Are you making the right decisions?

Exchange business under pressure: Risk payments and growth potential

This is a critical juncture for health plans involved in the exchange business as concerns rise about the security of risk payments under the 3Rs (reinsurance, risk corridors, and risk adjustment). Already, risk corridor payments are forecasted to only be a fraction of what was expected, and some health plans may find themselves returning payments if and when the CMS conducts audits of monthly enrollment data. However, this is not just about future solvency; it is also about future strategy. Indeed, those able to improve the efficiency of their exchange business today should be well placed to make the right decisions to grow tomorrow.

In some states, issuers also need to reconcile against state-based marketplaces, thereby creating an additional level of complexity.

Those health plans that took a conservative approach to 3Rs receivables in the past should feel vindicated. Those that did not are increasingly starting to recognize that a large portion of their risk-related payments from CMS (the Centers for Medicare and Medicaid Services) may actually be at risk. And, as a result, executives are losing faith in their balance sheets and financial forecasts.

Risk payments at risk

For many, the issue has been heightened by persistent challenges reconciling and submitting exchange business data. The challenges are many: lack of member-level reconciliation of enrollments and disenrollments, payments, or Advanced Premium Tax Credit payments; no exchange feedback on involuntary enrollments; lack of clarity on whether simplified or standard Corporate Social Responsibility calculations should be used; and EDGE Server reconciliations that result in unexpected "kick outs." In some states, issuers also need to reconcile against state-based marketplaces, thereby creating an additional level of complexity.

At the same time, some of the existing risk payment mechanisms are coming under stress. CMS has already suggested that it will only pay 12.6 percent of existing risk corridor payments to health plans in 2015 (leading to a $2.5 billion shortfall in payments this year). The reinsurance program—which paid out $7.9 billion in 2014—is due to end next year. Some sources at CMS are starting to worry that the loss of risk payments could lead to "solvency and liquidity challenges" for some health plans.[1]

This is not just about hitting 2015 financial targets and forecasts. With pricing for 2016 already submitted—largely based on expected risk payment equalizations—many health plan executives are now starting to see the longer-term implications of these challenges and are re-evaluating their strategies. And they are getting increasingly worried.

Many of the leading health plans have started to recognize the risk and are working hard to come to terms with what it means to their businesses.

An unenviable position for everyone

Today's situation is not entirely surprising. The rollout of the exchange program did not unfold exactly as planned. In the push to meet deadlines, many of the more process-oriented components of the program were lost. The rollouts of American National Standards Institute (ANSI) 820 (enrollment transactions) and ANSI 834 (payment transactions) continue to cause data transfer challenges. Continuous updates and iterations to the requirements from CMS are creating deep uncertainty and complexity for health plans. As a result, health plan executives have had to create and adjust their strategies on the fly and, without a CMS system of record to reconcile against, will continue to operate virtually in the dark.

The urgency to address reconciliation issues is further highlighted by growing exchange enrollment and the resulting decrease in uninsured individuals. Paid enrollment via the federal and state exchanges increased from 6.4 million people at the end of 2014 to 9.9 million as of June of 2015.[2] Overall, 15.3 million adults have transitioned from uninsured status to insured from the beginning of ACA enrollment in 2013 to the present. This represents a decline in uninsured individuals from 20.3 percent of the population to 12.6 percent.[3]

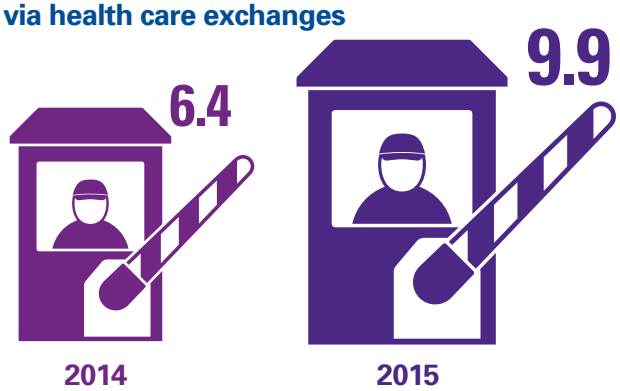
The experience to improve

Although there is much at risk and growing uncertainty, the reality is that most health plans now have about two years of experience under their belts—more than enough to start improving the efficiency of their exchange business reporting.

When we work with health plans to look at their exchange business, we often find a wide range of challenges that together manifest into massive risks down the road. Some are experiencing problems with their enrollment, billing, and collection data—enrollment dates do not match or enrolled customers have switched plans and data is not being collected and reported consistently across the business. Others are facing numerous enrollment-based customer service calls that lead to higher call times and longer, backed-up queues. Still others have had to make frequent changes to their actuarial models. These events are early indicators of future challenges with the exchange business.

Many of the leading health plans have started to recognize the risk and are working hard to come to terms with what it means to their businesses. We now spend a lot of our time helping health plan executives assess where they stand relative to their claims, whether their processes and controls are operating effectively, and what the liabilities and impacts may be if they expand into a new state or product.

Growth (in millions) **of paid enrollment via health care exchanges**



1 http://www.modernhealthcare.com/article/20151001/NEWS/151009996

2 http://www.modernhealthcare.com/article/20151001/NEWS/151009996

3 Department of Health and Human Services (2015). Health insurance coverage and the Affordable Care Act, ASPE Datapoint.

Taking the right steps

In our collective experience, there are six things that leading health plans are doing to start addressing the efficiency and effectiveness of their exchange business reporting.

1 **They are asking the right control questions.** As health plans move to grow their businesses, key decisions—particularly around pricing—will need to be made. Leading health plans are making sure they have the right controls around who makes those decisions; what assumptions they are based on; how they are analyzed, modeled, and monitored; how they are filtered through the organization; and who takes accountability and ownership for them.

2 **They are thinking strategically about the implications.** Realizing they cannot necessarily rely on credits to help fund their premiums, a growing number of health plans are starting to focus on larger strategic issues related to how they will develop their plans and pricing going forward. Leading organizations are creating strategic plans to essentially hedge their bets against the loss of their expected risk payments.

3 **They are working hard to identify their problems.** The reality is that—as with any new system—BUSINESS regulators expect problems to arise in the collection and reporting of data. But they also expect health plans to have a clear process for identifying, understanding, and remediating those problems. Those that know they have a problem and yet fail to address it may find themselves facing particularly harsh penalties from regulators.

4 **They are focusing on data governance.** In the short-term, many of the leading health plans are already taking steps to improve their data controls and governance to ensure they are submitting the right data to CMS servers and that it is being submitted in accordance with the current requirements. It takes a lot of effort to get information into the CMS server; making sure you are reporting the right information in the right way is critical.

5 **They are improving communication.** Leading health plans are focused on driving greater accountability by creating better lines of communication between all of the different groups involved in data collection and reporting. When problems are identified, they are finding effective ways to communicate that information back to enrollment, billing, or call centers so that they can take a larger role in resolving the issues.

6 **They are undertaking hindsight analysis.** The top health plans are going above and beyond CMS expectations and are using their data and CMS data (such as their 834 transactions) to look at their reinsurance and risk adjustment results and create likely predictive scenarios to help drive their business planning. Lining those insights up against possible audit protocols will add further value.

This is a critical juncture for health plans. The reality is that they can no longer count on risk payments to "make them whole" in the exchange business. As a result, current pricing assumptions and models may be severely outdated and risky, as they are based on inaccurate information and false expectations.

These days, it seems everyone is talking about healthcare transformation. However, "transformation" really only focuses on a subset of what is currently happening in the U.S. healthcare ecosystem and does not adequately address what is happening more broadly at a systemic level.

At KPMG, we believe that health plans, providers, and life sciences companies should be thinking beyond transformation and focus more on healthcare "convergence" and the broader implications of operating in a more collaborative and integrated U.S. healthcare delivery model. While transformation of current operations is likely going to be a business requirement, the real question for forward-looking organizations is what role they plan to play in a new and more converged health system.

Related links

The more I know, the less I sleep: Global perspectives on clinical governance – Examining the views of over 20 leading healthcare practitioners from around the world, this report offers valuable examples of best practice and shows how governance is the critical glue that can bring together delivery and assurance.

What Works - Paths to population health - Achieving coordinated and accountable care – Explore the steps health organizations need to consider in order to achieve coordinated care.

A Model for Value: Aligning provider IT organizational models in a value-based world – The most pervasive challenge for providers in the near future may be creating value-based payment models. Beyond ICD-10, Meaningful Use and Electronic Health Record (EHR) integration, all components of a new type of healthcare system, value-based payment is where meaningful, long-term change will be seen.

Health Care and Cyber Security – Increasing threats require increasing capabilities – This report helps healthcare providers and health plans better understand their greatest vulnerabilities for cyber threats and discuss ways to become better prepared and increase their organizational capabilities at all levels.

Healthcare 3.0: Helping organizations unlock the value of big data – Technology will revolutionize healthcare. The question the industry needs to answer is how much of this change is driven by healthcare organizations themselves or other forces.

Gaining an advantage - Joining a Medicare Advantage network may offer providers a stepping stone to risk sharing and value creation – As fee-for-outcomes accelerates, joining Medicare Advantage (MA) networks is one way providers can meet federal mandates. In our newest white paper, Gaining an Advantage, see how MA can help hospitals and individual physicians respond to the "consumerization" of healthcare; improve short- and long-term patient outcomes; and move toward risk-based contracting.

Contact us

Dion Sheidy
Partner
615-248-5519
dsheidy@kpmg.com

Mark Jamilkowski
Mananging Director
212 954 7410
mjamilkowski@kpmg.com

Joe Parante
Principal, Healthcare Advisory
267 256-2950
jmparente@KPMG.com

Gillie McCreath
Director, Healthcare Advisory
813 301 2163
gmccreath@kpmg.com

Eric S. Lowy
Director, Healthcare Advisory
410 949 8445
elowy@kpmg.com@kpmg.com

About KPMG

KPMG is a global network of professional firms providing audit, tax, and advisory services. We operate in 155 countries and have 162,000 people working in member firms around the world. The independent member firms of the KPMG network are affiliated with KPMG International Cooperative ("KPMG International"), a Swiss entity. Each KPMG firm is a legally distinct and separate entity and describes itself as such.

kpmg.com/socialmedia

kpmg.com/app

Download on the App Store