BRIEFING
FROM THE BELTWAY

Challenges Facing Health Insurance Exchanges and Related Administrative Data Efforts

March 21, 2013

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Reminder

This call is being recorded.

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Reminder

Please press mute when not speaking

(6 to mute, *7 to unmute)*

Agenda

- **4:00 – 4:05 PM** Welcome and Introductions
- **4:05 – 4:20 PM** Purva Rawal, PhD, Senior Manager, Avalere Health
- **4:20 – 4:35 PM** Elizabeth Nash, National Director, Exchange Advocacy and Implementation, UnitedHealthcare
- **4:35 – 4:50 PM** Gwendolyn Lohse, Deputy Director, CAQH, Managing Director, CORE
- **4:50 – 5:00 PM** Discussion and Announcements
- **5:00 PM** Adjourn

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Purva Rawal

Avalere Health

Regulatory Overview of Exchanges/ Operational and Data Challenges

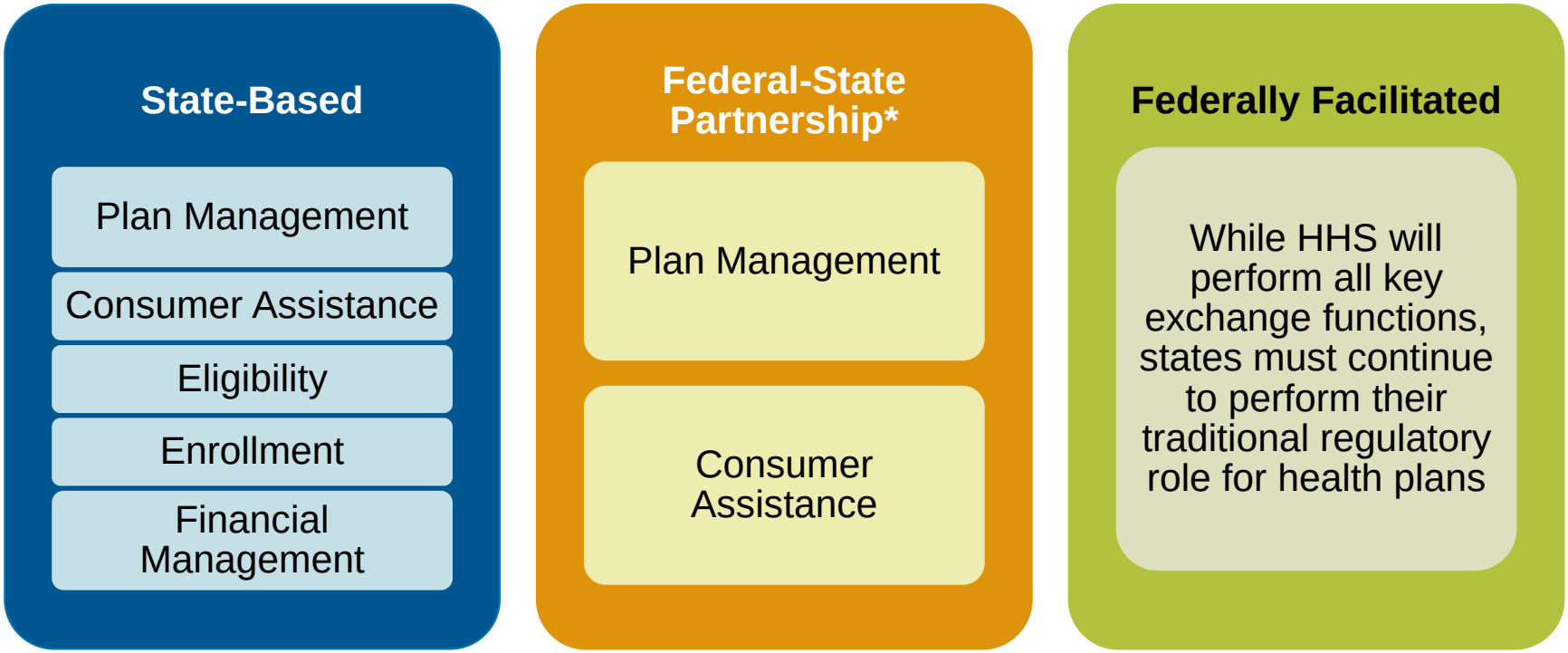
Purva Rawal, PhD

Avalere Health LLC
February 2013

Exchanges Aim to Offer One-Stop Shopping to Individuals and Small Businesses, Similar to Online Travel Sites

*Individuals with an offer of employer-sponsored insurance (ESI) are not eligible for subsidies unless their individual employer premium exceeds 9.8% of their income or does not provide minimum value.
Source: Congressional Budget Office, Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage February 2013, Medicare Baseline, February 2013

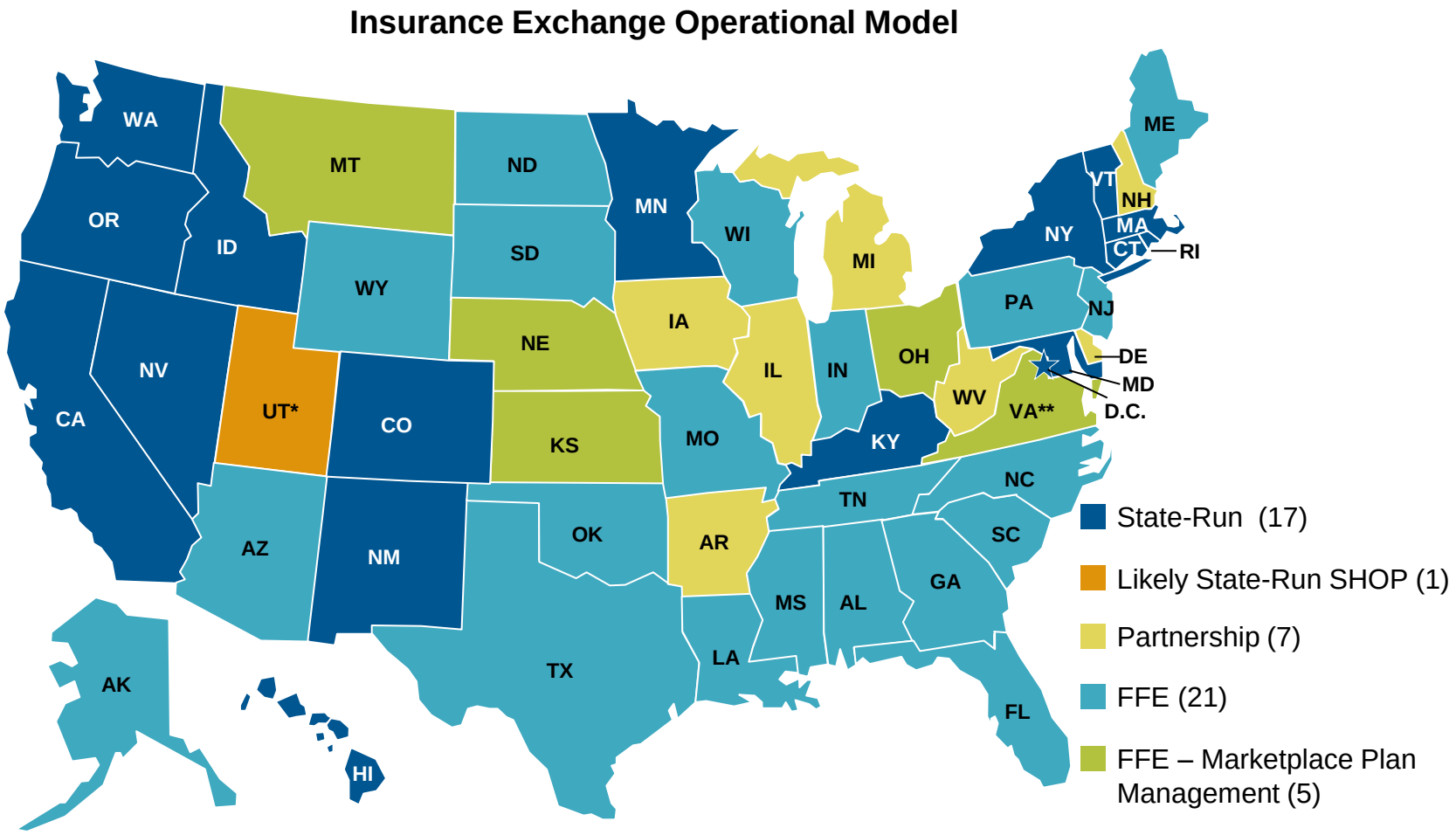
States Will Have Varying Degrees of Responsibility for Exchange Functions Under Three Exchange Models



HHS recently released an FAQ document confirming that states also have additional flexibility to retain some plan management capabilities as part of their established regulator role without submitting an exchange blueprint

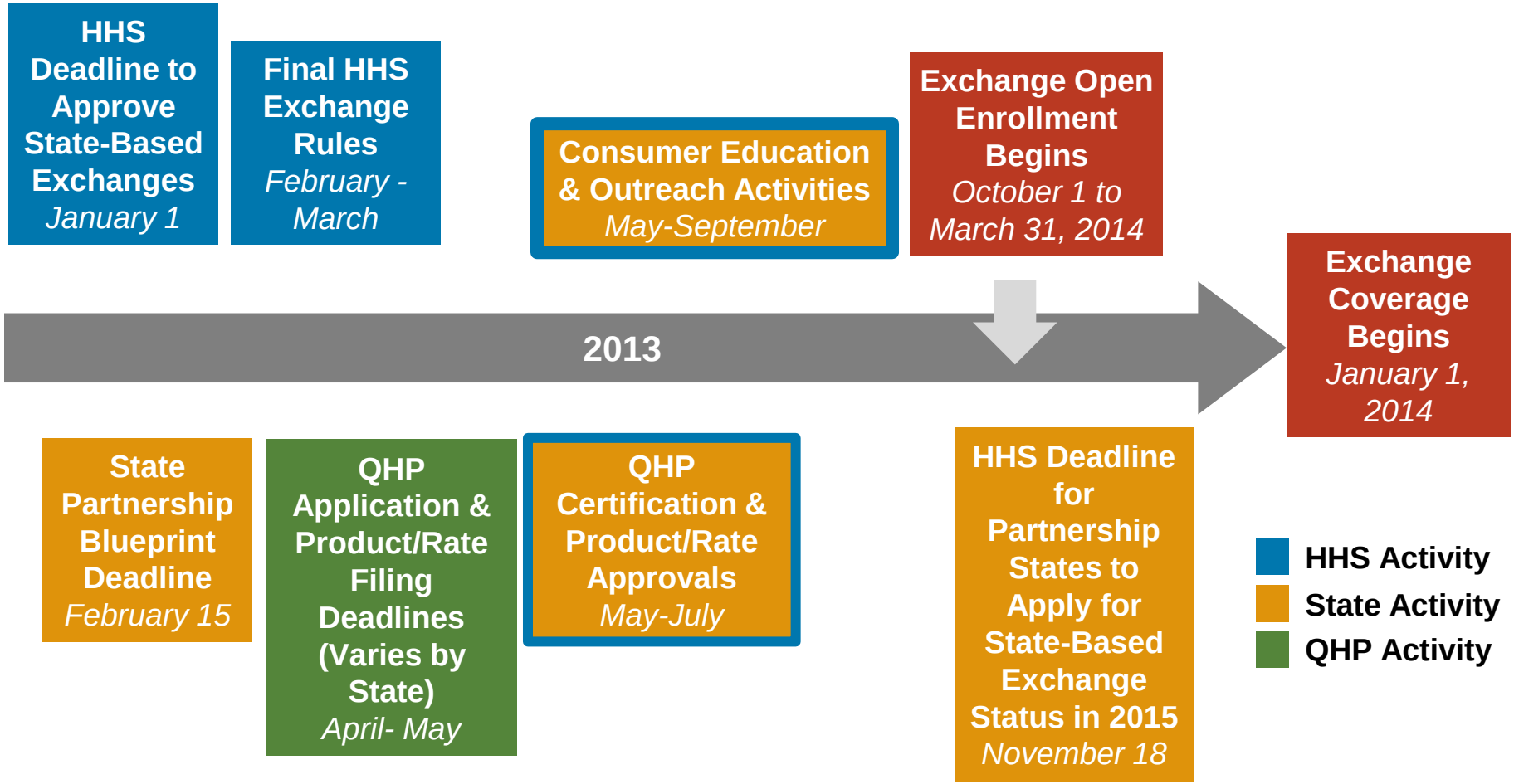
HHS: Department of Health & Human Services
*The federal government will perform other exchange functions, including eligibility, enrollment, and financial management.
FAQ document on FFE plan management flexibility: http://cciio.cms.gov/resources/files/plan-management-faq-2-20-2013.pdf

16 States and DC Will Run Exchanges in 2014, 7 States Conditionally Approved for Partnership



Source: Avalere *State Reform Insights*, March 14, 2013.
*UT will not pursue a state-run individual exchange but continues to request HHS certify its existing small group exchange.
**VA has indicated they will perform plan management functions and QHP certifications but has not received HHS approval like the other Marketplace Plan Management states (KS, MT, NE, and OH).

Launch of Exchange Products Will Be a Major Policy and Operational Focus Throughout 2013



HHS = Department of Health and Human Services
QHP = Qualified Health Plan

HHS Will Be Responsible for a Majority of Operational Functions, Especially Data Driven Ones

Function	Partnership Exchange		FFE	
	State	HHS	State	HHS
QHP certification	X			X
In-person consumer assistance hotline or navigator program	X			X
Internet portal		X		X
Plan rating and communication of options		X		X
Eligibility Determinations		X		X
Premium comparison calculator		X		X

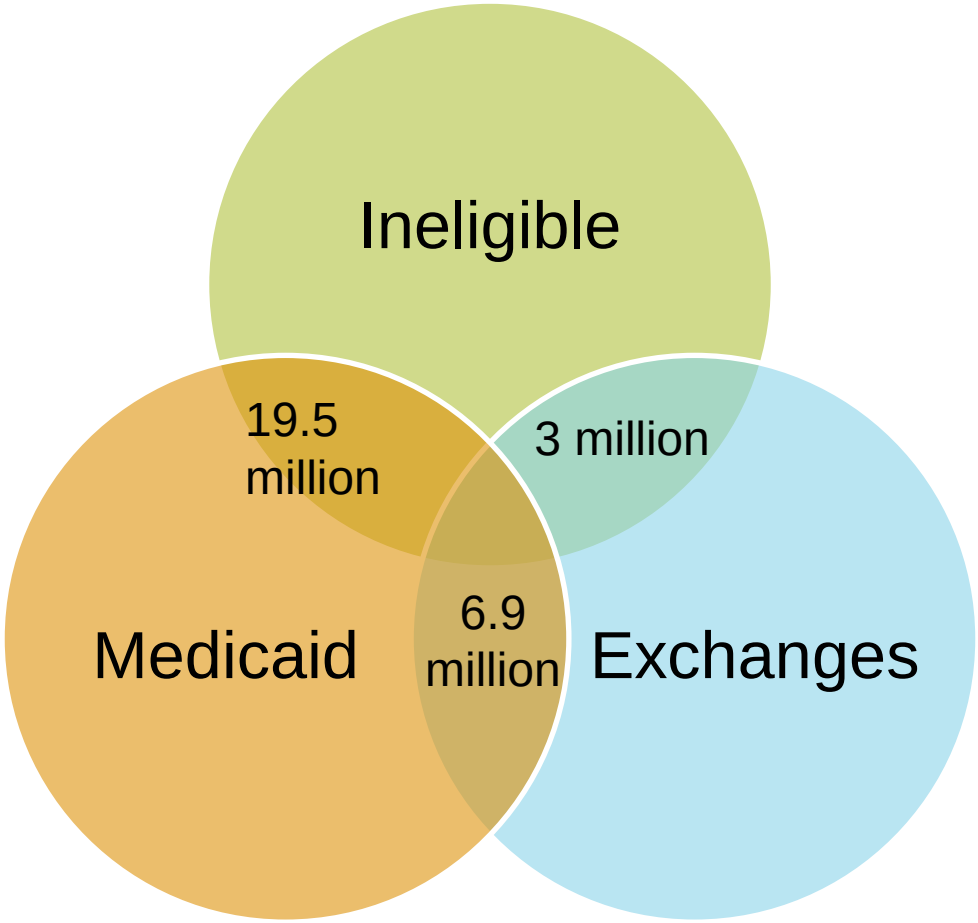
States will continue to play their traditional regulatory role, even if they chose not to be involved in the exchange established in their state. States will have to conduct their traditional regulatory and rate view processes for all product filings, both those that will be offered on- and off- exchanges.

Key to the Success of Exchanges Is the Operational Readiness of the Federal Data Services

- CMS' Data Services Hub will help exchanges verify applicant information used to determine eligibility for enrollment in QHPs in real time.
- It is critical that beneficiaries are able to receive a real time determination, and that after they have received a determination, they are able to select a QHP through the exchange online.
- If the data hub is unable to provide seamless real time determinations, enrollment in exchanges may be slower than anticipated, with only individuals who have pent up demand, or who need coverage seeking additional assistance to ensure they are able to enroll in a plan.

In late January, HHS released for public comment its single, streamlined application for individuals, employers and employees applying for health insurance coverage. According to HHS, it will take an individual seeking financial assistance, approximately 30 minutes to fill out the online application.

States Will Need to Address Individuals Who "Churn" Between Medicaid and the Exchange Due to Income Fluctuation



According to estimates, 29.4 million people will change coverage from year to year. This represents over 30% of the estimated 95.9 million people eligible for Medicaid or exchange subsidies in a given year.

Source: Urban Institute analysis of 2001 and 2004 Survey of Income and Program Participation, "Churning Under the ACA and State Policy Options for Mitigation," June 2012, Matthew Buttgens, Austin Nichols, and Stan Dorn.

Recent Delays Illustrate Data Challenges Facing HHS

No Wrong Door Eligibility Determination

- Combined eligibility notices for Medicaid and exchange coverage were originally supposed to be available beginning January 1, 2014
- However, due to IT challenges, HHS has proposed delaying the policy until January 1, 2015
  - » States maintain the option to implement the combined eligibility notice earlier

SHOP Exchange Premium Aggregation

- HHS included a premium aggregation function for the SHOP exchange designed to help employers whose employees enrolled in multiple QHPs
- However, this requirement has been postponed until January 1, 2015 due to other delays in related SHOP requirements and the operational challenges associated with premium aggregation

These early examples underscore the data and operational challenges HHS must overcome in the early years of both the individual and SHOP exchanges.

HHS = Department of Health and Human Services
SHOP = Small Business Health Options Program.

Elizabeth Nash

UnitedHealthcare®

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Health Benefit Exchanges

eHealth Initiative

Elizabeth Cabot Nash

National Director, Exchange Advocacy and Implementation

March 21, 2013

UnitedHealthcare®

State Exchanges
Minimum Responsibilities

UnitedHealthcare

ACA states that state Exchanges must be operational by January 1, 2014.

Key Responsibilities of State Exchanges

- **Set Market Rules** – network/plan requirements, rate review, participation mandates or "lock-out" periods (when a plan can enter if not Year 1).
- **Certification –** reviewing/approving the plans offered by carriers in the Exchange.
- **Consumer Assistance** – marketing, education, outreach. Selecting entities to support consumer purchase/enrollment (Navigators).
- **Infrastructure/Operations -** Website, consumer eligibility and subsidy administration, call center, enrollment, billing, data integration with carriers.

UnitedHealthcare has advocated to federal and state governments:

- A fair/efficient market that promotes competition, choice and innovation to encourage broad participation by carriers, small employers and consumers.
- Low cost administration – leverage what exists today, do not duplicate: state rate review, as well as carrier enrollment, billing and consumer service.

State Exchange Models

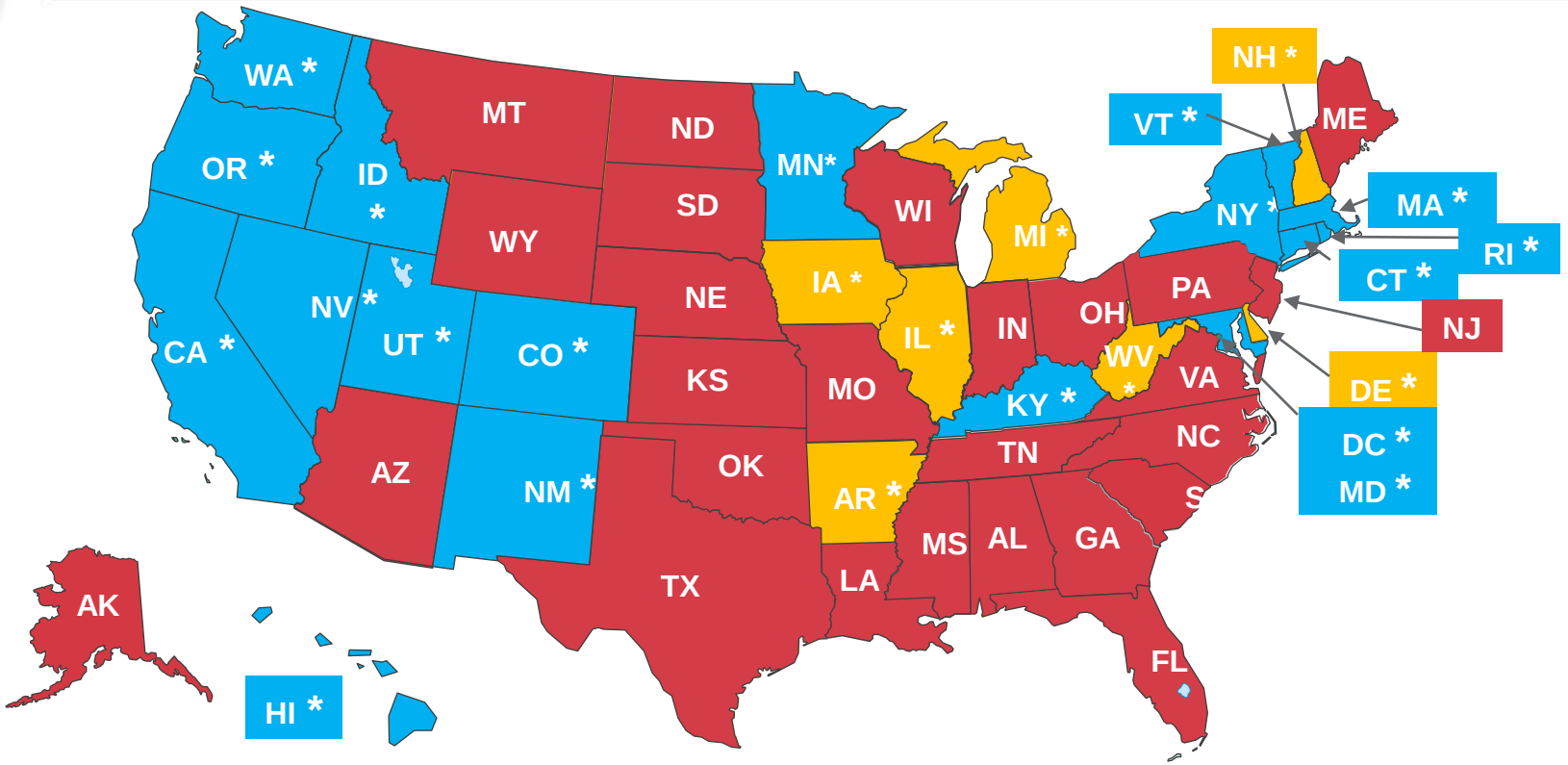
States Choose One of Three Options to Establish an Exchange

States can choose to take full responsibility, share responsibility or defer all activities to the federal government.

Exchange Model	Set Market Rules	Certification	Consumer Assistance	Infrastructure / Operations
State Based	State	State	State	State
State/Federal Partnership	Federal	State (Option)	State (Option)	Federal
Federally Facilitated Exchange (FFE)	Federal	Federal	Federal	Federal

State decisions on Exchange models were driven by local politics.

Health Benefit Exchanges in the States



Planning to Operate State-Based Exchange, Submitted Blueprint Application to HHS (17+DC)

Pursuing Federal/State Partnership Exchange (7)

No State-Based Exchange (26)

* Conditional Exchange Approval from HHS (17+DC State-Based, 7 Partnership)

Updated March 8, 2013

Subsidy Assistance in the Exchange

Generous Subsidies for Lower Incomes

Consumers who fall <400% of the Federal Poverty Level may have access to federal premium subsidy assistance in the Exchange

% FPL	$ Income (Individual)	Annual Premium Paid by Individual	2014 Annual Penalty
100%	$11,170	$223	$112
133%	$14,856	$446	$149
150%	$16,755	$670	$168
200%	$22,340	$1,407	$223
250%	$27,925	$2,248	$279
300%	$33,510	$3,183	$335
400%	$44,680	$4,245	$447

Subsidies will be fixed – calculated as the difference between gross premium for the 2nd cheapest Silver plan and maximum premium obligation set forth in PPACA

Employer Market Impact

Employers are factoring several variables into their decisions around whether to offer "affordable" coverage or pay the employer penalty.

Financial

- Tax deductibility of health insurance
- Employer mandate and penalties
- Affordability of future individual market
- Breadth/quality of state Exchanges

Human Capital

- Talent retention and recruitment
- Worker productivity
- Existing health, investments and control
- Competitor strategies and initiatives

Legal / Regulatory / Political

- Non-discrimination laws (must offer all health insurance options to all workers)
- Headline / reputation / political risk

Psychological

- Culture (e.g., unions, public sector)
- Moral obligation, paternalistic nature
- Inertia, "wait and see" on Exchanges

Research varies on employer coverage decisions for 2014

McKinsey	AAF	CBO	Lewin	RWJF	RAND
-30%*	-20%	-7%	-2%	Stable	+8%

* Note: McKinsey estimate is percentage of employers that dump, other estimates are percentage of employees that lose employer-sponsored coverage. McKinsey's estimate is slightly exaggerated as dumping is expected to be higher amongst small vs. large employers

Gwendolyn Lohse

CAQH, CORE

simplifying healthcare administration

CAQH®

Committee on Operating Rules for Information Exchange (CORE®)

Administrative Data Efforts

March 2013

Agenda

- Level-set: CAQH and Administrative Simplification Efforts
- Introduction: Federally Mandated Operating Rules
- Examples: Mandated CAQH CORE Operating Rules

CAQH: Current Initiatives

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Industry-wide stakeholder collaboration to facilitate development and adoption of national operating rules for administrative transactions. Over 130 participating organizations.

Universal Provider Datasource

Service that replaces multiple paper processes for collecting provider data with a single, electronic, uniform data-collection system (e.g., credentialing).

CAQH Solutions
EFT ENROLLMENT

Service that enables providers to enroll in electronic payments with multiple payers and manage their electronic payment information in one location, automatically sharing updates with their selected payer partners.

US HEALTHCARE EFFICIENCY INDEX

Objective industry forum for tracking progress and savings associated with adopting electronic solutions for administrative transactions across the industry.

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Newly Announced CAQH Initiative

- CAQH Coordination of Benefits Solution (COB) (http://www.caqh.org/PR201302.php)
  - Creates a source of timely and accurate coverage status, enabling providers to determine primary and secondary coverage for patients who are insured by more than one policy; confusion over insurance status can occur with patients who have lost or changed jobs or have multiple sources of coverage
  - Committed health plans include Aetna, AultCare, BCBS of Michigan, BCBS of North Carolina, BCBS of Tennessee, CareFirst BCBS, Cigna, Health Net, Inc., Horizon Healthcare Services, Inc., Kaiser Permanente, UnitedHealth Group, and WellPoint, Inc., on behalf of its affiliated health plans; together these organizations cover more than 165 million lives

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Context:
Why Does Administrative Simplification Matter?

As the number and diversity of covered patient visits increases, simplifying provider and member administrative exchanges is a key industry goal

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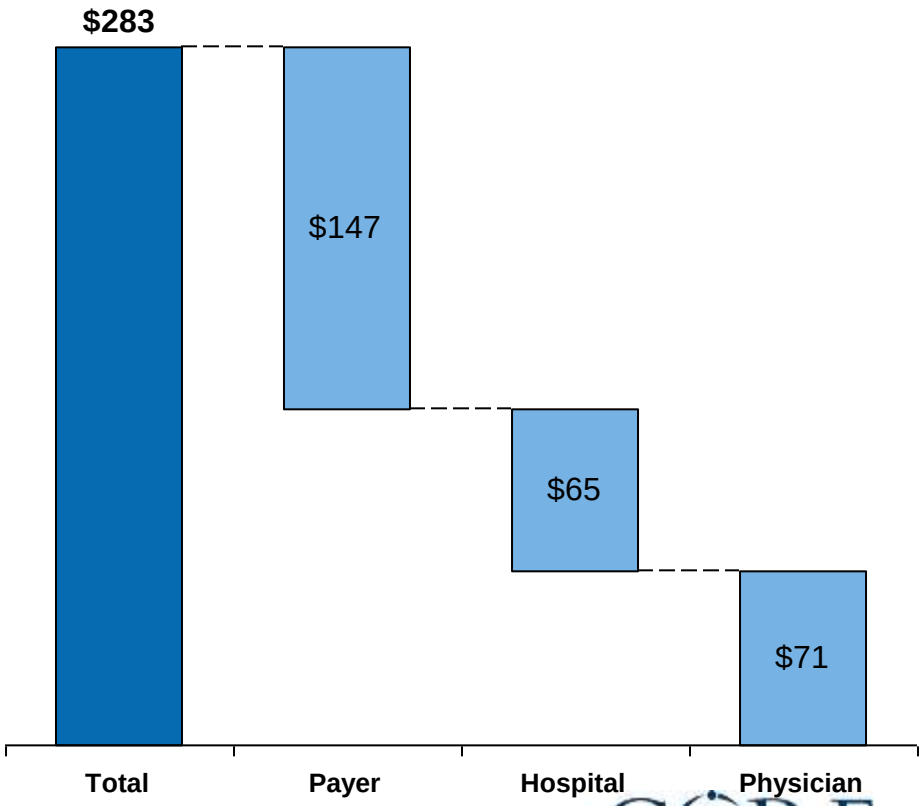
U.S. Healthcare Administrative Costs Are $280B / Year

- U.S. healthcare administrative spending was $283B in 2009 (10% of total healthcare spending) split evenly between providers and payers.
- While the Healthcare Industry continues to look at clinical costs, providers and payers are intensifying efforts at administrative cost reduction.
- As organizations improve their internal efficiency, the Industry is primed to tackle structural costs that are best addressed collaboratively rather than on an individual basis.

US Payer and Provider Administrative Costs

By Stakeholder ($ Billions, 2009)



Source: CMS National Health Expenditures (2009), Kahn, J.G. et al *Health Affairs* (2005), Booz & Company analysis

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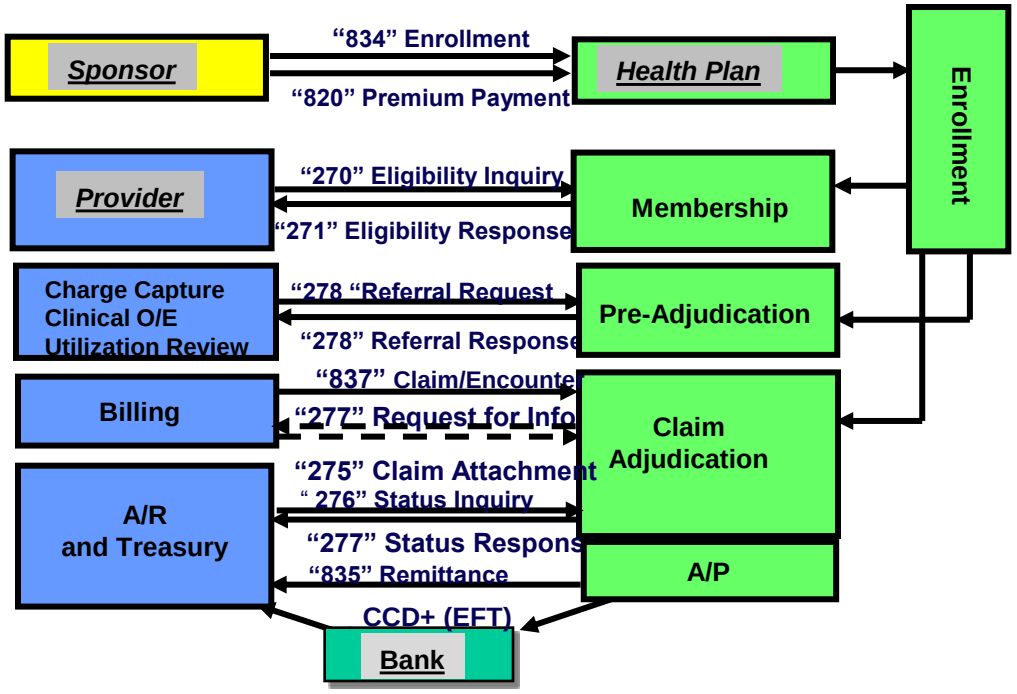
Introduction to
Federally Mandated Operating Rules

Transformation of Administrative Data Exchange: *A Spectrum of Change*

- Overarching goal is to generate a responsive, and adaptive, system-wide approach to administrative IT adoption that aligns with other U.S. healthcare strategic initiatives
- Each major transaction was addressed by HIPAA in 1996, but standards alone were not enough to achieve industry Administrative Simplification
- Due to the ACA and other market pressures, the revenue cycle process is experiencing significant transformation.



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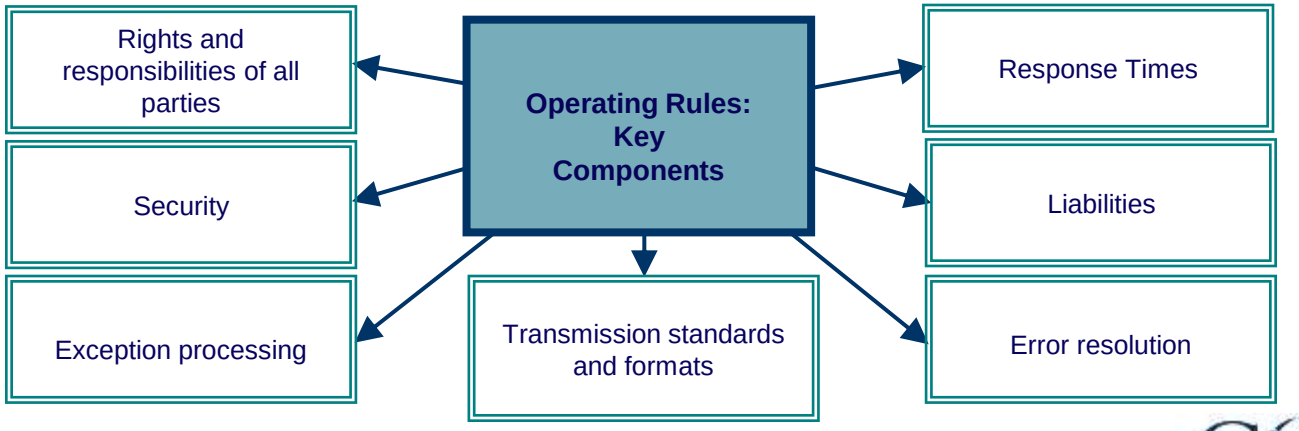
What Are Healthcare Operating Rules?

- The Patient Protection and Affordable Care Act (ACA) defines operating rules as *"the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications"*
  - Operating rules help refine the infrastructure that supports electronic data exchange, and recognize interdependencies among transactions; they do not duplicate standards
  - Operating rules and standards work in unison; current healthcare operating rules build upon a range of standards – healthcare specific (e.g., ASC X12) and industry neutral (e.g., OASIS, W3C, ACH CCD+) – and support the national HIT agenda
- Operating rules encourage an interoperable network and, thereby, are vendor agnostic



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Overview of ACA Section 1104 Operating Rules
An Amendment to HIPAA

- **HIPAA**
  - The Health Insurance Portability and Accountability Act (HIPAA) of 1996
  - *Administrative Simplification Provisions*
    - ***Requires the establishment of national standards*** for electronic health care transactions and national identifiers for providers, health insurance plans, and employers
- **ACA Section 1104**[1]
  - *Section 1104 of the Administrative Simplification provides of the Patient Protection and Affordable Care Act (ACA) established, among a number of things, new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs*
  - *In Section 1104(b)(2) of the ACA, Congress **required the adoption of operating rules for the healthcare industry** and directed the Secretary of Health and Human Services to "adopt a single set of operating rules for each transaction"…with the goal of creating as much uniformity in the implementation of the electronic standards as possible."*

[1] Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions; Interim Final Rule Federal Register / Vol. 76, No. 131 / Friday, July 8, 2011 / Rules and Regulations

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Who Must Comply with ACA Section 1104?
Required of all HIPAA Covered Entities[1]

- ACA Section 1104 mandates that all HIPAA covered entities comply with *healthcare operating rules*; additional guidance on HIPAA covered entity designations may be found HERE
- HIPAA Administrative Simplification standards, requirements and implementation specifications apply to[2]:
  - Healthcare Providers: *Any person or Organization who furnishes, bills, or is paid for healthcare in the normal course of business*[3].
    - Covered ***ONLY*** if ***they transmit protected health information electronically (directly or through a business associate) in connection with a transaction covered by the HIPAA Transaction Rule***[2].
    - Examples include but are not limited to: Doctors, Clinics, Psychologists, Dentists, Chiropractors, Nursing Homes, and Pharmacies
  - Health Plans
  - Health Care Clearinghouses

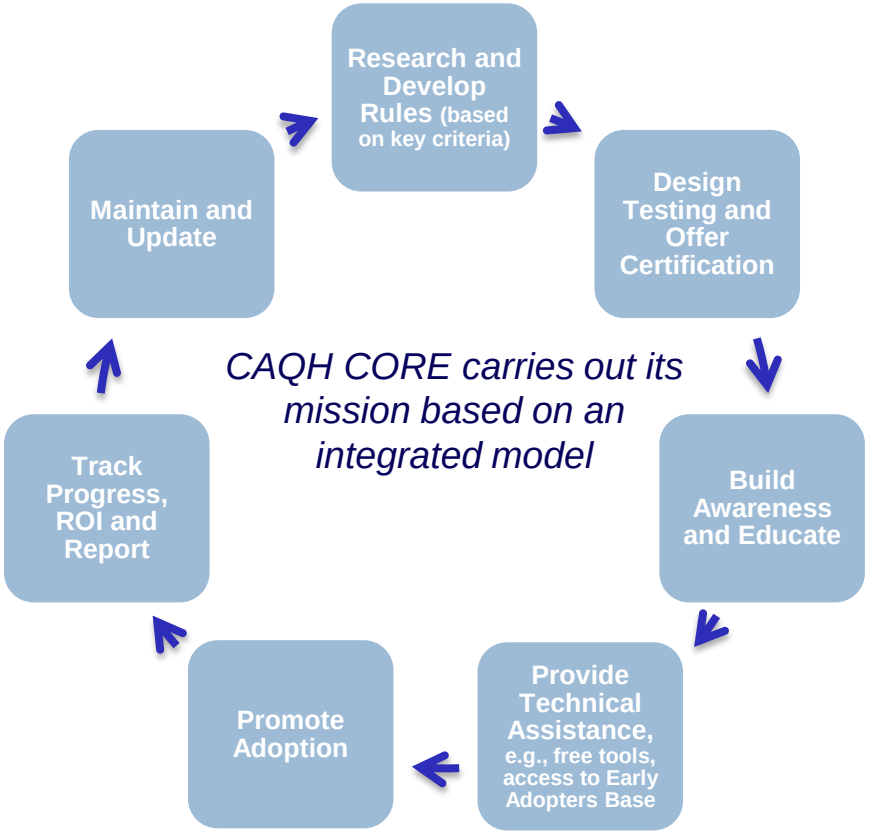
[1] Understanding HIPAA Privacy: For Covered Entities and Business Associates
[2] HIPAA Administrative Simplification: 45 CFR §§ 160.102, 164.500
[3] HIPAA Administrative Simplification: 45 CFR § 160.103

Industry Context:
Federally Mandated Operating Rules

- Today, operating rules support existing standards in many high-volume industries, e.g. cellular phones, financial services...*Consider the ATM*
- Prior to 2005, national operating rules for medical administrative transactions did not exist in healthcare outside of individual trading partner relationships
- In 2005 CAQH CORE began facilitating voluntary development of industry-wide healthcare operating rules
- In 2010, Section 1104 of the ACA required that *all HIPAA covered entities* be compliant with applicable HIPAA standards **and associated operating rules**

CAQH CORE Background

- A multi-stakeholder collaboration established in 2005
- ***Mission***: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between providers and health plans
  - Enable providers to submit transactions from the system of their choice (vendor agnostic) and quickly receive a standardized response
  - Facilitate administrative and clinical data integration
- Recognized healthcare operating rule author by HHS and the National Committee on Vital and Health Statistics (NCVHS)



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ACA-mandated Operating Rule Compliance Dates: *Required for all HIPAA Covered Entities*

Operating rules encourage an interoperable network and, thereby, are vendor agnostic

Compliance in Effect as of January 1, 2013

- Eligibility for health plan
- Claims status transactions

HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules

Implement by January 1, 2014

- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions

Implement by January 1, 2016

- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments

Rule requirements available.

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Examples: Mandated CAQH CORE Operating Rules

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How Will Mandated Operating Rules Impact Market?
Example: Eligibility and Claim Status

The ACA mandated Eligibility & Claim Status Operating Rules ensure real-time access to robust eligibility and claim status data for providers

- ***More accurate patient eligibility verification*:**
  - Real-time information on health plan eligibility and benefit coverage before or at the time of service
    - Providers experienced a 24% increase in electronic eligibility verifications*
- ***Improved point of service collections*:**
  - Real-time provider access to key patient financials including YTD deductibles, co-pays, coinsurance, in/out of network variances via the ASC X12 v5010 270/271 transactions
- ***Decrease in claim denials*:**
  - Real-time claim status data ensures provider is aware of status in billing process
    - Providers experienced a 10-12% reduction in denials related to eligibility*

* Based on the CAQH CORE Phase I Measures of Success Study when working with Phase I CORE Certified health plans.

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Drill-down Example: One Aspect of Mandated CAQH CORE Eligibility & Claim Status Operating Rule Set

For 51 Service Type Codes (STCs), an eligibility response to a eligibility request must include *health plan name and patient financials for co–insurance, co–payment, base & remaining deductibles plus network variance if applicable (in/out of network variances)*

1 – Medical Care	48 – Hospital – Inpatient	98 – Professional (Physician) Visit – Office
2 – Surgical	50 – Hospital – Outpatient	99 – Professional (Physician) Visit –Inpatient
4 – Diagnostic X–Ray	51 – Hospital – Emergency Accident	A0 – Professional (Physician) Visit – Outpatient
5 – Diagnostic Lab	52 – Hospital – Emergency Medical	A3 – Professional (Physician) Visit – Home
6 – Radiation Therapy	53 – Hospital – Ambulatory Surgical	A6 – Psychotherapy
7 – Anesthesia	62 – MRI/CAT Scan	A7 – Psychiatric Inpatient
8 – Surgical Assistance	65 – Newborn Care	A8 – Psychiatric Outpatient
12 – Durable Medical Equipment Purchase	68 – Well Baby Care	AD – Occupational Therapy
13 – Facility	73 – Diagnostic Medical	AE – Physical Medicine
18 – Durable Medical Equipment Rental	76 – Dialysis	AF – Speech Therapy
20 – Second Surgical Opinion	78 – Chemotherapy	AG – Skilled Nursing Care
33 – Chiropractic	80 – Immunizations	AI – Substance Abuse
35 – Dental Care	81 – Routine Physical	AL – vision (Optometry)
40 – Oral Surgery	82 – Family Planning	BG – Cardiac Rehabilitation
42 – Home Health Care	86 – Emergency Services	BH – Pediatric
45 – Hospice	88 – Pharmacy	MH – Mental Health
47 – Hospital	93 – Podiatry	UC – Urgent Care

See www.caqh.org for free implementation resources and guidance

Send an email to CORE@caqh.org to receive updates

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DISCUSSION

Next Briefing from the Beltway

Thursday April 18, 2013

4:00 - 5:00 pm (ET)

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