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Healthcare Payers' Adaptability Roadmap for Health Benefit Exchanges

Sreevatsa Sahasranaman

Prabhakar Ram

Selvakumar Chinnasamy

www.wipro.com

Table of contents

Health Benefit Exchange: Accelerating growth for health players

The Patient Protection and Affordable Care Act is a United States federal statute that was signed into law by President Barack Obama on March 23, 2010. The PPACA is aimed at creating state based Health Benefit Exchanges in the US. The Health Benefit Exchanges are expected to provide individuals and Small Groups (SG) access to affordable health insurance. The Congressional Budget Office predicts that by 2019, about 24 million people will have insurance through these exchanges.

Health Benefit Exchanges will make affordable health care available in a transparent manner. They will also accelerate the growth of the healthcare sector by presenting new opportunities for payers, providers and public health care administrators. Each state has been mandated to set up their Health Benefit Exchanges by January 2014. Understanding and meeting State and Federal compliance requirements will be the foundation for a faster go-to-market strategy.

Health Benefit Exchanges will transform the way individuals and Small Groups shop for health plans. They will function as aggregators, making standardized insurance plans easily comparable for individual and Small Groups buyers. The impact of the transparency will be a fall in insurance costs.

Ensuring transparency by enabling plan comparison in web portals is a fairly revolutionary idea in health care, but it is not a new business paradigm. For years, airline fares have been comparable on a variety of travel websites, ensuring that travelers can make well-informed choices. Health Benefit Exchanges will work in a similar manner. They make a wider and cheaper set of choices available to small healthcare buyers who earlier could not find the deals that large employers or groups enjoyed. By enabling choice for a wider spectrum of insurance buyers and equipping them with decision support tools, Health Benefit Exchanges can expect to increase sales and improve customer satisfaction levels. This contributes to a win-win situation for both buyers and providers.

The nature and structure of Health Benefit Exchanges will make a significant difference to:

- Plan pricing
- Online enrollment mechanisms
- Transparency (benefits, premium costs, provider network)
- Plan performance (Wellness care, chronic illness, overall customer satisfaction and public ratings)
- Competitiveness
- Quality of service

Exchange operators (State or the Federal Government) will be pivotal to success. They will be responsible for delivering the guided buying experience, monitoring plan performance and quality ratings. They will also become responsible for the IT infrastructure of the exchange, data integration, and interoperable data exchange standards. In addition, operators will need to set up customer management and support infrastructure for phone-based exchange services.

The Exchange Operating Model has been left to the discretion of individual States. Each State can adopt a model from a variety of approaches:

- States can co-operate American Health Benefits Exchange (AHB) and Small Business Health Options Program (SHOP) exchanges together
- Operate different exchanges for the different segments (Individual and SG)
- Participate in a regional multi-State Exchange
- Not operate a Health Benefit Exchange. In this case the Federal Exchange will cover that State
- Leverage a private aggregator model – contract a Health Plan or Third Party Services Firm

Each State also has the latitude to decide the degree of regulation beyond PPACA they may wish to implement. This will position the states as Active Regulators or Passive Enablers.

Health Plan Exchange Capability Model (To-Be): Forcing cost leadership

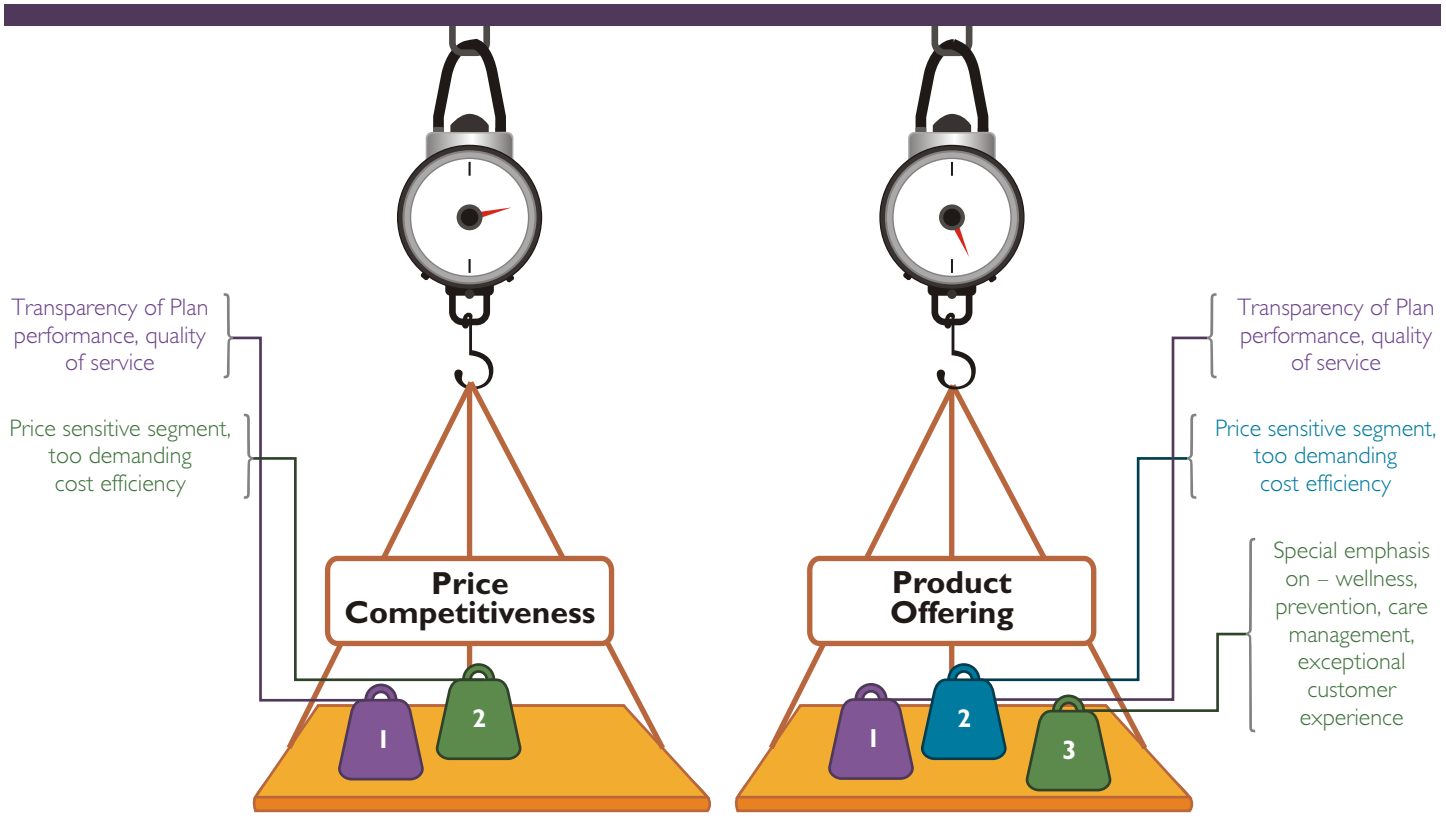
The PPACA mandate on health benefit exchanges has caused dilemma for most health insurance companies. The contour for decision making may differ from payers to payers. But the main concerns are on the following lines. Should health plans participate in an exchange-based model? If they participate, should it be in all States or selectively in a few States? If they don't participate, are they losing a large pie of prospective customers? Also, regardless of the number of States the health plans participate in, which are the best segments (subsidized individual, unsubsidized, small group etc.) to address? These choices will determine the to-be capability model each player must fulfill.

State Exchange participants could design products most appropriate for target groups or adhere to the operating models of individual State Exchanges. The risk they face is that the regulation and demands vary across States. This places barriers to operational efficiencies across Health Benefit Exchanges.

On the contrary, Federal Exchange participants operate in specific States that do not have their own exchanges. They will have to adhere to Federal Exchange requirements.

Regardless of how they operate, it is apparent that products of the health plans will have to be broadly standardized for segments. The outcome of standardization will be commoditization. As a result, product differentiation is less, leading to challenges in premium pricing.

This lack of differentiation has a straightforward implication according to Porter's Generic Strategy. Cost leadership will hold the key to success to gain a competitive advantage. However achieving Cost leadership is difficult.

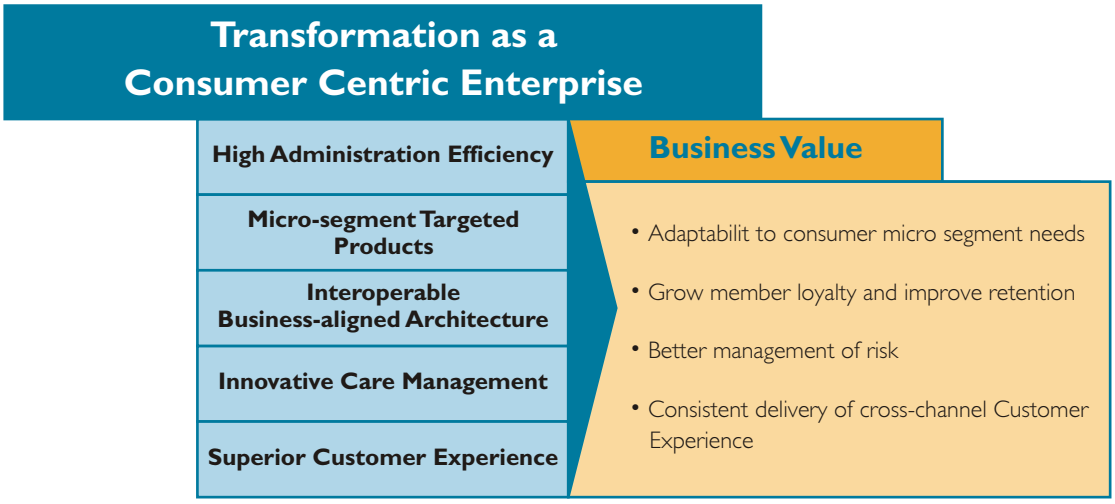


Cost leadership is attainable through lean and automated next-generation internal capabilities and the simplicity of the products offered. However in this case, the business model in itself lacks the ability to create value. Ideally, exchange participants need to focus on higher administration efficiencies, target products at micro segments, deliver innovative care management and superior customer experience in addition to creating an interoperable business-aligned architecture.

The Winning theme for health plans should be to transform themselves into a consumer enabled service as explained below

Win Themes for the Exchange Business

What are some of the key win themes that can generate business value?



Functional stakeholders of Health Benefit Exchange have their tasks cut out. The transition in business strategy they need to make is clear and unambiguous. Unfortunately, the transition is unlikely to be a simple one.

Stakeholder	Transition Strategy
Exchange Operators	• Ability to participate and integrate bi- directional data exchanges • Ensure transparency • Set rules and validate subsidy • State based regulatory reporting and compliance
Distribution Channels	• Focus on online advertising and promotions • Redefine broker incentive models for Small Groups and individuals • Manage broker incentives and broker proxy for rural communities
Small Group Marketing Segment	• Differentiated underwriting and pricing for various segments • Demonstrate premium processing capability • Position as single point of contact for enrolment, administration and member access
Individual Market Segment	• Develop products for micro-segments • Simplification of real time underwriting process • Manage subsidy processing • Address the challenges of multiple sources of premium payments

The business capabilities that are expected from the exchange participants in each function to drive the win themes are

Plan Products	• Create new products targeted at micro segments of the demography for each State within the Exchange approved plan configuration. • Delivery of Guided Sales content, Cost Calculators • Simplified Plan Product Benefit package designs with ability to easily change configurations
Underwriting	• Online rating system with ability to update product pricing easily • Synchronize the underwriting for individual and small group business under one team for exchange participation
Enrollment	• Synchronize the enrollment operations for individual and small group business through HIPAA 834 transactions • Integrate eligibility verification for income subsidy, tax calculation
Customer Service	• Health plans will need to upgrade their self service portals and other channels for the members to be able to track subsidies, bill payments • All member touch points have to be improvised with portability of customer experience measures

Exchange Gateway	• Ability to route inbound and outbound transactions, content to the Exchange in real-time and batch • Authentication, authorization, encryption security mechanisms with HIPAA compliance.
Lean Automated Administration	• Due to simple product designs and benefit rules, the plan should have a Straight Through Administration Processing – STAP Capability in real-time. This should cut down costs.
Technology enabled Care Management	• Sponsor or enable Remote Home Care and Monitoring for Providers, due to significant emphasis on Plan's Care Management as a performance measure • Specialist consultations for residents leveraging Tele health technologies • Manage risk factors like blood sugar level in diabetes patients, etc • Remote Consultation-Reduce admission, read missions, and complications
Web 2.0 based Customer Experience	• Interactive technologies and Rich Internet Applications for superior customer experience • Social media technologies for capturing Voice of Customer and collaboration • Marketing campaigns, loyalty programs, sales based on customer buying behavior and trends • Sharing of customer information across business lines, channels

Technology plays an important role in achieving the goals set by the stake holders.

Innovation should be the core theme while setting up the exchange. The technology capabilities required for innovating within an exchange are discussed here.

Health Plan Situation Analysis (As-Is): The need for business and IT transformation

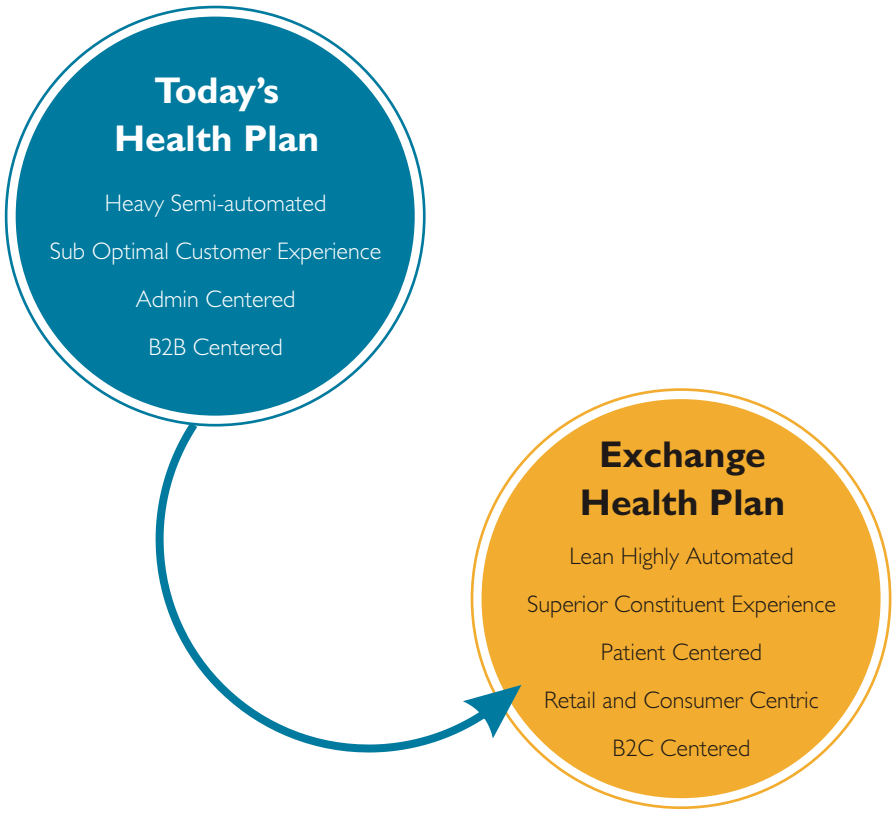
Today's health insurance companies are not prepared to make the transition to the exchange model for a number of reasons. Without a well-defined blueprint for business and IT transformation, creating value will be a challenge. The challenges are:

- Sub optimal customer experience:
  - No portability of customer experience across channels
  - Each channel is designed separately.
- Administration focused, not adequately patient-centric:
  - Patient centricity is crucial to optimizing medical costs and improving quality of care delivery (integration of PHR and clinical content).
- Inadequate retail centricity, large group based model:
  - Processes and systems are designed for B2B and may be unable to meet demands of retail consumers.
- Non-lean operations, semi-automation:
  - Complexity in legacy systems, operations with manual intervention and paper work.
  - Not geared for real-time straight-through processing.

Insurance companies are poorly aligned with the requirements of Health Benefit Exchanges. Can they swiftly change their products, operational processes, IT systems, business models and partnerships to position themselves as winners in the Health Benefit Exchange landscape? The ones who do are the ultimate winners.

Health Plan Business Case Model: Vast gaps to be bridged by business blueprint

The journey from current state to the necessary "To-Be" state underlines the key success criteria for a business blueprint:



The Core Strategic Themes of To-Be State are

1. Understand customer segments and drive focus to each segment

• Focus on non-subsidized individual and SG customer segment, understand various demographic micro segments, leverage learning from Medicaid markets

• Design robust and optimal networks for more profitable non-subsidized market and subsidized market

2. Gain cost leadership through low cost operations and automation

• Design lean processes with least manual interventions, automate and increase auto-adjudication rates to 99%, increase real-time data integration and communication

• Design individual / SG segment motivation models for delivery of effective care management program to manage high risk population

3. Use analytics and single view of stakeholder experience

• Develop deeper capabilities in analytics to model customer needs, measure satisfaction, and the impact of exchange on sustainable margins

• Synchronized and real-time pricing/underwriting capabilities

4. Influence through collaboration with State agencies

• Participate and influence the State legislative laws that are being currently drafted by State regulators

• Work with regulators to forge market place that encourages participation by all stakeholders

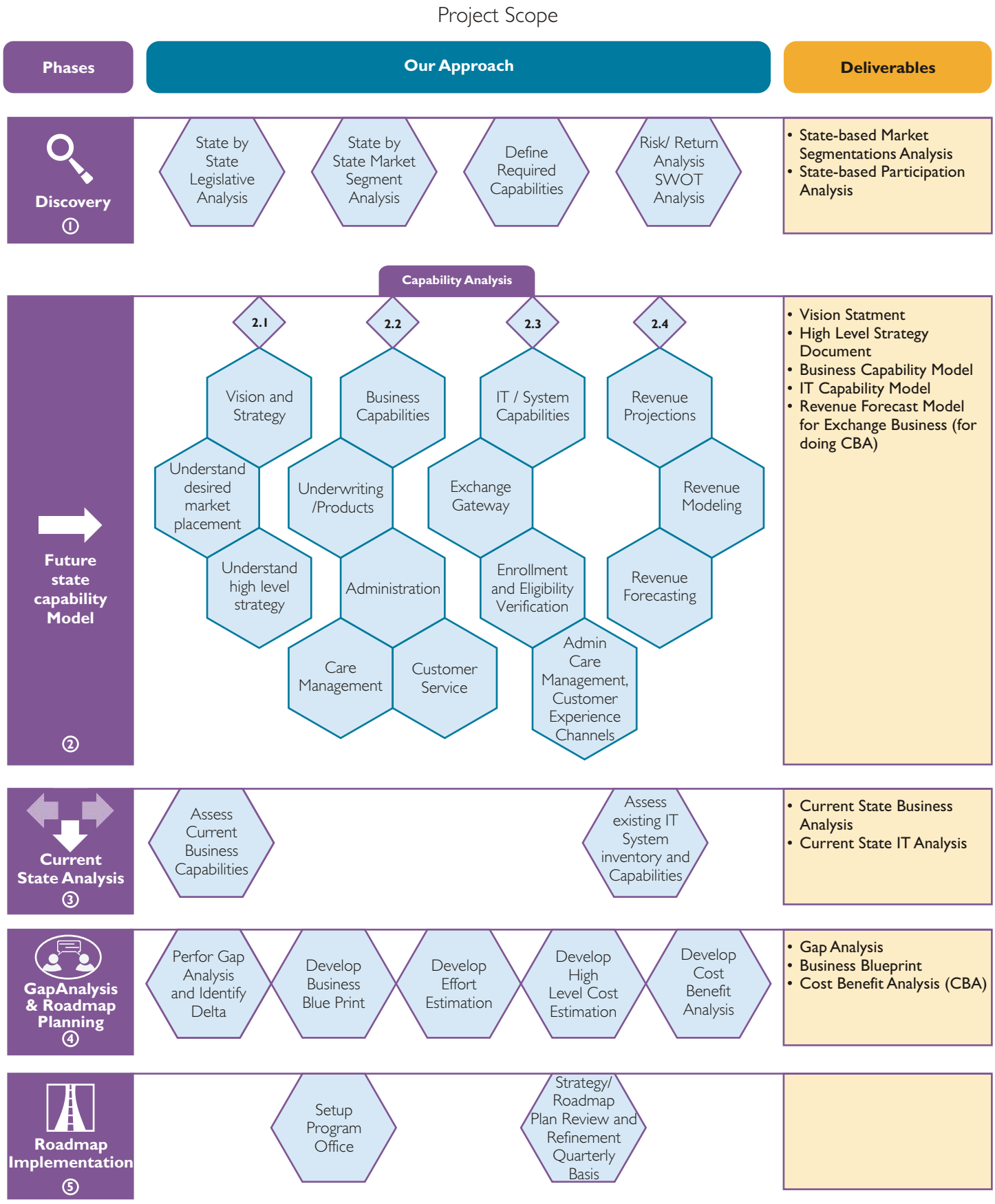
Wipro's Methodology for Creating a Business Blueprint:

Wipro's methodology for designing a business roadmap begins by creating a State by State understanding of legislation, market segments and a risk/return analysis. The central question that needs a convincing and detailed answer is, "What are the best identified choices? What is the range of future capabilities required to ensure success for the choices made?"

Given the desired target position, what should the high level Health Benefit Exchange strategy be? A winning, ready-to-execute strategy is an outcome of the vision presented by leadership. Once the vision is articulated, it has to be proficiently translated into business capabilities (underwriting, product development, care management, customer service) and a heightened retail focus around the target Health Benefit Exchange segment.

Blueprint Methodology

How do we get there from here?



The delivery of business capabilities could well hinge on the role IT plays in integration with external parties, customer service systems, the plan for retail and patient centric systems, how the plan to significantly increase auto-adjudication rates is defined, how synchronized and real-time pricing/ underwriting capabilities are identified and the increased use of analytics to create insight and efficiencies.

The Health Benefit Exchange opportunity before health payers can transform business. Payers should leverage the opportunity calls for a close examination of regulatory requirements that help create a best-fit and faster go-to-market strategy.

Payers need to start working with a technology partner who understands the underlying philosophy of a Health Benefit Exchange and can deliver a compelling customer experience by being retail centric.

Health insurance has had a history of moving away from the individual and SG customer. But to the astute health payer, they offer a fresh opportunity for growth.

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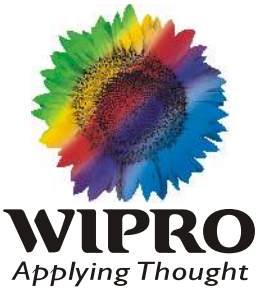

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