How to balance promises and priorities to sustain hyper-growth

Private health insurance exchanges are experiencing hyper-growth. There is enthusiasm and adoption among many employers, consumers and carriers alike. Accenture predicts that private health insurance exchange participation will approach public exchange enrollments by 2017—if not sooner, as enrollment figures indicate an earlier-than-expected growth spurt. Accenture estimates there were more than 3 million individuals that enrolled in private exchanges during the 2014 benefit year. While rapid growth is encouraging to exchange sponsors, it’s important to consider how exchanges can sustain this positive trajectory. Now that the first material open enrollment period has concluded, exchange sponsors have the opportunity to reflect on what has worked and what hasn’t. For instance, have the core promises of private health insurance exchanges been met—are these exchanges delivering the retail-like, front-end experience that consumers expect? Are employers feeling a reduced administrative burden?

Employer expectations, and corresponding service levels and capability maturities, will vary widely across exchange models (see Figure 1). However, no matter how “premium” or “simple” the exchange, there are fundamentals that all private health insurance exchanges should consider as key factors to help sustain their growth.

**Potential pain points**

Lagging “back-end” benefits administration capabilities (see Figure 2) will emerge as a likely culprit restricting some exchanges’ growth trajectories. These capabilities represent the most likely pain points for exchanges.

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**The Core Promises of Private Exchanges**

**Consumers:**
- A simple, retail-like shopping experience across multiple channels
- Increased choice and flexibility for benefits
- A diverse product set
- Decision support tools that help me “choose what’s right for me”

**Employers:**
- Reduced administrative burden
- Access to standardized products
- Greater control over costs
Figure 1: A variety of exchange models—
More complex customer needs and expectations will typically require a more tailored, premium exchange solution.

1. Simple
- Small employer (typically <100 employees),
- looking for core health & life benefits, self administration

2. Basic
- Single region/site employer (typically 100-1,000 employees),
- looking for core health & life benefits and some benefits administration

3. Advanced
- Multi-site, multi-region employer (typically >1,000 employees),
- looking for increased benefit choice and competition, standard benefits administration support

4. Premium
- Jumbo employer (typically >50,000 employees),
- looking for customizable solutions and service

Source: Accenture

Figure 2. Benefits administration expectations increase for more “premium” exchanges.

<table>
<thead>
<tr>
<th>SIMPLE</th>
<th>PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrollment &amp; Eligibility</strong></td>
<td>Support more complex benefit configurations, product rules, and validation services</td>
</tr>
<tr>
<td><strong>Billing &amp; Financial Mgmt.</strong></td>
<td>Carrier billing direct to employer for each product on exchange</td>
</tr>
<tr>
<td><strong>Employer payroll deduction extract files with limited carrier integration</strong></td>
<td>Consolidated billing across products and carriers including integrated remittance and reconciliation</td>
</tr>
<tr>
<td><strong>Comm. &amp; Fulfillment</strong></td>
<td>Customized employer payroll integration and integration with numerous carriers, savings and spending account administrators, and TPAs</td>
</tr>
<tr>
<td><strong>Reporting &amp; Analytics</strong></td>
<td>Basic employer and consumer enrollment and contribution reports</td>
</tr>
<tr>
<td><strong>Data Mgmt.</strong></td>
<td>Highly targeted, digital and print employee communications and marketing campaigns</td>
</tr>
<tr>
<td><strong>Premium</strong></td>
<td>Customized dashboards, reports, analytics, and segmentation</td>
</tr>
</tbody>
</table>

Source: Accenture

Enrollment and eligibility

Most employers believe benefits are a key differentiator in the market for talent. To this end, many tailor their benefit plans for specific sets of their workforce. While for smaller companies this tends to be fairly simple, for larger companies this process can be complex. Benefits often vary based on workforce elements such as full-time vs. part-time, executive vs. non-executive and geography. These variances can influence differences in what products are offered and how much is subsidized by the employer.

Although exchanges are working hard to standardize product offerings, they should offer solutions to manage these complexities. These challenges are compounded by the introduction of new defined contribution strategies that may have a variety of permutations across these employee groupings.

Further adding to the complexity of managing enrollment is the abundance of changes to an employee population that occur over the course of the year. New employees join the workforce, existing employees get promoted, move across states, take a leave of absence or quit/are terminated. Each of these situations could result in a change in benefits. Life events, such as marriage and childbirth, could also prompt a consumer to modify his or her benefits.
With such a large volume of information, issues arise around how to pass data back and forth across organizations, or how to handle exception processes and reconciliation. Exchange operators will be expected to address these increased complexities, often managed by benefits administrators today.

Exchange operators must ask—and find answers to—questions including, how should data be packaged and processed to carriers? Should there be one enrollment file per group, or one across the marketplace? How do these increased complexities impact legacy carrier systems and processes for employer and member setup? How does the exchange integrate with employer payroll systems to ensure accurate employee deductions? How will the emergence of defined contribution impact pre- and post-tax earnings?

Successful exchanges will develop thoughtful approaches to data management that can help simplify their employer and payer partners’ data complexities.

**Billing and financial management**

When employers are used to getting five bills per month—but now they are getting 15—they are not feeling administrative ease. Exchanges must provide employers the ability to support the efficient processing of bills from multiple carriers.

Many exchanges are deferring billing functionality or delegating it to carriers altogether, providing data files that say, “here are the products your employees purchased, and here is how much to take out of employees’ paychecks.” Furthermore, some exchanges fail to provide reconciliation. Employers must trust that the exchange and carrier systems are in sync in a complex environment ripe for errors and that offers little visibility into the source of truth. Mature exchanges will help emulate the ideal experience: an employer pays one bill (consolidated billing) across all carriers and products with assurance that the balance matches employee elections on the health insurance exchange (reconciliation).

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**Fine-tuning the front end**

Advancing the “front-end” consumer marketplace will also distinguish leading exchanges (see Figure 3). Consumers expect the retail-like, personalized and data-driven experience that they get in other parts of their lives. These are some areas in which exchanges are improving the front-end experience.

**Personalized decision support powered by analytics**

According to an Accenture survey of 2,000 US consumers, 87 percent identified “tools to help project my expenses and select coverage levels” as an important feature, with 58 percent identifying it a very important or critical feature.1 Personalized decision support tools better enable consumers to assess/predict their own benefits utilization to drive product recommendations. Advanced analytics may also help with product recommendations by leveraging claims data to forecast expected out-of-pocket costs and showing products that “people like me” may have bought.

**Integration with provider look-up tools**

Most exchanges today link to carrier tools so that a consumer can manually determine which products cover which doctors. Integrating these tools will make it more convenient for consumers to understand this critical factor in the decision-making process.
Product bundling

When exchanges enable a retail-like experience, consumers will see recommended product bundles that are pulled from a fuller library of health and ancillary products. Ultimately, the overall shopping experience will be faster, and checkout will also be simplified and expedited.

Integration with savings and spending accounts

Front-end integration with healthcare savings and spending accounts makes it easier for users to manage current and future contributions/balances. This information could also feed into the decision support tools mentioned previously, better enabling consumers to forecast the longer term financial impacts of their elections.

Stretching to sustain growth

The private health insurance exchanges that make the right moves in the next 18–24 months will be the ones who are better positioned to achieve sustainable growth as this robust market matures. Getting the front end right will draw in customers, and getting the back end right will retain them.

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