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Fall 2022
EXECUTIVE ADVISORY COUNCIL

What Success Looks Like in Government Markets

Insights from the 2022 Fall Executive Advisory Council

Executive Advisory Council Overview

The Softheon Executive Advisory Council (EAC) is an invitation-only think tank of healthcare's most innovative minds. Senior executives from national and regional health plans, representing more than 50% of the U.S. population, meet twice a year in a collaborative, small-group setting to discuss how to improve healthcare affordability and accessibility.

In October 2022, 15 health plan and government-health agency senior executives met with Softheon leadership. This two-day meeting discussed what success looks like in government health plans and strategies utilized to achieve it. Sessions featured thought leaders from organizations such as Humana, CVS/Aetna, Cambia, Elevance, Washington Health Care Authority, Independence Blue Cross, and UnitedHealthcare.

Executive Summary

As enrollment rates decline in the large-group market and premiums rise for employers and employees alike, health plans are focusing their attention on government-sponsored markets. Ongoing and upcoming policy changes allow for continuous growth in the ACA, Medicaid, and Medicare Advantage markets. To capitalize on the significant gains in stability and profitability, health plans must first understand what success looks like in government-sponsored markets.

The value of retaining members transitioning between different coverage types can't be overlooked. In 2020, **16% of all adults ages 19 to 64 were uninsured at a point.** Gaps in coverage between government-sponsored programs largely contribute to uninsured rates and a reduction in health plan profitability.

Benefits beyond the immediate financial gain of transferring individuals between different coverage types include a positive user experience that increases retention rates. Health plans can reduce gaps in coverage by prioritizing continuity of coverage through targeted member outreach and a seamless shopping, eligibility, and enrollment interface.

Nine Headwinds and Tailwinds Affecting Government-Sponsored Markets

The government-sponsored insurance market has made significant gains in carrier stability and profitability during 2022. As industry leaders continue to expand their offerings, more will follow suit and capitalize on the growing opportunity in the ACA, Medicare Advantage, and Medicaid markets.

EAC participants identified the nine most influential headwinds and tailwinds in the coming years:

		Affected Lines of Business
1	26M baby boomers and 4M ACA enrollees will age into Medicare	**Tailwind**—Medicare Advantage & D-SNPs
2	The end of the PHE will result in 5.3-14.2M Medicaid members losing coverage	**Tailwind**—ACA Marketplace **Headwind**—Medicaid
3	A shift in coverage distribution toward government markets due to the pending recession	**Tailwind**—Medicare Advantage, D-SNPs, ACA Marketplace, and Medicaid **Headwind**—Medigap
4	A continued increase in government-sponsored plans through support for Medicaid Expansion & QHPs	**Tailwind**—Medicaid, ACA Marketplace
5	Enrollments in D-SNPs nearly tripled in the past 10 years with the highest federal per capita spend	**Tailwind**—D-SNPs
6	The ARPA Extension increases affordability of Marketplace coverage	**Tailwind**—ACA Marketplace & Medicare Advantage
7	More choices for Medicare Advantage plans increases market competition and demands an increase in plan quality	**Tailwind**—Medicare Advantage
8	Struggling health plans leave the individual market, triggering surges in enrollments for competitors	**Tailwind**—ACA Marketplace
9	Greater funding for Navigators allows targeted outreach strategies in hard-to-reach populations	**Tailwind**—ACA Marketplace

Definitions of Success Across Markets: Informing the Nine Needed Capabilities

EAC participants completed a pre-event survey detailing their definitions of success across different lines of business.

Softheon compiled a summarized list of what success looks like for health plans regarding member acquisition, retention, and continuity of coverage.

Definitions of success can apply to multiple lines of business, as seen in the following chart:

	ACA Marketplace	Medicare Advantage	Medicaid
Shared	■ On-demand, precision analytics that allow for personalized and frequent outreach		
	■ Repeatable processes and technologies that promote continuity of coverage		
	■ Staffed local, regional, and DC lobbying and PAC		
	■ Integrated shopping, eligibility, and enrollment platform & experience		
Acquisition	■ 7.3% online-shopping conversion average (Enhanced Direct Enrollment) ■ 95.5% effectuation rate ■ Pay Now functionality ■ Digital outreach and marketing strategies with informative analytics ■ Auto-payment of low-cost, initial binder payments	■ 10% online-shopping conversion average ■ 40-50% call-center conversion average ■ 100% of enrollees receive a new-member packet ■ 90% of enrollees experience a welcome visit and social needs assessment ■ CAHPS and stats digital capture at point of care ■ Automated PCP selection process	■ Automated eligibility determinations ■ Targeted door-to-door enrollment and local presence ■ Use of subsidized care coordinators ■ Life-stage SDOH and targeted coverage interventions ■ Adhering to the "Reasonable Compatibility" Federal standard
		■ Increasing choice for enrollees with flex cards	
	■ Addressing data validation concerns through interoperability		
Retention	■ 72% member retention rate ■ Waving co-pays when applicable ■ Pay Now and ACH functionality ■ 50% digital-member engagement ■ Expanded self-service options ■ Analytical models that predict member-diversified communications channels and the use of QR codes ■ Improved broker technology and incentive programs ■ Collaborating with states to improve QHP health outcomes	■ 96-98% member retention rate ■ 64%+ broker assignment rate ■ Automatic notifications about new offerings ■ Flex cards for dental, vision, or hearing ■ Preferential MD appointment blocks ■ Virtual annual wellness assessments ■ STAR digital reminders at point of care ■ Wellchecks six months prior to Open Enrollment ■ Benefits parity or better at Open Enrollment	■ 70% market share in core service areas ■ 90% contact accuracy ■ Increased eligibility checks & data availability ■ 12 months of continuous eligibility and automated renewals ■ Express-lane eligibility (Enhanced Direct Enrollment) ■ Presumptive eligibility during provider office visits ■ Monthly state collaboration regarding SDOH
	■ Preventative care and incentive programs		
	■ Informed plan designs based on SDOH		
	■ Improved broker technology and incentive programs		
Continuity of Coverage	■ Achieving 50% conversion rate from Medicaid to Marketplace ■ Coordinated outreach effort to assist individuals transitioning to Marketplace	■ Supporting aging individuals transitioning for employer-sponsored coverage to Medicare	■ Increasing automatic application closure period to 45 days ■ State monthly termination files ■ Coordination of monthly termination files and reasons

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Nine Capabilities Needed to Achieve Success

EAC participants identified and refined the top 9 capabilities their health plan needed to succeed, considering market headwinds and tailwinds.

The following capabilities were deduced using insights from a pre-EAC survey and discussions during the conference:

1 Integrating the shopping, eligibility, and enrollment platform & experience— Top 3 EAC Priority

Members have a growing number of options when it comes to where and how they buy insurance. The general shift toward e-commerce means health plans must utilize a variety of avenues to target and enroll members in government- sponsored markets.

A state Medicaid Director provided the Figure 3 to depict the complexity of an integrated network of government sponsored programs.

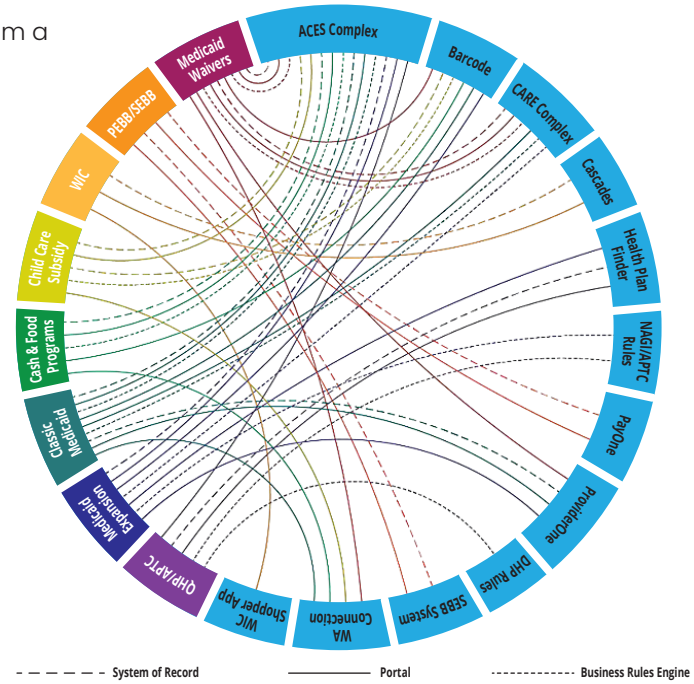

Figure 3 A Framework for Integrated Eligibility

In the EAC live poll, EAC participants unanimously identified a unified shopping, eligibility, and enrollment as a funded initiative at the start of the conference; however, only 18% considered it a top priority. Following discussions with other like-minded health plans, participants voted a no-wrong-door approach to coverage as a top 3 priority.

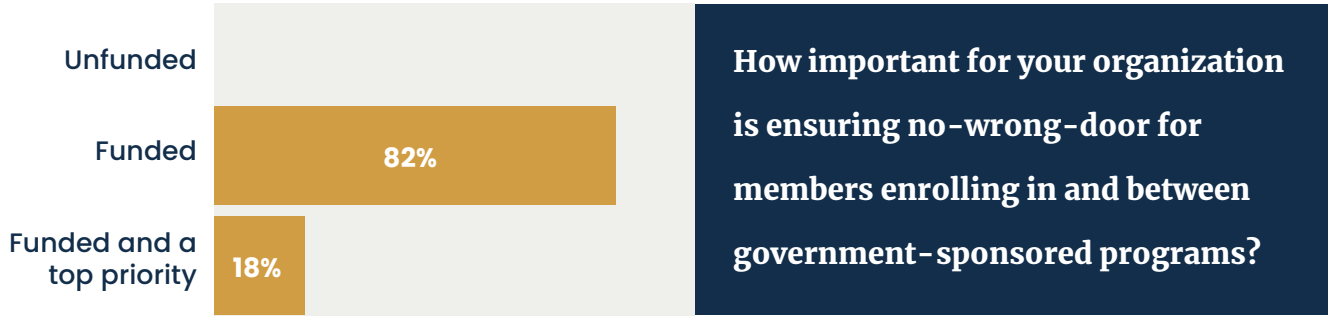

Figure 4 Poll Results during the Fall 2022 EAC

2 Addressing data validation concerns through interoperability—Top 3 EAC priority

As the end of the PHE approaches, and to support member engagement, health plans grow more concerned over the quality of member contact data. Changes in address and contact data prove to be a barrier to coverage as enrollees need to respond to notices urging them to update their eligibility information.

EAC participants have already begun the process of integrating with external data sources. Fast Healthcare Interoperability Resources (FHIR) offers a promising and common set of application programming interfaces (APIs) for healthcare systems to communicate and collect vital contact data.

3 Defining a 6-star member experience—Top 3 EAC priority

A health plan with over 1.5M members shared that the top reason for voluntary Medicare Advantage disenrollment is members not understanding the product offering. Members transitioning from a guided coverage shopping, enrollment, and management experience — complete with a dedicated HR department — might get lost in the confusing world of government-sponsored coverage.

> **"69% of commercially insured 60-64 year olds are 'strongly concerned' they'll have worse insurance under Medicare"**
>
> ***— shares an SVP of an insurer operating in four states***

To improve retention rates, health plans are simplifying their plan offerings and enrollment journey.

4 Centralizing the enrollment control center for a single source of data truth

The director of a state's Department of Human Services shared the challenges associated with siloed eligibility operations. To improve renewal rates and the enrollee experience, all enrollment data—from program operations, managed care organizations (MCOs), and providers—should be accessible through an Enrollment Control Center.

Increased data visibility produces actionable insights for leadership, program staff, and partners alike.

> **"To permanently improve Medicaid operations during PHE Unwinding, stakeholders should prioritize a real-time monitoring capability to allow visibility into all aspects of Medicaid operations, eliminating silos that can mask developing issues and problems"**
>
> ***— shares a HHS director***

5 Collaborating with states to improve QHP health outcomes

Participants shared their challenges with qualified health plans (QHPs) that failed to improve the overall quality and cost of care versus traditional fee-for-service (FFS). While health plans may see enrollment success, program success will be measured by the impact on clients' health and overall cost trends.

Investing in analytics that can routinely determine statistically significant clinical program yield will be a no-regret investment.

6 Ensuring brokers do even more

EAC participants called for brokers to take a more active role in helping enrollees understand and navigate their benefits. This gap in benefit information is particularly prevalent with Medicare Advantage recipients. Establishing brokers as a vital source of information for this population helps combat the top reason for voluntary disenrollment.

> **"The "#1 reason for voluntary disenrollment—not understanding the product/benefits**
>
> ***— Shares SVP at an insurer with over 2M members***

7 Capturing member sentiment at the point of provider services

Health plans called for the use of surveys in clinical settings to assess member satisfaction. Similar to Consumer Assessment of Healthcare Providers and Systems (CAHPS), these surveys allow for rapid feedback and encourage member engagement. Vital operational and Star Rating improvements become apparent when data capture is offered at point of care in a less abrasive manner.

8 Increasing choices for enrollees with flex cards

Health plans have seen success promoting flex benefits for Medicare Advantage and Medicaid recipients. The flexibility to select a set amount each plan year allows coverage to remain affordable despite changes to plan design and periods of unexpected financial loss.

9 Determining success in clinical programs

Regardless of the number of additional capabilities and programs initiated by a health plan, true success comes from determining what is and is not working quickly. Determining if a clinical program generates a positive financial yield or improves access to coverage can be a challenge.

Health plans must first determine what success looks like on a small scale and invest in automated and causal analytics capabilities to ensure benchmarks are met.

Three Strategic Takeaways from the Fall 2022 EAC

At the end of the 2022 EAC, EAC participants identified their top three takeaways from the event below:

1 Adapt broker role to focus on the member experience

Regardless of how your plan feels about brokers, they continue to be an important part of the Medicare Advantage experience.

One leading plan found that members with a broker scored approximately 10 points higher on CAHPs surveys compared to their non-brokered counterparts. Until your processes can make it as easy to enroll and explain complexity better than brokers do, they must remain an essential channel.

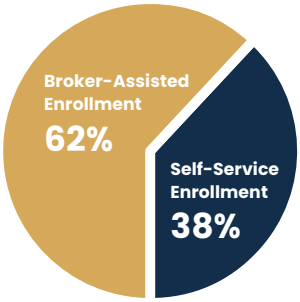

Figure 5 A Breakdown of Broker-Assisted Enrollments

Health plans should not overlook the impact that agents and brokers can have on penetrating the insurance market. In 2022, 62% of individuals that enrolled through HealthCare.gov or a private direct enrollment partner's website were guided by brokers.

2 Collaboration between health plans defines the 6-star member experience

To improve the member journey while reducing gaps in coverage, health plans must work collaboratively. Too often, health plans approach increasing acquisition and retention rates by actively working against other plans. From divisive (and conflicting) messaging to overloading the markets with low-quality plans, anti-competitive behavior hurts members much faster than the competition.

Softheon's 2022 EAC was a step toward our incentive to establish a more collaborative relationship between health plans and state agencies that support government-sponsored coverage.

In today's landscape of increased consolidation and carrier exits, having an inside look into the operations and successes of like-minded carriers helps to focus efforts on initiatives that produce results. Candid conversations expose the added complexities of providing coverage on the individual market. A process often oversimplified by health plans that have mainly operated in the group space until recent years.

3 Invest in a seamless member experience in the wake of market trends

The value of retaining members transitioning between different health coverage types should not be overlooked. But it also serves as an opportunity to show you "know" your member and create loyalty through positive user experiences regardless of line of business.

Losing Medicaid coverage or transitioning from an employee-sponsored plan can be confusing for individuals. Your health plan and a seamless user experience can be their constant.

About Softheon

Founded in 2000, Softheon's Software-as-a-Service (SaaS) and Business Process-as-a-Service (BPaaS) solutions solve complex operational and service challenges for health plans and government health agencies.

By offering modular solutions designed to integrate with existing systems, Softheon reduces administrative burdens by streamlining critical processes in healthcare. Softheon's rapidly adapting technology and agile approach to implementation enables clients to proactively respond to changing regulatory environments and consumer demand.

Softheon has been recognized as a leading SaaS and BPaaS provider by IDC, AHIP, ACAP, and HCEG. Trusted by CMS and 8 State agencies, Softheon's clients span multiple industries. In 2021, Softheon ranked on the Inc. 5000 regional list for fastest growing companies, and Best in Biz Awards named Softheon one of the top Companies of the Year in the Northeast Region.

To learn more about how to expand revenue sources and improve outcomes while meeting community demand, contact:

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