EXECUTIVE INSIGHTS

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Healthcare Exchanges: Building a Care Model for the Newly Insured

Health plans and providers alike are preparing for the introduction of some 30 million previously uninsured Americans into the U.S. healthcare system through the Patient Protection and Affordable Care Act (PPACA). These new patients and health plan members will begin entering the healthcare system through health insurance exchanges starting on Jan. 1, 2014. How are payers preparing for these new users of the healthcare system, for whom little prior utilization history, behavior patterns and underlying conditions are known?

The health insurance exchanges will be the new platform through which individuals will select, purchase and join health plans. The exchange population will be comprised of three primary groups:

1. Individuals who previously purchased small group or individual commercial policies

2. Individuals for whom states have mandated health insurance coverage by virtue of their high medical need (high-risk pool)

3. Individuals who until the passage of PPACA were previously uninsured or underinsured

The first two groups are more or less known entities to health plans – these are members for whom payers have historical utilization histories, diagnoses and underlying conditions. Further, these members are familiar with health insurance benefits and how to access them. Although there are high-need individuals who require support and care coordination by health plans in these first two groups, their underlying care needs, utilization patterns – and associated risks – are relatively known (or knowable) to the care management teams within payer organizations today.

The third group – the previously uninsured and underinsured – are the source of the greatest uncertainty for health plans. As payers struggle with how to design a care model for this segment of their membership population, many are adopting a "wait and see" approach. However, there are several key known characteristics of this population that—along with research about uninsured Americans and learnings from the Massachusetts Exchange experience—may serve as important strategic assumptions upon which health plans can build their Exchange Care Model 1.0.[1]

[1] The care model – defined here as the array of medical management programs and services offered by payers to their members – is designed for the purpose of encouraging and facilitating appropriate utilization, seeking preventative health, improving compliance and adherence to treatment and maintenance regimens, avoiding acute events, hospitalizations and deterioration of condition, and improving outcomes.

Healthcare Exchanges: Building a Care Model for the Newly Insured was written by **Joan Kim**, Managing Director in L.E.K.'s Healthcare Services Practice.

The previously uninsured present that two major categories of risk to the health plans are preparing to serve these members once exchange offerings go live:

1. Uncontrolled medical costs. With little or no claims or utilization history, it is difficult for health plans and providers to predict how these individuals will use services once they have health coverage.

2. Resource intensity required to support them. Knowing that this is a population with some fundamentally different characteristics than the commercial population, health plans and providers are concerned about the support services these individuals will need, and therefore the staffing costs of providing such support.

Characteristics of Exchange Populations Contributing to High Medical Cost

Key underlying characteristics of the previously uninsured exchange population are the root causes of these two categories of risk.

Deferred/neglected care, and the resultant pent-up care needs

It's understandable that individuals who previously have not had access to healthcare services would have neglected and deferred health needs. However, all known research on the uninsured indicates that both the diagnoses and the prevalence rates of the uninsured population are likely to be comparable to the current commercial populations on an age-adjusted basis. The key factor here is that even with the same diagnoses, a previously uninsured individual will likely have a higher intensity of care needs, poorer health habits, and lower compliance and self-management skills than a commercial counterpart due to the lack of access to regular, preventative and maintenance care while uninsured.

Adverse Selection

A core provision of the PPACA legislation is that along with the universal access to healthcare insurance, the individual mandate will require all Americans to join a healthcare plan, or face a financial penalty. Nevertheless, the "young invincibles" and similar cohorts may perceive that healthcare coverage will cost more for them than what they are likely to immediately access, so will opt to pay the penalty rather than join a health plan and pay the monthly premiums. The result is adverse selection in the system, as the portion of the previously uninsured population who do opt to join health plans through exchanges are more likely to be sicker and more likely to utilize services than their commercial counterparts.

Characteristics of Exchange Populations Contributing to High-Resource Intensity

Lack of familiarity with how to access appropriate care

The most frequently cited risk of the previously uninsured population related to high-resource intensity is patients' higher tendency to access care through the emergency room (ER). Individuals who have previously been uninsured or underinsured will need considerable help and support in learning how to access regular and preventative healthcare in the appropriate settings. This includes significant help in the fundamentals; for example, selecting a primary care physician, selecting (and if applicable, self-referring to) specialists, and receiving a detailed explanation of what kinds of services their healthcare benefits include.

Higher likelihood of the socio-economic disadvantages that exacerbate care needs

As a group, the previously uninsured are less likely to have a college education, less likely to be employed, more likely to speak English as a second language, and more likely to have social isolation and instability (including fluctuations in living arrangements, employment status and eligibility for social services). These factors are proven contributors to healthcare status, and indicate a need to provide more support to the previously uninsured segment of the exchange population than to their commercial counterparts.

Lower health literacy that impacts compliance and outcomes

In addition to the language barriers, the previously uninsured

will exhibit lower health literacy than their commercial peers. The reduced ability to understand health information, information about their benefits, and instructions from their physicians and other providers will necessitate that both health providers and insurers will need to provide more coaching and hand-holding to the previously uninsured in order to achieve the same comprehension and results.

How Should Insurers Respond?

What we do know about the exchange population points to specific care-model tactics that are likely to be effective in dealing with the underlying risks that these new members will present to the health plans they join.

ER Diversion

The emergency room has been one of the few points of access to healthcare the uninsured have had prior to the Affordable Care Act. Member education to discourage deferral of care and inappropriate reliance on the ER will be important. Watching the utilization data, identifying the ER "frequent flyers" early, and educating and coaching those members to seek care through physician visits and urgent-care centers will be critical components of an overall ER-diversion strategy, which may also include hospitalist and physician education initiatives as well.

Availability of PCP hours and urgent appointments

In addition to educating members to seek appropriate care rather than frequent the ER, primary care physicians (PCPs) will need to play their part in making urgent appointments more readily available, expanding their appointment hours, and reducing delays in the ability of their patients to see the doctor. Extending appointment hours and access and incorporating measurements on inappropriate ER utilization by their patients into PCP contracts and incentive payments will help ensure that PCPs are doing their part to encourage successful integration of the previously uninsured into the healthcare system.

More accessible, creative outreach mechanisms

Innovative ways to reach and engage members is a universal goal for health plans across all membership segments, but will be particularly important for the exchange segment. As mentioned above, the previously uninsured and underinsured will have lower health literacy and a relative lack of familiarity with the healthcare system and how to access their benefits appropriately – all factors that point to a need to revisit and adapt communications, including membership outreach materials and media. Research indicates that newly insured members are much more likely to read their membership welcome materials. Health plans therefore have a unique opportunity to reach new exchange members with key messages and orientation content when these members first join.

Significant orientation, coaching and hand-holding in accessing healthcare system

An expanded orientation program to onboard members, explain their benefits in clear terms, and familiarize the previously uninsured exchange members to the appropriate ways to access services will be critical in ensuring that health plans make the most of the one-time opportunity to get exchange members off to the right start. The standard welcome packs and calls to new members currently used for commercial members will likely be insufficient – the previously uninsured exchange members are not just new to the health plan, but new to healthcare. Time, attention and customer service investments upfront will help avoid inappropriate utilization behaviors (and their associated high medical costs). Emphasizing the new array of services and benefits that are now available to these newly insured exchange members will also help gain member traction by encouraging members to perceive their new health plan as the enabler of access to benefits and (appropriate) services, rather than the denier of claims.

Improved collaboration with facilities

When the previously uninsured first enter the healthcare system, they are likely to have a low awareness of their actual healthcare coverage needs. A previously uninsured patient may choose a bronze plan (lowest tier) based on the price tag alone, but actually have the underlying benefit and coverage needs more commensurate with a gold-tier plan. The risk of healthcare bills that such individuals are ultimately unable to pay is an exposure to both providers and payers. Payers and providers

will need to collaborate more closely to mitigate the risk of bad debt from utilization beyond benefit limits on the part of the uninsured, particularly in areas like ER usage and concurrent review of inpatient stays.

Benefit design

A clear way to reinforce appropriate utilization patterns is benefit design to encourage appropriate utilization behaviors (e.g., zero co-pays for PCP visits) and discourage inappropriate behaviors such as non-emergent ER visits. Early feedback from the market seems to indicate that in the initial years, health plans will be concerned about competitive pricing on the exchange, with perhaps less focus on benefit design to bolster care model objectives. However, benefit designs that support utilization management objectives will be important to longer-term success.

Although many providers and health plans are adopting a "wait-and-see" approach to the incoming exchange population, L.E.K. Consulting has been working with health plans to proactively anticipate the unique needs of the exchange population and adapt or design their care models to accommodate these individuals by the end of the year. Considering that merely months after the exchange goes live in January 2014, payers will already be preparing their benefit designs and bids for 2015, the wait-and-see approach of relying on claims and utilization data to accumulate before designing their care model strategies could translate into a two-year impact for those unprepared, leaving those payers flat-footed until 2016, when the competitive landscape will likely have evolved around them.