ACA Participation: What we’ve learned and what lies ahead

To the American public, the herky-jerky rollout of health insurance exchanges made it seem as though few in the health care field or the federal government prepared sufficiently for the creation of the Affordable Care Act. But, out of public view, the health plans and provider networks comprising these exchanges were continually breaking new ground across the country in arrangements perceived to be what the ACA required, and they lived to see another open enrollment period — replete with lessons learned and earned.

“The message in the rollout aftermath, and as the 2015 sign-up commences, is that the exchange world is no longer an unknown, not doomed to fail, and that the infrastructure is there to make participation a good thing for any health organization that wants to embrace it,” says Todd Stockard, president of Valence Health, a consulting firm that helped several exchanges and provider networks to get rolling.

That said, a rapidly evolving array of new constructs in the provision of care demand a keen understanding of the varied opportunities awaiting both insurers that list on the exchange and providers that contract with them, but tempered by a spectrum of financial risks to consider, organize for and keep under control.

The proliferation of exchanges — now called marketplaces in federal lingo — makes the whole health plan focus more local than national, unleashing market forces that pull regional health plans even with national insurance powerhouses in attractiveness to employers and individuals who are seeking coverage. Provider-sponsored health plans now make more sense. In addition, the hard work attendant in efforts to pull together a clinically integrated provider network can pay off, presenting an exchange with a cohesive business unit around which to shape most or all of a provider service network.

But for all its potential, the pursuit of exchange business by providers has created a new set of tasks to master and potential threats to anticipate and neutralize (just like pursuit of Medicare, Medicaid or other commercial business). Providers contracting with health plans

3 LESSONS FROM YEAR 1 of health insurance exchanges

For starters, a year’s worth of experience in the real world of exchanges revealed these impediments:

1. The educational expense and information-tailing for the new group of first-time insurance shoppers was massive. A majority of enrollees “were relatively clueless about what they were buying, or even the concept of what a benefit design looks like,” says Todd Stockard, president of Valence Health.

2. The economics of narrowly defined provider networks heightened the significance of keeping attributed patients in them. That takes tracking expertise and technology, and educating new-to-insurance enrollees who didn’t grasp why they should seek care only in the exchange’s network.

3. Decisions by a health plan on what providers it needed and didn’t need had dire implications for the “didn’ts” in a market. Just ask executives of Seattle Children’s Hospital, which was excluded from four of six exchanges in its market, and the alarmed parents of kids whose health status depended on their continuing to go there and be covered.
need to manage patients differently in order to profit under the rates they will receive/ negotiate with those plans (often 20 percent less than traditional commercial). Providers must make sure they figure into the many assumptions health plans make about how to cover the most geography and clinical access at the most affordable cost. Because so many individuals who are purchasing insurance on the exchanges were previously uninsured (about two-thirds during 2014 enrollment), providers have to manage heretofore uninsured masses in uniquely different ways without draining their budgets.

Market gains await providers

The ACA provisions on health insurance access were meant to advance the precept that plans and providers become locally more responsible and develop the means to take risk for populations. That, combined with information technology incentives and Medicare accountable care initiatives such as the shared savings program, tells providers that they have to step up to financing and delivering care efficiently.

They now have a competitive opening. The marketplace advantage of large health plans — namely, a national presence that attracts the health-coverage business of nationwide corporations — is starting to slip as large employers change their buying behavior along with the rise of exchanges. “This presents an opportunity for providers to compete with the larger national health plans,” says Stockard.

When health plan decisions are made by a corporate office for a workforce scattered among many states, the logical tendency is to pick one with national reach rather than to contract separately with plans wherever they have regional operations. But, if corporations take advantage of the exchanges now in place, where individuals make decisions about their health care purchases, provider-sponsored health plans that offer prices and benefits equal to or better than national health insurers have a chance to take market share away from those nationwide plans market by market, Stockard explains.

The current attraction of buying a single, national, health plan network for a national workforce will deteriorate, as the convenience of exchanges encourages employers to give workers vouchers to buy coverage of their own choosing locally. Health plans realize this and have scrambled to compete in individual exchange markets — buying practices, providing direct care and assembling their own clinical delivery systems to go head-to-head with provider-sponsored plans. Hospitals and physician groups not already affiliated with a provider-sponsored plan can elect to jump onto the nets of national plans, compete by joining local plans or develop their own.

“Any provider that doesn’t participate in exchanges and, consequently, is out-of-network for most plans, will lose market share within the next three to five years,” says Stockard. Valence Health forecasts that about 50 percent of the commercially insured, non-Medicaid population will be on public or private exchanges by then.

Provider-sponsored plans react

The need to protect existing business extends to provider-sponsored health plans as well. One such entity based in suburban Atlanta, Alliant Health Plans, had a contingent of 20,000 covered lives in small-group coverage, and it knew that a number of groups were going to stop offering that coverage and have their workforces go to the exchange market instead. As a 15-year-old provider-sponsored plan, owned 50/50 by the corporate parent of Hamilton Medical Center and an independent practice association, Alliant had an enrollment base to protect. Facing ‘a potential dilution of their existing business,’ Alliant had to follow its covered lives to the exchange or risk losing them, says Stockard. An exchange product on the open market also promised to pick up some previously uninsured enrollees, so Alliant saw no short-term downside. It ended up adding 6,000 lives, 2,000 through conversion from small-group to exchange-based coverage, and the plan grew by 30 percent.

Another strategic issue underlying Alliant’s participation in the state’s exchange was defensive in nature: heading off the chance for national plans, such as Blue Cross, Cigna or Humana, to gain a foothold in its market.

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Alliant has a 60 percent market share for commercial business and a strong brand in the region, and it wanted to be just as present and available on the exchange as national plans to maintain its position in the market.

“Where providers have a greater market share and a brand name, they also can trade on an ability to stay more focused and responsive locally than a national, corporate America-focused health plan can be,” says Karen Janousek, president of health plan services, Valence Health. They can be more attractive to participating providers because, owned by providers themselves, the plans understand the challenges in front of providers in rendering care generally and meeting local health care needs specifically, she says.

**NONPROFIT PLANS TAKE OFF**

The Accountable Care Act established another alternative to commercial plan giants, the Consumer Operated and Oriented Plan program or CO-OP, which created a new class of nonprofit health insurance issuers to compete for members in the individual and small-group markets. And compete they have. In Maine, for example, a state-wide CO-OP called Maine Community Health Options put together a broad provider network, assisted by a $65 million low-interest loan from the Centers for Medicare & Medicaid Services, and expected 5,000–15,000 members the first year. It enrolled more than 40,000, about 90 percent of the exchange business in competition with a Blue Cross Blue Shield plan.

“Among other reasons, a competitive premium that paid for a far broader provider network than its narrow-network competition made Health Options attractive to shoppers,” says Kevin Lewis, chief executive officer. “Pricing was fair, and reflected actuarial assumptions about the population, with estimates on the behavior of the previously uninsured,” he says.

The plan also built into its calculations a “tremendous amount of risk,” sponsored as it was by a primary care association comprising the state’s community, tribal, migrant and homeless health centers. “We weren’t risk-averse going into this,” says Lewis. “Our focus has been to get people into coverage — not only to attract healthy people, but to be open to everyone’s getting coverage, and move the needle by achieving the Triple Aim through a program of care management.”

The big enrollment provides momentum going into the second year, in which Health Options boasts no increase in premiums for individuals and a 10 percent decrease for small groups. That was the result of its calculations based on claims experience and the impact of care management. “We priced based on what we needed to cover our claims and our overhead, and we didn’t want to build in any excess cushion just because we were afraid of the unknown.”

A lot less is unknown after the first year, some of it learned the hard way. That included a hectic period of ramping up for phone and online shopping volume — and fundamental tutoring on the basics of insurance — that went far beyond expectations. Maine was not alone; the challenges were nationwide.
Uninitiated insurance shoppers

“Whether it’s a Consumer Operated and Oriented Plan or an established health plan selling on the exchanges, people buying coverage often were confused by what that meant,” says Karen Janousek, president of health plan services, Valence Health. To first-time insurance shoppers, the information coming at them was laced with foreign words and phrases: deductible, co-payment; maximum out of pocket; accumulator formulas. Websites such as healthcare.gov had explanations that Janousek read and understood, “but I read it as a reader who understands this business.” The sheer volume of calls about fundamental aspects of benefit plans took exchange plans by surprise.

Valence Health has other CO-OP clients across the country in addition to Maine, who were seeking advice on how to start up their plans and provide the data, analytical and actuarial operational support these organizations need to learn how to work with their providers efficiently and handle financial risk. As Valence brought up their health plan and CO-OP clients for the open exchange enrollment, “we thought we were overstaffed for customer service, and it turns out we had probably half the staff we should have had, waiting to take those calls,” says Todd Stockard, president.

Maine Community Health Options started with five call center staffers; it’s now at 25. Other staff with insurance broker licenses were mobilized for the information crush, and executives also manned the enrollment front lines. “We had a team of anywhere from 20 to 30 on any given day and, even then, that was insufficient at times,” says Kevin Lewis, chief executive officer.

First, the average two-minute inquiry typical of commercial customer service went five to seven minutes, much of it dealing with the basics of insurance. Then, there were calls a few days later from the same people wanting to have the whole conversation all over again to cement their understanding. Once new members accessed care for the first time, many were on the phone again asking why they got a bill reflecting deductible, co-pay and other cost-sharing — “I thought I was insured.”

For the second-year enrollment cycle, much work has gone into developing aids so that health plans can manage inbound call volume better; namely, explanatory language that is easier for the uninitiated to grasp; promoting self-service communications through video clips, mailings with simplified diagrams about how the insurance process works; and other step-by-step aids. New rounds bring new issues into the mix; for example, switching plans for the first time and the attendant re-education process, and keeping the members that a plan enrolled the first year. Ongoing success depends on engaging people to become members and renew year after year, and that involves creating an educational dimension that the plans legitimately hope will pay dividends in retention rates for years going forward.
FORCED TO DEFINE NETWORK ADEQUACY

In Seattle, six choices of health plans debuted on the exchange covering that market, and four of them excluded the prominent pediatric provider, Seattle Children’s Hospital. It took months of debate between Seattle Children’s and those four narrow networks over the cost vs. benefit equation of value, and the reactions of distressed parents and their primary care providers, to reverse those decisions. In the aftermath, it became clear that neither side can make assumptions of worth with so much on the line.

Seattle Children's had a high profile in heart and cancer care, with more than two-thirds of the statewide discharges for pediatric heart surgery and cancer. Seattle Children’s, the only full-service children’s hospital in a four-state area in the Pacific Northwest, also provided 100 percent of the care for the market’s pediatric organ transplants. Strictly by numbers, the market share for many high-end tertiary and quaternary services “was really in and of itself evidence of our value,” says Sanford Melzer M.D., vice president and chief strategy officer. “However, for some payers, it wasn’t sufficient, because they had a lot of questions about diagnoses like appendicitis, asthma, bronchiolitis — common pediatric conditions.”

Initially, Seattle Children’s was considered to be too expensive for those conditions, which plans thought could be handled by pediatric specialists at general hospitals, with Seattle Children’s only needing to be contracted with on a case-by-case basis when its expertise was necessary. But those assumptions suffered from “miscalculation of where else in the market those services were available and limited understanding of the needs of children with complex medical problems,” says Melzer. Over the course of seven months, several hundred appeals for referrals to Seattle Children’s were submitted, of which the plans approved 80 percent. Seattle Children’s negotiated itself back into the exchange business.

Ultimately, Seattle Children’s proved that the services it delivered could only be done there, that it was delivering high-quality care, and that its costs were in line with other pediatric hospitals that delivered high-acuity medical treatment. “While that type of care isn’t cheap, a closer examination demonstrated its value to the community and to referring physicians, and Seattle Children’s inclusion in exchange products was needed to provide true network adequacy,” says Melzer.

Narrow-network cost issues

Patients who don’t follow coverage rules can cost themselves and their health plan money. Going out of network has always meant a higher share of the bill for plan members and a higher cost for the plan, but the exchange-inspired movement to narrow-network development heightens the hurt. When a member is in a bed outside the selective network, “nine times out of 10, that ends up being uncompensated care because it’s out of network,” says Stockard. Besides having to reimburse the nonparticipating hospital, the network likely will pay 60 percent of the bill.

“One aim of narrow networks is to keep costs low and premiums affordable by identifying low-cost providers that demonstrate reasonably high quality and excluding others.”
says Rick Bobos, Valence Health director of consulting services. But part of the cost advantage is offset by the cost of monitoring. When you build a narrow network, you have to spend time, energy and resources to keep your patients and providers in the network. Often, a patient goes elsewhere at the direction of a provider, and that has to be spotted and, perhaps, preempted.

In any network, and especially in narrow networks, the ability to track and evaluate referrals requires a combination of technology, analytical tools and health care expertise to identify the most impactful referral patterns for a given market. To help health care networks achieve this objective, Valence Health offers a suite of interconnected population health management solutions. Two key solutions in this platform are Vision and vQuest. From a provider’s perspective, Valence Health’s Vision integrates multiple data assets from practice management systems, EMRs, hospitals, labs and pharmacies to proactively identify and stratify patients by type and severity of risk. Patients are accurately attributed to a primary care provider, care gaps are identified, and needed interventions are highlighted. From a network management perspective, Valence Health’s vQuest looks across comprehensive coverage and payer information to identify services in or out of the network. It also provides numerous ways to investigate and analyze the drivers of these patterns.

Through its combined population health management solutions, Valence Health provides multiple levels of understanding about how to most effectively manage the health care of a defined population. “With accurate and recent integrated clinical and financial information across a set of doctors, higher-quality practitioners will emerge and referrals can be appropriately managed to improve the network's quality while lowering its costs,” says Bobos.

A narrow network can be approached in different ways, and it may be up to providers in a clinically integrated network or other organized continuum of care to design their own network — plugged into the payer mindset of cost control, but governing and designing their own metrics and clinically oriented efficiency. The objective is not to wait for payers to drive the narrow-network design, but still be attractive. Valence drives active engagement in provider organizations around presenting such alternatives, or advising them on how to avoid being cut out of networks that plans devise with little provider input.

### Building Narrow Networks that Actually Deliver Value

#### KEY COMPONENTS
- Physicist-led, physician-driven
- Parity, fairness and transparency must be part of the program to build trust
- Clear value proposition for all stakeholders: physicians, hospitals, payers and employers
- Clinical initiatives focused on quality and efficiency
- Material performance-based incentives to support change

#### TYPICAL CHALLENGES
- Community and employed physician practice standardization
- Collecting data on quality metrics
- Physician attribution
- Technology and data standards
- Building and funding health management capabilities
- A preference for less costly, narrow-network plans over more expensive ones by the uninsured and people who purchase their own coverage

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**The risk road incline**

Valence Health’s consulting extends to putting providers, clinically integrated networks and provider-sponsored health plans in position to benefit from participation in exchanges. It starts with an assessment of where the organization is on the spectrum leading to integration and bearing risk. That includes reviewing information and interviewing physicians and others in the organization to determine internal and external capabilities, behaviors of payers, patients and the market, and demographic shifts.

Through that assessment, a road map is developed for the organization to follow a path to ever-higher capability, he says. Some are prepared to jump into risk; for others, “it’s going to be baby steps” such as pay-for-performance incentives, shared savings and shared risk. Gaps are identified in the infrastructure, quality metrics, physician network, technology and whatever else it takes to get from one level of risk to the next.

“Ultimately, these efforts have to connect with payers. By keeping their interests in mind and taking their suggestions seriously during design, providers can engineer a network that all can live with,” says Bobos. “Payers are concerned about reducing costs and, ultimately, these networks always have been able to show that they have a way to reduce costs and keep things in network.”

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**Providers can start small when managing risk and evolve into more advanced models over time**

Source: Valence Health, 2014
About Valence Health

Valence Health is a leading provider of value-based care solutions, helping hospitals, health systems and physicians to better manage their patient populations and accept financial responsibility for the quality of the care they provide. With unique data collection and analytics solutions, Valence Health serves dozens of clients from physician groups to standalone hospitals to large IDNs. From risk-based contracting to accountable care organizations (ACOs) to administering provider-sponsored health plans, Valence Health has been helping providers since 1996. Headquartered in Chicago, with three other office locations, Valence Health serves more than 39,000 physicians and 120 hospitals, helping them to manage the health of 20 million patients nationwide. Follow Valence Health on LinkedIn and Twitter @ValenceHealth.

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