WHITE PAPER

REFINING THE INSURANCE ENROLLMENT PROCESS TO GAIN EFFICIENCY AND SCALE

INTRODUCTION

Now that the initial enrollment efforts for the Affordable Care Act (ACA) are over, phase two can begin. In the coming months, insurers will focus once again on enrolling millions of uninsured Americans. As was the case last year, insurers will face the challenge of having to manage the process effectively or face the chaos that ensued last year.

When open enrollment begins again on Nov. 15, insurers and federal and state officials will seek to manage enrollment more smoothly than it went in the first year under the ACA. While there are challenges, there are also opportunities, emerging solutions, and lessons to be learned and implemented from the problems they faced in the fall of 2013 and into the spring of 2014.

Into the wild: today's enrollment marketplace

By the time initial enrollment was complete, approximately eight million Americans had enrolled, but the effort for health plans, community clinics and other organizations enrolling members was far from complete. Medicaid enrollment continues throughout the year and new consumers are continually being added to insurers' rolls or dropping out due to qualifying events such as job loss, divorce and other life-changing events.

What's more, insurers and other organizations enrolling consumers are still addressing issues such as missing or incomplete data or assisting enrollees who experienced problems during enrollment.

Applications were still pending in June, for example, for more than 900,000 Medi-Cal enrollees, according to news reports. At about the same time, officials in 15 states reported that more than 1.7 million individuals were still waiting for their applications to be processed and that some applications had been pending for eight months, according to Kaiser Health News. Among those states were Alaska, Georgia, Illinois, Kansas, Michigan, Missouri, North Carolina, South Carolina and Tennessee.[II]

Many enrollees are in limbo from the moment they start the enrollment process in part because insurers and enrolling organizations have established few processes to identify those whose applications lack requisite information. In many places, enrollment was chaotic and inefficient, and the result for insurers, the federal government and of course consumers is confusion, delays and increased costs.

Among the reasons for the chaos was a web site (at www.healthcare.gov) that was not ready for the heavy demand last fall and winter from consumers and the uninsured. Federal officials and contractors were working this summer to retool the site but problems may be common once again, according to **The Wall Street Journal**.[IV]

The challenges of the new frontier

It's not just individual enrollees who face challenges. Insurers face challenges in several key areas, including:

- Excess and uncertain costs
- Missing data and erroneous information
- The need to apply subsidy information for each enrollee
- Processes to manage denials and outliers
- Payment process
- Grace periods and reconciliation
- Enrollment deadlines and limitations

Excess and uncertain costs

One of the uncertainties insurers face is determining how much it costs to enroll a consumer. Some basic costs are known, but there are unknown factors as well, such as what happens when an application is problematic. One large health plan estimated that each time an enrollment specialist handles an application, it costs the plan $7 to $10, minimal on an individual basis, but it can quickly add up to thousands of dollars when insurers process hundreds of thousands of applications. These costs were even higher for enrollees with complex needs, such as for those requiring subsidies or enrollment into the Children's Health Insurance Program (CHIP). Officials in Nevada expected to spend $42 per enrollee each time a facilitator would assist individuals completing insurance applications. Instead, the per-enrollee cost for assistance was $199, state officials said.[IV]

Missing Data

One important way for insurers to make enrollment more effective and efficient is to develop processes to ensure that all information for each enrollment is accurate and complete. All applicants need to provide precise information on the name, address, income and other demographic and basic health information for all members who are enrolling, including each child.

During open enrollment in 2013, however, insurers and those organizations working on behalf of insurers to enroll individuals reported that as much as one-third of all applications had errors or were missing data. In June, the Associated Press reported that at least two million people who enrolled for subsidized health insurance have data discrepancies that need to be resolved before they affect

how much the enrollee will need to pay for coverage and legal right to benefits. The discrepancies mean the information enrollees supplied, such as for income verification, does not necessarily match what the government has on record, the AP said.[VII]

In a report issued July 2, the federal Office of Inspector General reported that many of the inconsistencies involved questions about citizenship and income, and federal marketplace was unable to resolve 2.6 million of 2.9 million of them because the federal eligibility system was not fully operational. The abilities of the state marketplaces to resolve inconsistencies varied, the report said.[VIII]

Later in July, the federal Government Accountability Office (GAO) reported to Congress that it tested the marketplace's ability to detect fraud and found that 11 of 12 fictitious applicants who applied by phone and online received subsidized coverage. One applicant was denied for not supplying a Social Security number, the GAO said.[IX]

Any data that was missing from an application was a challenge because plans found they often lacked contact information and so had no way to reach the applicant. There are operational issues involved as well. Many health plans and clinics enrolling patients do not have automated or standardized workflow processes. Many are using systems designed for traditional health plan enrollment, which do not load information into a system until all the patient information is received. Perhaps most disconcerting is that even large organizations still rely on spreadsheets, manual folders, and paper forms to manage enrollment.

The need to apply subsidy information for each enrollee

There remains considerable uncertainty about how to manage subsidies, which is one of the most critical components of the ACA, and also one of the most difficult for insurers to manage. Proof of income is needed to calculate subsidy amounts and matching those forms to an enrollment is a challenge for any automated system, particularly for those linked to the federal exchanges under the ACA. Another critical factor is that many consumers, particularly those who have been without health insurance in the past, have not had full-time work.

Therefore, they are less likely to have employer-sponsored health insurance. Instead, they may have a number of parttime jobs, and for each one the enrollee would need to verify income. Having a number of part-time jobs also means enrollees' income likely fluctuates from month to month. Therefore, health plans need to find a way to get the income verification from each enrollee and then monitor the member's eligibility for subsidies over time.

Denials

While health insurance is now available to many more Americans than were eligible previously, denials are not uncommon, primarily due to inaccurate or incomplete information or because of enrollment errors.

The challenge comes in what happens next. What should occur is that the reason for a denial would be identified quickly; the enrollee would be contacted and informed about the need to take further steps (such as re-enrolling using accurate demographic information) and if appropriate, the applicant would be re-enrolled or referred to another plan.

Insurers are finding, however, that the denial and reenrollment processes are taking months, instead of days. For consumers, denials could be particularly problematic because many believed they were enrolled successfully, when in fact the application was in limbo pending action from the health insurer if more information or corrected data were needed to move the application toward completion.

Outliers

Family health insurance needs are typically much more complex than those of individuals. Some family members may be employed and covered through a company plan, others may be unemployed and not covered under the spouse's employer-sponsored plan, one child may have special needs warranting special coverage, and another may not. Last fall, the enrollment systems of most insurers were not equipped to identify or categorize such needs. If one child qualified for CHIP, for example, then that application may have delayed that child's enrollment or the family's enrollment or both.

Premium payments

In many, but not all states, applicants have 90 days to pay their premiums. In this time, the enrollee's insurance coverage will continue, but after 30 days the insurer may not pay the enrollee's physician, hospitals, or other providers. In addition, some plans offer grace periods of varying lengths. The federal Centers for Medicare and Medicaid Services says any individual who enrolls on the exchange and gets a subsidy has 90 days to pay his or her first bill. Other health insurance plans may have grace periods giving members 30, 45, or 60 days to pay the first premium. While this grace period allows providers to deliver care to new members, claims must be held until payment is received. Then claims can be paid.[X]

For providers caring for patients who have not paid their first premiums, the grace period can drive up administrative costs for services such as paying staff to check on claims status, reprocess claims, and seek payment for claims delayed. During that time, the patient's status may have changed because the enrollee has started a new job, enrolled in a different plan, or moved. Whatever the reason, insurers and providers may not be paid in a timely manner.[XI]

In addition to payment grace periods, some plans provide reprieves for chronic or qualifying conditions, such as end state renal disease. Insurers and enrollment organizations must be able to identify those enrollees and verify their coverage status.

Timing

Under the ACA, insurers have strict deadlines to meet when processing applications for enrollment. Under current law, the application for anyone enrolling by the 25th of the month must be processed and approved by the end of the month. This requirement is designed to ensure that consumers are enrolled in a timely manner, but such short timing means that insurers have little time to process and verify the data on enrollment applications. Often applicants are enrolled conditionally without verification of all data, and then verification is conducted the following month. Some of these applicants might get an approval at the end of one month and then get a denial a few weeks later.

In addition, some states mandate that if a potential new member submits enrollment by a defined date within the month the person must be enrolled. Then the applicant's eligibility is confirmed after the initial date of coverage creating an additional step in the process requiring reconciliation of the applicants.

Disenrollment

One of the challenges insurers, providers, and consumers all face is disenrollment. Consumers may disenroll for a variety of reasons ranging from moving out of state to finding better coverage elsewhere. In addition, health plans may elect to disenroll members for many reasons, such as failure to pay the premium. Once a disenrollment occurs, however, the health insurer and the organizations managing the enrollment need to track the reasons for each disenrollment and contact the enrollee to provide each one with the information they need to re-enroll if they so choose and to adjust the insurer's internal records so that billing can be stopped or adjusted as needed.

A TALE OF TWO ENROLLMENTS

Mark and Susan Jones work for a small flooring company in New York. They have three children, aged 23, 18 and seven. The 23-year-old works part-time and is in graduate school out of state, the teenager is in college, and the seven-year old is disabled. Mark and Susan's combined gross income totaled $65,000 annually. Because their employer does not provide health insurance, the Joneses shopped for a plan on the New York State Health exchange and found that they qualify for a subsidy.

Enrolling in a plan that met their needs proved to be difficult, however. One challenge was finding coverage for their 23-year-old who lives out of state. The exchange plan they selected would not cover the older child, because the plan had no network affiliates out of state. Also, the plan would cover only part of the disabled child' costs because he was eligible for a separate subsidized plan for dependent children with special needs. In addition, many of the medications the youngest child needed were not covered under the plan offered.

Seeking the best, most cost-effective care for their youngest child while also finding appropriate care for the rest of the family was an issue. Also Mark and Susan Jones were confused about how much they should pay in premiums, when the premiums would be due and how much they would need to pay in copayments and deductibles.

What the Jones' family and their health insurer needed was a system that would consolidate and streamline the process, providing the information the Jones family needed to manage the entire enrollment process efficiently.

Taming the new wild west

Though enrollment challenges may seem insurmountable at times, there are systems and processes an insurer can employ to help tame the new frontier of the exchange marketplace. The following (Figure 1) illustrates a typical member enrollment workflow at a very high level, beginning on the left with normalization of incoming sources of data. The goal of these steps is to get the applicant fully enrolled, with accurate information, as quickly as possible.

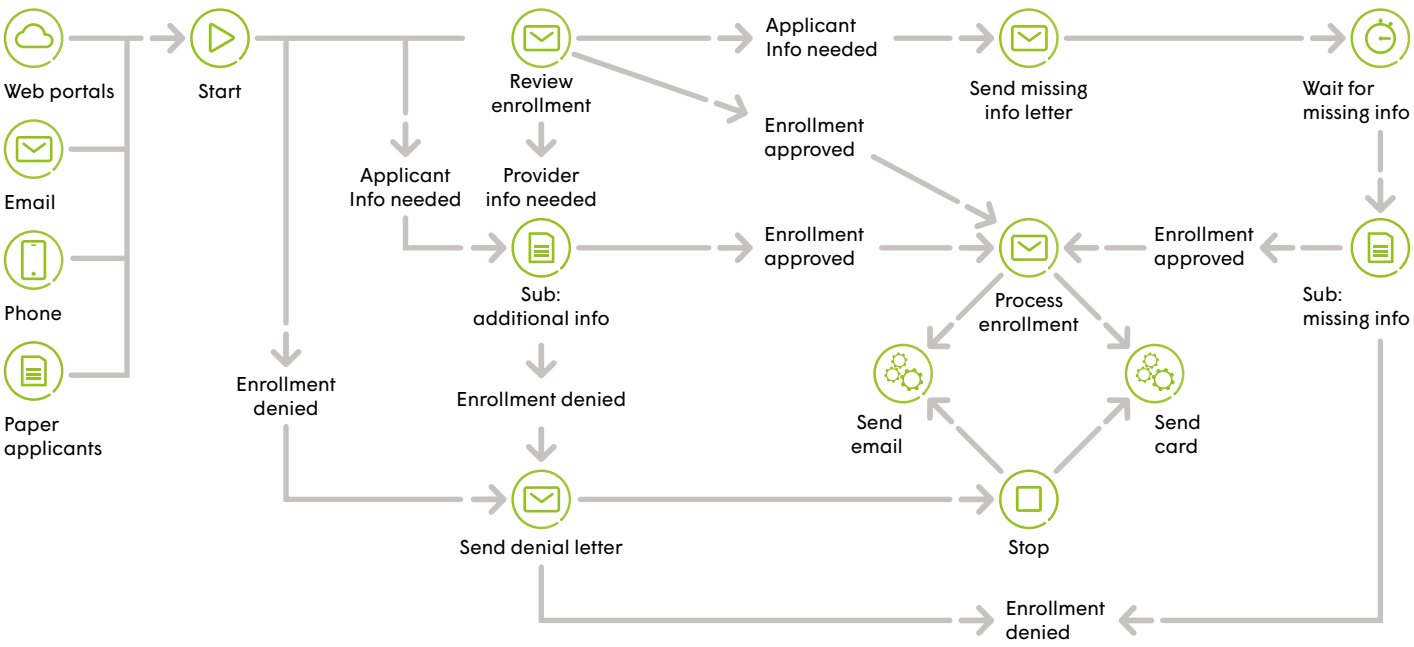
Member Enrollment Workflow

Data Sources are quickly normalized, and a streamlined enrollment process begins. Key steps in the member enrollment process typically include:

- Front-end data capture – Critical to the success of any enrollment process, this step involves capturing data from a paper enrollment form, a fax, or from a web portal or email to gather all the required information, identify any errors or omissions, route the application to the next appropriate reviewer, and record the status of the application and any needed data or problems left to resolve.
- Auto creation and population of a work item or service form – In this step, the system creates the appropriate forms and populates them with the appropriate data from each enrollee.
- Pre-populated correspondence letters with values from a work item or service form – The system automatically prepares letters for the enrollees explaining coverage options and costs.
- Responses to inquiries monitored – The system maintains a list of any missing data and fills in any gaps as the information becomes available.
- Communication among the various entities – The system facilitates communication among third parties that need to be involved to resolve problems with applications or gather any missing data.
- Timely receipt of applications from multiple sources such as the web, paper, and fax. In this process, the system enrolls consumers who have used a variety of ways to enroll, such as enrollment systems, host systems, and data feeds from federal, state, and local sources. Notification of external parties (such as CHIP or Medicaid). Once notified, these organizations should begin corresponding with the enrollee.

As these key steps are being completed, insurers also need to ensure that they have processes in place to answer any appeals and resolve grievances quickly. Grievances may result from incorrect or missing subsidies, dependents being directed to delegated entities (such as CHIP and Medicaid), and missing or invalid data in enrollment forms. Once the above steps are completed, an insurer begins the reconciliation process. This process typically includes verifying data for enrollees and dependents (e.g., Social Security numbers) and reviewing proof of residency forms and documents for income verification. If all forms are in place and all information has been verified, the insurer will send identification cards and welcome letters. After each member enrollment is complete, insurers then monitor enrollees continually for any change in family status or income that may affect subsidies or lead to a disenrollment.

Figure 1: example of a member enrollment workflow



Automation in the enrollment process

Digging deeper into the enrollment process, an insurer may discover several areas to further automate and streamline the process. Such areas for automation might include:

- Auto-creation and population of a work item or service form.
- Automated alerts to track mandated federal government timelines.
- Pre-population of correspondence letters with values from a work item or service form.
- Automated responses to specific inquiries monitored within the system.

Insurers can automate many areas of the enrollment process, if they know where to begin. By automating these processes, insures can realize immediate efficiency gains.

On the trail to success

The need to find efficient systems and effective technologies to streamline and improve the enrollment process will continue. New reports indicate that a growing number of insurers are joining the health insurance exchange marketplace. At least 13 million people are expected to use the exchanges for enrollment in 2015, almost double the number who did so in 2014. More enrollees will mean insurers will face more challenges and potential problems.

The time to move forward with finding answers and approaches is now. Solutions are available. By partnering with organizations that have experience with 2014 enrollment as well as the insights and innovative technology to successfully launch enrollments into 2015, insurers will be able to efficiently and effectively continue to help Americans gain access to needed health insurance programs.

ENROLLMENT BEST PRACTICES

The nation's efforts to develop an effective and efficient process to provide healthcare services to millions of people is a clear example of a massive culture-shifting initiative still in process. It may take years to fix all the problems identified since enrollment began; but it will happen. The challenge for insurers is to find solutions to these problems and improve the system in a cost effective way now.

Steps to take include:

- Ensure the organization is familiar with current requirements and guidelines.
- Pledge to work within the system. Be actively involved in efforts to improve the system by supporting industry associations and collaborating with peers.
- Identify key obstacles in the enrollment process by assigning troubleshooters to address problems in difficult enrollment applications.
- Develop the technology and processes needed to streamline the system and quickly enroll prospective members, or work with partners that have the technology and processes.
- Develop a workflow to track missing data and what steps have been taken to date to acquire all missing data.
- Create a business process management solution that is configurable and allows for integration of third party systems. For example, insurers will need to track and store correspondence.
- Ensure health plans have the right technology to streamline the enrollment process. Processes must be in place to automate, communicate and coordinate each step in the process, including those for enrollment, billing, and claims.
- Explore other tech capabilities such as bar codes on all incoming documents to eliminate opportunities for error and oversights and ensure better tracking and configuration.
- Develop policies and protocols to manage group insurance as well as exchange business.
- Establish clear systems and policies for disenrollment and re-enrollment. These processes must be seamless and automated because health plans will want to retain those members they enrolled.
- Standardize the appeals process, specifically by streamlining the processes for families with diverse needs.

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