This is a critical juncture for health plans involved in Federally facilitated Marketplaces and/or State-based Marketplaces (collectively Marketplace or Exchange) business. There are some concerns regarding the risk payment programs (i.e., the reinsurance, risk corridor, and risk adjustment programs). For example, risk corridor payments appear to be a fraction of what was expected, and there has been a call for a review of the risk adjustment process and formulas by many plans operating on exchanges. Additionally, some health plans may find themselves returning payments if the Centers for Medicare & Medicaid Services (CMS) conducts audits of monthly enrollment data impacting the advanced premium tax credit (APTC) or cost-sharing reduction (CSR) programs. While these cash flow concerns may have an impact on future solvency, it is also about health plan strategy. Health plans able to improve the efficiency of their internal financial processes and operations related to 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.

Risk payments at risk
In our experience in working with various health plans, there have been challenges reconciling and submitting Exchange business data. The challenges include: lack of member-level reconciliation of enrollments and disenrollments, reconciliation of payments due, such as APTC and CSR, limited visibility into exchange involuntary enrollments; confusion related to using simplified or standard CSR calculations for balance sheet bookings; and EDGE server reconciliations that result in unexpected “kick outs.” Issuers offering products on state as well as federal marketplaces have the additional complexity of reconciling against state-based marketplaces as well.
At the same time, CMS has paid 12.6 percent of existing risk corridor payments to health plans in 2015 (leading to a $2.5 billion shortfall in payments in 2015), which has prompted some health plans to seek legal action. The reinsurance program—which paid out $7.3 billion in 2014—is due to end next year. The risk adjustment program and its assumptions and calculations are being challenged as well.

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.

A new market, new challenges

Today's situation is not entirely surprising. In the push to meet deadlines, many of the more process-oriented components of the program were delayed. The rollouts of American National Standards Institute (ANSI) 820 (payment transactions) and ANSI 834 (enrollment transactions) continue to cause data transfer and reconciliation challenges.

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 12.7 million as of January 31, 2016. Overall, 20 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 11.5 percent. The newly insured continue to represent a challenge to issuers with uncertain care needs and potentially challenging cost management issues.

Atlantic, there are still significant numbers of plans being offered, with differing levels of competition and choice by state. Some health plans are announcing profits. For others, improvements are needed to be competitive and realize the opportunity an Exchange strategy offers.

The experience to improve

Health plans now have about two years of experience under their belts—more than enough to start improving the efficiency of their Exchange business, both in terms of operations as well as reporting.

In our experience with health plans and their Exchange business, we often find a wide range of challenges that together have the potential to become 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.

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 and strategy.

Although a few high-profile health plans have announced they are leaving the Marketplaces due to financial losses, 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 and strategy. 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

<table>
<thead>
<tr>
<th>Year</th>
<th>Growth in Paid Enrollment (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>6.4</td>
</tr>
<tr>
<td>2016</td>
<td>12.7</td>
</tr>
</tbody>
</table>

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.

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.

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. For example, The 2017 Benefit and Payment Parameters Final Rule discusses penalties for health plans failing to comply with RA and reinsurance program data requirements, as well as elimination of the good-faith compliance safe harbor that was in place for 2014 and 2015.

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 Exchange (EDGE) servers and that data is being submitted in accordance with the current requirements; making sure you are reporting the right information in the right way is critical. Furthermore, data savvy health plans are customizing reports and analysis to ensure transparent communications with state regulators regarding utilization and related trends to further support rate actions and help shape regulatory policy and decisions.

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, the plans 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.

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. Additionally, they are using this data to establish or improve risk stratifications of their enrollment to improve efficiency and impact of medical management programs. This is a critical competency required for future strategic decisions. Lining these 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 LLP (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.

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