HRI's closer look

Health exchanges
Open for business

First in a two-part series

At a glance

As the uninsured begin shopping on new online insurance exchanges, the broad coverage expansion could be a financial booster shot for the nation's hospitals. Yet few hospitals and health systems have begun to aggressively pursue these new customers. Early movers and new players are quickly seizing opportunities.

Health systems developing strategies to capture newly-insured

Introduction

Up to 16 million people are expected to gain health insurance coverage in 2014 under two major provisions of the Affordable Care Act (ACA).[1] The coverage expansion, one of the largest in history, is an opportunity for hospitals to allay recent financial woes resulting from declining admissions, care moving outside of hospitals, and reduced government payments.[2]

Yet few hospitals have developed comprehensive strategies to identify, educate and help enroll people in private health plans sold through the new insurance marketplaces known as exchanges.

Many hospitals may not be fully prepared for the coverage expansion set to kick in Jan. 1, according to interviews and analysis by PwC's Health Research Institute (HRI). Health systems with large uncompensated care burdens in particular, have much to gain if they can attract and manage these new paying customers. At the same time, some higher-priced providers, are being left out of the new marketplaces as insurers rely on narrow networks to hold down costs.

Equally important, this new "retail" approach to selling health insurance —via private and state exchanges —begins to fundamentally alter the $2.8 trillion health sector. The sooner health organizations adapt to the new dynamic, shifting the focus to individual consumers, the brighter their future.

This summer HRI interviewed executives from major health systems that collectively represent more than 150 hospitals across 25 states, as well as national hospital associations and patient advocacy groups. A few health systems have energetically pursued innovative ways to reach the uninsured or underinsured in their communities who soon will be shopping for subsidized coverage via the new online exchanges. Most, however, said they are in the early stages of adjusting to the ACA landscape and need additional time and staff to understand the ramifications of the new marketplace.

The changes come at a time of challenging economic realities for US hospitals today. The sector has seen inpatient admissions fall—three of the nation's largest systems reported

declines between 1% and 5% this year.[3] Government, meanwhile, is demanding higher value and reducing its healthcare funding. Under the new law, hospital payments will be slashed by $316 billion over the next decade.[4] The reductions come in many forms, from several programs, including most notably the Medicare and Medicaid disproportionate share hospital (DSH) payments made to compensate for providing indigent care.

National hospital groups see the health law's expansion of coverage, through Medicaid and the subsidized exchanges, as an important way to make up for lost revenue. Many of the planned payment cuts in the ACA were based on the original premise of about 30 million more insured customers by 2019. But health systems that are slow to identify and help enroll the uninsured may not capture all of the available new money. And those hospitals that don't have a communication and outreach plan risk losing newly insured customers to the competitor across town.

Delays, 'fatigue' impact hospital priorities

The lack of focus on enrollment efforts can be attributed to several factors, including "reform fatigue." Health systems expended considerable energy urging states to fully expand Medicaid while also fighting at the national level against budget cuts.

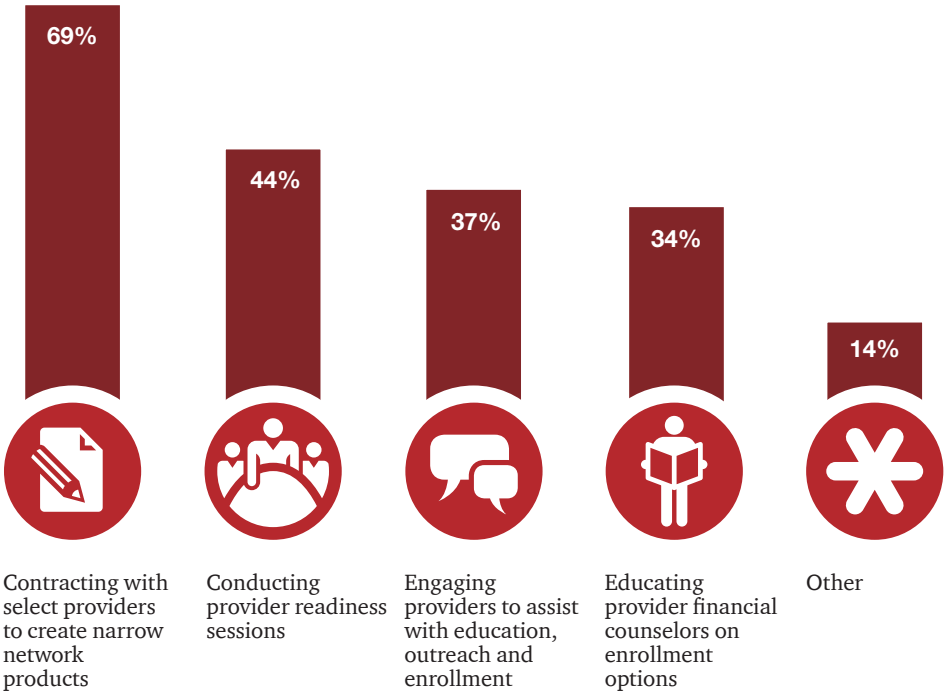
Other challenges persist that have stalled enrollment activity. Health system leaders interviewed by HRI said they first needed to finalize contracts with insurers. A few said they wanted to better understand the health status and medical needs of the 7 million people who will buy a health plan on the exchanges before pressing ahead. (Another 9 million will gain coverage through an expansion of Medicaid and children's health).[5] Others indicated the need for additional regulatory guidance.

"What's hard about this is that there is so much unfolding as we speak," said Katrina Reynolds, chief revenue officer at the University of Mississippi (Jackson) Medical Center. The medical center will serve as a "navigator"—a designation that allows it to use federal grant money to aid enrollment efforts. "There's very little information that we can touch or practice with today."

Bill Carpenter, chairman and chief executive of LifePoint Hospitals Inc., a for profit health system that operates more than 60 hospitals in 20 states, underscored the importance of exchange enrollment in July when he characterized hospitals as "the largest visible representative for information about healthcare in a community." Since most Americans do not fully understand how they will be affected by the ACA, Carpenter said that hospital personnel could offer one-on-one guidance including enrollment assistance.

But HRI research points to disconnects between hospitals and their communities and between providers and insurers. A survey conducted by HRI of more than 100 insurance executives found that insurers and health systems are not collaborating on enrollment and outreach. Less than half (44%) of insurers that plan to offer coverage on the exchanges said they have conducted provider readiness assessments. (See Figure 1). Only 34% said they have educated hospital financial counselors on various types of enrollment options.

Figure 1. Coordination limited between insurers, providers



Note: Remaining percentage reflects non-responders
Source: PwC Health Research Institute insurance company executive survey

Figure 2. CMS enrollment and outreach designations

	Navigator	In-Person Assister (IPA)	Certified Application Counselor (CAC)
	Conduct outreach activities to raise awareness. Assist individuals with electronic and paper applications to determine eligibility	*Assist individuals with electronic and paper applications to determine eligibility*	*Assist in educating individuals about Medicaid, CHIP and plans sold through the exchanges*
Exchange participation	• Federally-facilitated exchange • Federal/state partnership exchange • State-based exchange	• Federal/state partnership exchange • State-based exchange (optional)	• Federally-facilitated exchange • Federal/state partnership exchange • State-based exchange
Training requirement	• Navigators must be certified, which requires up to 30 hours of web-based training • Annual recertification	Must complete comprehensive training	Must complete comprehensive training
Funding	• Federal government provided 105 applicants in federally-facilitated and partnership exchanges with $67M • State-based exchanges will provide navigator programs with grants from their budgets	State-based programs will apply for exchange establishment grants to fund IPAs	Not Applicable

Source: PwC Health Research Institute

For their part, many providers have been slow to promote the expanded coverage options. Five of the largest US health systems had not offered information about the ACA's coverage expansion on their websites in the final weeks before the start of the open enrollment period. The decision to do so often varies by patient mix—hospitals with a high number of privately insured consumers feel less pressure to supplement that revenue with presumably lower reimbursement rates from exchange customers.

Many industry executives blamed the balky start on the slow trickle of information from regulators. On August 15, CMS finally announced $67 million in grants to more than 100 organizations that will serve as navigators.[6] The lineup includes a dozen hospitals and medical centers—University of Mississippi is one—plus broad coalitions that include community and advocacy groups, as well as faith-based organizations. (See Figure 2.)

But questions over certification requirements and staff training remain. The navigator designations are voluntary. Most health systems plan to apply for—and likely receive—status as a "certified application counselor." That designation is similar to the navigator title, sans the additional money. In effect, it allows hospitals to certify that their own employees and volunteers may aid in enrollment. It also allows a smoother flow of information between the hospital and the exchanges.

Eighty percent of insurance executives surveyed by HRI however said they worry that navigators and certified counselors will lack sufficient training to match the uninsured with the most appropriate health plan. And 63% said they are concerned about potential missteps as navigators steer the newly eligible to insurance brokers.

Hospitals, however, have the infrastructure and experience in place that will allow them to swing into action. Health systems already enroll patients in Medicaid, children's health plans and other government programs through their financial counselors. Many more could follow the lead of some of the early movers who have been working with community groups and their state exchange representatives to help publicize the coming enrollment period.

"As we think about enrolling folks in the exchanges, there certainly is crossover with the skill set of the employees who are enrolling people in Medicaid as we speak," Richard Bracken, chairman and chief executive of Nashville, Tenn.-based HCA Inc., told investors in August. He added that HCA, which owns and operates about 162 hospitals in the US, would make a big outreach push ahead of the October enrollment period.

"Financial services personnel have already been providing in-person assistance to help [patients] identify what they're eligible for."

–Collen Scanlon, senior vice president of advocacy, Catholic Health Initiatives

Newly eligible pose an enrollment challenge

Studies indicate that many Americans do not fully understand the basics of health coverage and struggle with common terms such as deductible, copay, coinsurance and out-of-pocket expenses. Fewer still can accurately compute insurance costs for routine care and more complex hospital stays.[7]

Exchanges add another layer of complexity—government subsidies. About 86% of individuals who purchase a health plan on the exchange will receive some government money to help pay for it and HRI research indicates the exchange population as a whole is less educated and may not speak English as its primary language.[8]

That lack of understanding could directly impact the success of the insurance marketplaces. People that do not fully understand how health insurance works are more likely to make poor coverage decisions. Field research conducted by Enroll America, which is working in 10 states to promote the ACA, found that most people will require multiple conversations before they begin to understand their coverage choices.[9]

"Financial services personnel have already been providing in-person assistance to help [patients] identify what they're eligible for," said Colleen Scanlon, senior vice president of advocacy at Englewood, Colorado-based Catholic Health Initiatives, which operates 87 hospitals in 18 states. "I think it's just the breadth of this is so much larger. Some of this will be a continuation and understanding of that need to provide in-person assistance, but there will be new knowledge that needs to be there."

Mark D. Birdwhistell, vice president of administration and external affairs at UK HealthCare in Kentucky, leads a team studying the impact open enrollment may have on the system's medical center and clinics.

"Two main concerns have emerged," he said. "One, timely access to care in the appropriate setting and the demand for more primary care, and two, that consumers may buy less expensive plans without realizing that can limit access to certain services and specialty providers."

Such misunderstandings could impact health outcomes for the patient as well as revenue and reputation for the hospital. The tradeoff for low monthly premiums is typically higher out-of-pocket deductibles, which could catch patients unaware after they are treated and later billed. The hospital may be forced to absorb any amount that goes unpaid. And since the patient has coverage, the hospital won't be able to apply for federal compensation.

In the HRI insurer survey, 91% of executives said consumers are most likely to focus on the cost of monthly premiums; a full 40% said they were concerned that people may not pay enough attention to their deductibles—the costs that may affect health systems the most.

Upfront conversations with those who newly qualify for coverage may help. Financial counselors at UK HealthCare on average help about four patients an hour. As open enrollment ramps up and the number of insurance options expand, the average number could drop to half that amount, meaning counselors will be spending more time explaining how the new coverage works. UK HealthCare has been working to find the right balance. (See Figure 3.)

Other wrinkles are sure to surface as health systems determine their role in outreach and enrollment—and some are inclined to use the first open enrollment period as training for 2014 and beyond.

"We're all in the same place—learning," Reynolds told HRI. "No one has this down pat. [We've] been good about keeping the message about October first just being Day One, and you can continue learning and optimizing."

Narrow networks could leave some hospitals out

Other pressing issues have also emerged around narrow networks. Some health plans will offer limited access to large academic medical centers, which tend to treat high-risk patients, by including only select hospitals and physician groups in their exchange offerings.

Insurers passed over major medical centers in Chicago, Indiana, Kentucky, Los Angeles, Tennessee and elsewhere in an effort to tamp down hospital and

Figure 3. Work in progress: Two health systems used an early start to identify opportunities, risks preparation

	Trinity Health System	UK HealthCare
Summary	84 hospitals in 21 states.	Academic medical center, 2 hospitals, 80-plus specialty clinics
Situation	Senior leaders identified five main focus areas: • Policy Influence • Payer Contracting • Communications and marketing • Consumer outreach • Clinical quality and patient satisfaction	Identified ways coverage expansion would impact hospitals and clinics: • Included schedulers, registrars, financial counselors, revenue managers, clinic administrators, physicians and clinicians • Studied the impact on its employed physicians, clinics and outpatient services.
Results	• Successfully advocated for state engagement and qualified health plan management • Negotiated beneficial contracts and narrow networks with major payers • Developed ways to educate target audiences • Tied enrollment to community benefit initiatives to ensure low-income individuals, the uninsured and underinsured are reached effectively	Devised plan for patient flow—directing newly-insured to proper care venues: • Maximize use of UK HealthCare clinics or community care • Use "Patient Access Center" to link patients to state's exchange hotline, navigators, in-person assisters, or agents
Outreach/ Enrollment Efforts	• Trained financial counselors and facility staff members to help with enrollment efforts • Collaborating with community organizations to identify and educate newly eligibles • Providing in-person support to those who need it and, in some markets, developing mobile kiosks so that they can reach the broader community outside the hospital • Some facilities are creating in-hospital "storefronts" where patients and visitors to the hospital can learn more and/or explore their health plan options	• Assessed impact of new enrollees on staffing and service levels • Training more than 100 staffers to become certified application counselors • Approved by exchange to deploy seven enrollment kiosks in UK hospitals and clinics

medical costs. Doing so enables health plans to offer lower premiums.[10] But the use of narrow networks may also lead to higher out-of-pocket expenses, especially if a patient has a complex medical problem that's being treated at a hospital that has been excluded from their health plan.

"What we're hearing at the local level is that certain plans have already begun excluding essential community hospitals," said Xiaoyi Huang, assistant vice president for policy at America's Essential Hospitals, which represents many of the nation's safety net providers.

Rate negotiations vary, however. Tenet Healthcare, a for-profit system with 49 hospitals, said most of its exchange contracts are based on commercial pricing—not Medicare or Medicaid—and would only consider lower rates if the plan offered a narrow provider network.[11]

Conclusion

An influx of millions of newly-insured customers holds the promise of added revenue for many hospitals and health systems at a time when reimbursements are being squeezed and demands for value have reached a crescendo.

Despite significant challenges deciphering new regulations, the opening of 51 insurance exchanges provides a unique opportunity for healthcare providers to pursue a new customer base in the changing environment. The coming year will be a testing period for health systems with money available for those that can effectively attract, manage and retain the wave of exchange patients.

Strategies for health systems to get up to speed quickly

Run the numbers. Hospitals should review the amount of charity care they provide, and then compare it to the potential new revenue it would receive as patients gain some level of coverage. The model should include Medicare and Medicaid DSH reductions, lower federal payment rates and the government dollars that are in play under a variety of quality reporting programs. Even if a patient enrolls in a Bronze level plan—the lower-tiered option with the highest of out-of-pocket expenses—the potential payments may still prove a better deal than unpaid care.

Tap frontline staff to become counselors. Develop exchange training for financial counselors and hospital volunteers. Consider adding staff but be aware the first open enrollment crush ends March 31, 2014. The University of Mississippi Medical Center plans to hire four new counselors for one-year only, at salaries between $35,000 to $40,000.

Wire into state exchange boards. Stay close to the decision-makers at the state and federal level. One medical center has staff that monitor all of the state's insurance exchange activities, and some even sit on a state task force.

Target the right audience. St. Louis-based Ascension Health, a non-profit system with more than 113 hospitals, is considering sending out a mailer that explains the new coverage option to those patients who qualified for charity care in the past. More novel ways of reaching the new customers include visiting health fairs, community events such as football games, and businesses such as laundromats to help people sign up on the spot.

Plug into local networks. Outreach efforts have a better chance of success if they are targeted, tailored and hyper-local. One strategy is to identify a hospital employee who matches the profile of those eligible for subsidized coverage. For instance, a member of the hospital's food service team may also be a respected deacon in the local church. When armed with the right information, these community leaders can effectively carry the hospital's message.

Tag team with state, community and local groups... It worked in Massachusetts, where leaders from the health sector partnered with advocacy groups and the business community to help publicize the new mandate and plan options. They even enlisted the Boston Red Sox, which allowed ads to be filmed at Fenway Park to reach younger audiences.

...But remember, there's no substitute for one-on-one discussions. While broad coalitions can help raise awareness, few will actually be concerned about enrolling people in the "right" coverage. Hospital staff have the experience—and the incentive—to help identify the appropriate level of care through initial health screenings and predictive modeling.

Rethink the role of financial counselors. Remember, they're often the first contact a patient has with the hospital. And now that most patients will have more of a say in their care—including where they choose to receive it—it's important that financial counselors have a full picture of the expanded insurance options that are available. It's no longer about writing a script, but rather it's about re-educating them to focus on the patient as a consumer.

Invest in advertising. Couple word-of-mouth campaigns with targeted ad buys. Radio, television, Internet and newspaper ads reach a large share of those who will qualify for Medicaid and exchange subsidies since more and more people will have coverage, they'll have choices. Advertising also can build brand loyalty.

Rethink the hospital's long-term goals. It's not just about preparing for the first wave of newly insured Americans. Rather, use the prep work to revisit the hospital's long range strategic plans, especially when it comes to potential growth opportunities. It could make sense to expand the hospital's footprint to regions that have seemed previously unattractive due to a high concentration of uninsured.

Endnotes

1. Congressional Budget Office projections include Medicaid and exchange estimates, May 2013.
2. PwC Health Research Institute, "Medical Cost Trend: Behind the Numbers, " June, 2013. Twenty-Four percent of consumers used a retail clinic in 2012. http://www.pwc.com/us/en/health-industries/behind-the-numbers/index.jhtml#readmore.
3. PwC Health Research Institute analysis of first and second quarter earnings reports for three top for-profit hospital chains.
4. Includes a phased in reduction of $56 billion in Medicare and Medicaid Disproportionate Share Hospital (DSH) payments from 2013-2022; and $260 billion in Medicare hospital payment rates, 2013-2022; Congressional Budget Office estimates.
5. CBO, "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," May 2013.
6. HRI, "Providers make up only a small percentage of "navigator" sites," HRI As We See It weekly newsletter, August 18, 2013.
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8. Analysis of CBO May projections and PwC's Health Research Institute, "Health Insurance Exchanges: Long on options, short on time," 2012.
9. John Gilbert, national field director, Enroll America, speaking on an August 12, 2013 conference call.
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11. Tenet Healthcare second quarter analysts call, August 6, 2013.

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