**Lessons Learned: Making the Leap from Medicaid Managed Plan to the Public Exchanges**

By Mike Gordon, Chief Product and Strategy Officer

 At first glance, creating a health insurance offering for the public exchanges created by the Accountable Care Act (ACA) may seem like a natural move for Medicaid Managed plans.

After all, Medicaid Managed plans already have an established provider network they can carry over. They also have a good understanding of beneficiaries who sit below and just above the Federal poverty level. Yet many payers that have already done it are finding it’s more challenging than they originally thought.

Make no mistake – the opportunity is there. But it’s probably going to require your plan to make some significant adjustments to its business operations. Here are some of the lessons learned by Medicaid Managed plans that we have already helped make the leap.

**Increased Customer Service Requirements**

 One of the biggest shocks Medicaid Managed plans receive when they first start supporting membership acquired via the public exchanges is how much more customer service is required.

 For example, Healthx has had a client tell us the call volume for marketplace members was 10X greater than for their Medicaid members, and the calls themselves typically lasted 8X to 10X longer.

 Why such an increase? One big reason is that plans purchased through the public exchanges are relatively more complex. Suddenly members have questions about deductibles, co-pays and other out-of-pocket expenses. They have questions about how much of a physician visit, emergency department visit or hospital stay is covered by their benefit plan. These are all things the customer service department never had to address when it was focused on Medicaid.

 Neither did the new members. Many have never had insurance before, so they’re not even sure of what to ask or how to ask it. The result is a (hopefully) large new group of members asking the same basic questions of an overwhelmed group of customer service representatives.

 Then there’s the fact that rather than having a single Medicaid Managed plan, you will be offering different levels of plans, each with their own nuances, on the exchanges.

 One way to prepare for this influx of questions is by increasing staffing in the customer service department. But increasing it by 10X to handle peak volumes is unrealistic.

 A more cost-effective option – and one that has proven successful for our clients – is to offer enhanced member engagement tools that allow members to answer most of their own questions or look up basic information online or from their mobile phones. For example, a simple FAQ section specific to the member’s plan level may provide answers to many questions without the need for a phone call. The member portal or mobile app can also allow members to look up their progress toward deductibles, total out-of-pocket expenditures and other benefit-related information.

 A mobile app makes it even more feasible to digitally engage Millennial members; they are accustomed to using their smartphones or tablets for interacting with everyone and everything, including their service providers. Our customers have found implementing a third-party digital engagement solution (rather than attempting to build a portal or mobile app internally) has helped them get to market faster, with a higher quality, less expensive, and more engaging solution in the long term.

 Additional call center capacity can be freed by automating responses to provider inquiries. For example, providers checking member eligibility can use technologies such as a provider web portal, interactive voice response system instead of phoning the call center, freeing up staff to handle the more complex member inquiries.

 The better consumer experience your plan delivers starting at the point of enrollment and continuing throughout the course of the year, the more likely you are to retain those members when they make the decision whether or not to continue as your customer at re-enrollment time.

**More Data to Manage**

 Many of those same issues come into play when it comes to managing data. Medicaid Managed plans don’t have to deal with data issues such as tracking out-of-pocket maximums for individuals and families. They’re also not used to collecting premiums or out-of-pocket payments from individual members, or making adjustments to allowed amounts based on whether the care was provided by an in-network or out-of-network provider.

 Several plans have found it difficult to get that data out of their claims systems so it can be retrieved by customer service representatives or displayed on member portals or mobile apps. It’s not that their claims systems can’t do it; the systems they purchased years ago may have originally had those capabilities. But the data fields are now being used for other things, so job one is learning where that information is stored so it can be exposed and shared with customer service applications and web portals/mobile apps.

These plans are also challenged to respond with accurate answers if a provider asks how much to collect from the member for their co-pay and co-insurance, and whether the member has met their deductible. All of this requires a tremendous amount of data processing expertise.

 The solution here is to engage your claims system vendor to help you identify where the information is being housed and how it can be retrieved to allow members to service themselves through a portal and/or mobile app. In some cases, it may require a retrofit to re-enable capabilities that were deactivated or repurposed in the past due to a lack of business need. In other cases it may require additional effort to reconfigure the system.

 The IT department will then need to do the heavy lifting to ensure these new data elements are made available to members. Making this investment before the new plans are made available on the exchanges will reduce expense and member dissatisfaction down the road.

**Greater Investment in Education**

 Plans that made the move from Medicaid Managed to the public exchanges quickly discovered how important member (and staff) education is to success.

 As we have seen, plans purchased through the exchanges introduce a higher degree of complexity compared to a Medicaid plan. They can be confusing and difficult for members to understand, especially for those without prior experience purchasing or using commercial health insurance. Payers realized they need to provide a whole new layer of education about the basics of health insurance, such as definitions of common industry terms written in simple language, to prospects and customers. This education provides two key benefits.

 First, it helps these new prospective customers understand what the plan offers. While you may think terms such as “family deductible” are self-explanatory, experience shows they are not. Providing simple descriptive information helps prospective members make better decisions about their plan.

 Many of the people who were new to health insurance were nervous about making the wrong selection. Providing materials that are easy to understand helps create a comfort level that simplified the decision.

 The second benefit gets back to the consumer experience. When prospective members first come to your website, they may be there to look at pricing. But they are also subconsciously comparing the online experience to those they’ve had on iTunes, Amazon.com and other retail sites. The more the user experience meets their expectations, the more appealing their perception of your offering will be.

 Having materials on the web portal or mobile app that are clearly written in everyday language (rather than insurance jargon), and architecting the navigation in an intuitive, consumer-centric way, goes a long way toward winning the business. Making help available in context, e.g., having an explanation about deductibles in the section where members look up information about their deductibles, further cements the idea that you are the better option. This same approach should carry over into all communications with members – email, regular mail, social media, etc.

 Finally, it will likely require additional training for your customer service staff. While they may be excellent at explaining the components of a Medicaid Managed plan to members, they will need to learn how to explain all of the new pieces of marketplace plans in terms that are easy to understand – even by those with no prior experience with insurance.

**Make a Smooth Transition**

 While the rewards are appealing, transitioning from a Medicaid Managed plan to the state and federal exchanges requires advance preparation, effort, and investment. There are new skills, capabilities, and technologies required for your organization to prosper in that environment.

 Know what you’re getting into, and learn from the experiences of those who have already made the leap. With the proper planning, and the right people and technology to execute it, you’ll be in a better position to ensure ongoing success.

*Mike Gordon is the Chief Product and Strategy Officer at Healthx. He has more than 23 years of software and information technology experience, with extensive expertise in product development for healthcare payer organizations. His passion is developing innovative, disruptive solutions that will transform the healthcare industry. He can be reached at* *mgordon@healthx.com**.*