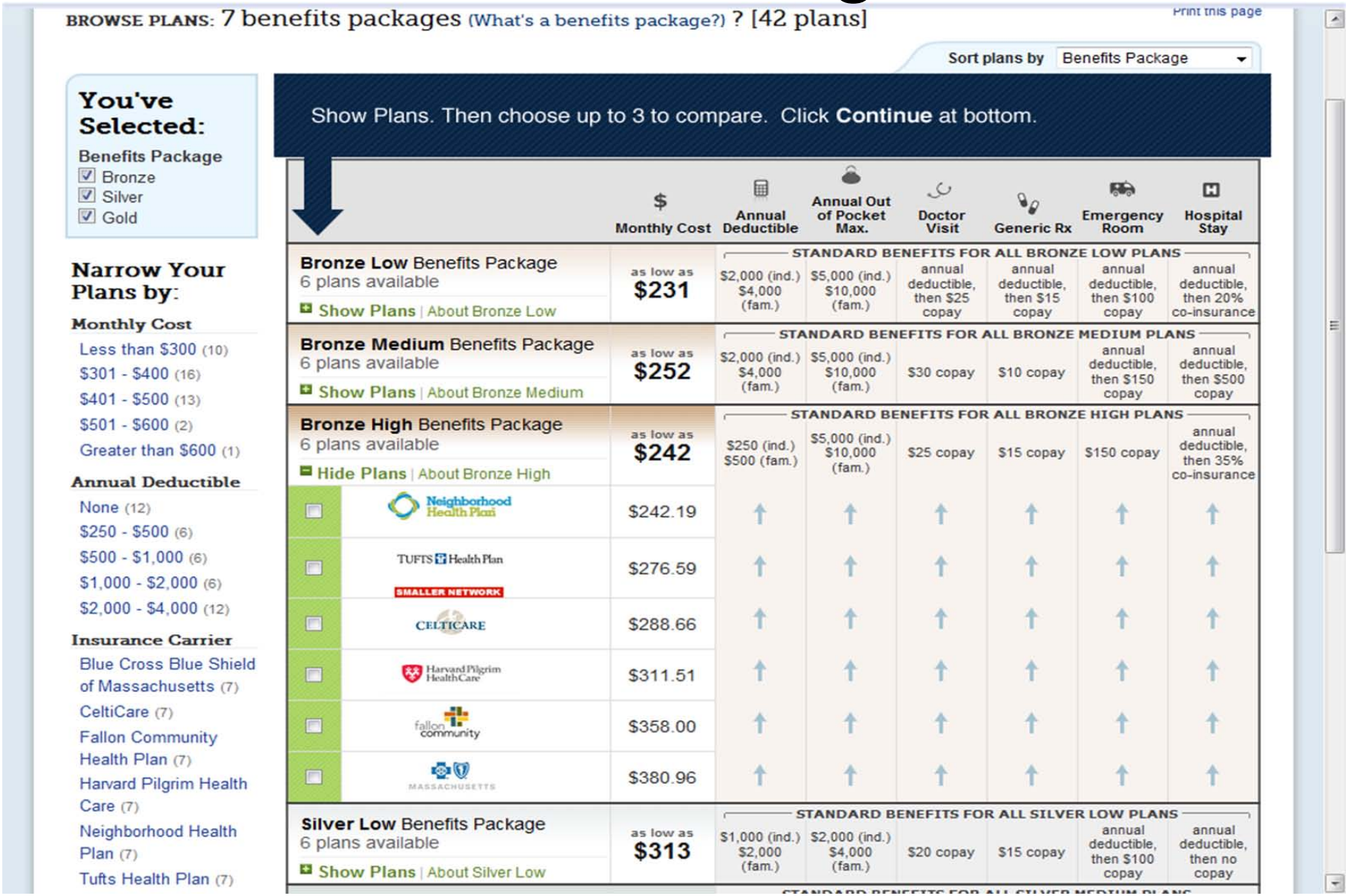
“Price is king”



BROWSE PLANS: 7 benefits packages (What's a benefits package?) ? [42 plans]

Print this page

Sort plans by Benefits Package

You've Selected:

Benefits Package
- ☑ Bronze
- ☑ Silver
- ☑ Gold

Narrow Your Plans by:

Monthly Cost
- Less than $300 (10)
- $301 - $400 (16)
- $401 - $500 (13)
- $501 - $600 (2)
- Greater than $600 (1)

Annual Deductible
- None (12)
- $250 - $500 (6)
- $500 - $1,000 (6)
- $1,000 - $2,000 (6)
- $2,000 - $4,000 (12)

Insurance Carrier
- Blue Cross Blue Shield of Massachusetts (7)
- CeltiCare (7)
- Fallon Community Health Plan (7)
- Harvard Pilgrim Health Care (7)
- Neighborhood Health Plan (7)
- Tufts Health Plan (7)

Show Plans. Then choose up to 3 to compare. Click **Continue** at bottom.

	Monthly Cost	Annual Deductible	Annual Out of Pocket Max.	Doctor Visit	Generic Rx	Emergency Room	Hospital Stay
Bronze Low Benefits Package 6 plans available Show Plans | About Bronze Low	as low as **$231**	STANDARD BENEFITS FOR ALL BRONZE LOW PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	annual deductible, then $25 copay	annual deductible, then $15 copay	annual deductible, then $100 copay	annual deductible, then 20% co-insurance
Bronze Medium Benefits Package 6 plans available Show Plans | About Bronze Medium	as low as **$252**	STANDARD BENEFITS FOR ALL BRONZE MEDIUM PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	$30 copay	$10 copay	annual deductible, then $150 copay	annual deductible, then $500 copay
Bronze High Benefits Package 6 plans available Hide Plans | About Bronze High	as low as **$242**	STANDARD BENEFITS FOR ALL BRONZE HIGH PLANS					
		$250 (ind.) $500 (fam.)	$5,000 (ind.) $10,000 (fam.)	$25 copay	$15 copay	$150 copay	annual deductible, then 35% co-insurance
☐ Neighborhood Health Plan	$242.19	↑	↑	↑	↑	↑	↑
☐ Tufts Health Plan (SMALLER NETWORK)	$276.59	↑	↑	↑	↑	↑	↑
☐ CeltiCare	$288.66	↑	↑	↑	↑	↑	↑
☐ Harvard Pilgrim HealthCare	$311.51	↑	↑	↑	↑	↑	↑
☐ Fallon Community	$358.00	↑	↑	↑	↑	↑	↑
☐ Blue Cross Blue Shield Massachusetts	$380.96	↑	↑	↑	↑	↑	↑
Silver Low Benefits Package 6 plans available Show Plans | About Silver Low	as low as **$313**	STANDARD BENEFITS FOR ALL SILVER LOW PLANS					
		$1,000 (ind.) $2,000 (fam.)	$2,000 (ind.) $4,000 (fam.)	$20 copay	$15 copay	annual deductible, then $100 copay	annual deductible, then no copay

Reform Begets Reform

- 2006: Chapter 58 of the Massachusetts General Laws
- 2008: Chapter 305
- 2010: Chapter 288
- 2012: Payment reform legislation?

Health reform changes the competitive landscape in Mass.

Exchange Design Elements

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QHP Plan Management

- QHP Certification, Recertification, Decertification Process
- QHP Compliance & Monitoring
- QHP Rate Review
- Data Interchange

Funds Flow

- Self-sustainability
- Revenue generation options
- Premium billing
- Pass-through
  - Carriers
  - Brokers/agents
  - Intermediaries

Risk Adjustment & Reinsurance

- Markets impacted
- Federal or state-based program
- Data availability
- Implementation issues

IT Systems Development

- Significant capital costs
- Highly integrated with Medicaid eligibility systems
- Initially federally-funded, but exchange must offset ongoing operating cost
- Critical for exchange viability

Exchange Administration

- Accounting system
- Financial & management reporting
- Subject to federal and state audits
- High degree of transparency

The Massachusetts Experience

Boston Medical Center: A Provider Perspective

February 23, 2012

Richard W. Silveria

Senior VP of Finance and CFO
Boston Medical Center

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Contracting and Market Impacts

- Massachusetts offers subsidized, “Commonwealth Care” and a non-subsidized “Commonwealth Choice” plans through the healthcare “Connector”
  - Greatest market penetration has been in the most highly subsidized plans
  - Potential future role of the Connector versus insurance exchanges is not entirely clear
- Variation in provider rates dependent on market factors, such as brand and “essentiality” of the provider in the network
  - Negotiated rates tend to be benchmarked to public payer rates
- Commercial “connector” products have yet to have a large impact on employers dropping current employee health plans
- A key healthcare reform impact has been in the “merged” commercial insurance market (individuals and small group employers) relating to premium affordability – with heightened governmental focus on premium levels and increases; causing indirect impacts on provider rates

Hospital Operational Impacts: Access

- Enrollment and eligibility
  - Patients are screened for assistance via the Massachusetts "gateway" where providers gather and submit patient demographic and financial information on a common application. This application process determines eligibility for:
    - Medicaid
    - Commonwealth Care – subsidized insurance for patients up to 300% of the Federal Poverty Income Guidelines
      - Individuals are eligible for *Commonwealth Care* if they are under 65 and meet the residency and income requirements for the program; they are not eligible for Medicaid; and they do not have medical insurance or access to medical insurance through an employer.
    - Health Safety net – for other Massachusetts patients not eligible for the above
      - Typically citizens that have other health insurance (such as Medicare) and are considered low-income but are above the income level for Medicaid
  - Hospitals will also inform patients on how to select and enroll in Commonwealth Choice, non-subsidized plans

Hospital Operational Impacts: System and Processes

- Adapt systems and processes
  - Update system applications with new insurances and associated rules
  - Increase staffing for financial counselors and insurance follow-up
  - Establish “application pending” financial classes to track the process and manage the risk of multiple applications
  - Work queues and enhanced insurance verification systems and processes are essential to ensure proper payer classification

Revenue Cycle Impacts: Financial Counseling

- Patient financial counselors will spend more time educating patients on:
  - The need for a patient to select a health plan and pay a premium, as needed
  - The selection of a health plan may change where patients receive their medical care
  - Failure to pay premium will result in either a reassignment to a zero premium plan or termination of their insurance
  - The benefits of receiving care at their doctor's office, rather than the emergency department due to copayment differential
- Patient financial counselors will also assist and help advocate for patients who wish to file a premium hardship waiver, appeal for a health insurance change, or need more information about open enrollment

Hospital Operational Impacts: Revenue Cycle Management

- Referral and authorization management
  - Primary care referrals, authorizations for selected services and managing care within contracted networks are similar to the requirements of other managed care products
- Accounts receivable management
  - Payers process transactions via standard HIPAA transaction code sets
  - Providers need to value claims based upon expected/contracted payment rates and manage any underpayments as they would with other payers

Key Questions Finance Leaders Should Be Asking

Share Your Thoughts with the Speakers

February 23, 2012

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Help Us Expand a List of HIX Questions

HFMA recently developed a series of questions designed to help HFMA members prepare their organizations for the exchanges
http://www.hfma.org/Templates/InteriorMaster.aspx?id=30454

As the speakers review and comment on this list, please share additional questions that might be added to the list via the webinar's chat function. Our goal is to compile a longer, more in-depth list for Forum members.

Near-Term Profitability Questions

- Will your state's exchange be an active or passive purchaser?
- Will the exchange evaluate insurers based on their progressiveness as a value-based payer (e.g., support for medical homes or use of P4P, shared savings, and/or bundled payment contracts)?
- How are your outcomes (from a quality perspective) compared to other hospitals?
- Does your organization have the capabilities necessary to manage value-based reimbursement?

Near-Term Profitability, cont.

- Will exchange selectivity force payers to put additional pressure on rates?
- How are your costs (to payers) in comparison to other area hospitals?
- Is your market over-bedded?

What Other Near-Term Profitability Questions Should Finance Leaders Be Asking?

Long-Term Strategy Questions

- How do you expect the addition of potentially sicker patients into the insurance pool to impact insurers' network development and care management strategies in your market?
- How do you expect employers to react?
- What percentage of your insured low-income patient population currently receives coverage from an employer?
- How can you work with employers to make ESI sustainable for all employees?
- How price sensitive will consumers in the exchange be?
- Can the organization provide accurate estimates of patient responsibility?

Long-Term Strategy, cont.

- How competitive is your state's/region's insurance market?
- Will the exchange drive further consolidation?
- How many of the payers will compete in the exchange?
- Will the exchange result in more restricted provider networks?
- Are there opportunities for the health system to offer coverage through the exchange?
- If you already offer an existing insurance product, is there an opportunity for new offerings that could provide continuous coverage regardless of an individual's income?

Long-Term Strategy, cont.

- How will a change in the volume of services provided impact profitability, staffing, and capital needs?
- How will payer mix changes impact profitability and capital planning?

What Other Long-Term Strategy Questions Should Finance Leaders Be Asking?

Revenue Cycle/Price Transparency/Patient Access Questions

- How do you expect your revenue cycle needs to adapt to the exchange?
- What revenue cycle processes can you put into place to manage “payer churn?” (Providers will face this challenge as the newly insured continually transition between payer classes)
- How will your organization provide the level of price transparency necessary to help individuals make purchasing decisions?
- How do you educate patients about the availability of subsidies through the exchange?

Revenue Cycle, cont.

- How does this alter the role/responsibilities of your existing financial counselors?
- Will the exchange have a mechanism to facilitate Medicaid enrollment?

What Other Questions Related to the Revenue Cycle, Price Transparency, or Patient Access Should Finance Leaders Be Asking?

Other Questions & Remarks

- Please share your questions and comments about the health insurance exchanges via the webinar chat function.

Closing Remarks

- The audio and slides of this Forum event will be posted on the Forum websites in the next few weeks. We will also post the expanded list of questions about the exchanges that was developed during this event.

Thanks for attending!

Speaker Biographies

- Jon Kingsdale, PhD, is managing director, Wakely Consulting Group, Inc., and former executive director, Massachusetts Commonwealth Health Insurance Connector Authority (jonk@wakely.com).
- Patrick Holland is managing director,Wakely Consulting Group, Inc. (patrickh@wakely.com)
- Richard W. Silveria is vice president finance and CFO, Boston Medical Center (Richard.Silveria@bmc.org).
- Jim Landman is director, Thought Leadership Initiatives, HFMA (jlandman@hfma.org).