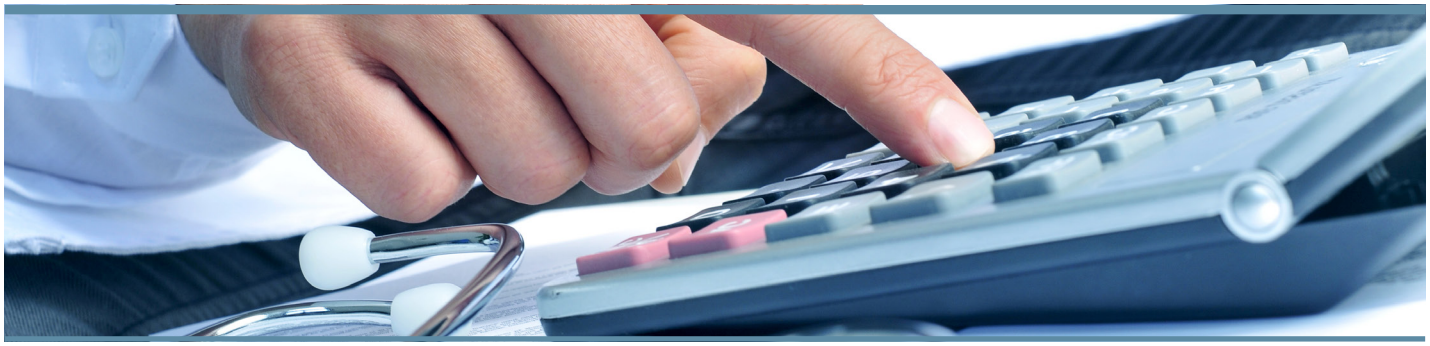

Profitability on ACA Public Exchanges: In the Eye of the Storm or the Heart of the "Churn"?

Participating in the public health insurance exchanges established by the Affordable Care Act (ACA) has been a tremendous financial strain for most health plans. Approximately three-quarters of exchange plans lost money in 2015.

Medicaid specialists Centene and Molina have been among the few bright spots on the ACA exchange markets in the first two years. Both companies report growing profits and expanding membership. In this Executive Insights Healthcare Spotlight, we examine how these few profitable exchange plans may yield some insights — and raise key questions — as to how sustainable exchange plans will evolve.

Rough Beginnings on the Exchanges

Many national and large commercial health plans reported significant losses from their exchange lines of business in 2015. For example:

- UnitedHealth lost $475 million (for approximately 500,000 enrollees) and has announced that it will exit all but "a handful" of states in 2017
- Aetna lost more than $100 million (for approximately 1 million enrollees)
- HCSC lost $1.5 billion (for approximately 1.6 million enrollees)
- Highmark lost $590 million (for approximately 350,000 enrollees)
- While still in the black, Anthem reportedly missed its profit targets for exchange products, which lowered overall earnings and signaled declines in enrollment in 2016 (from 791,000 enrollees in 2015)

There has been much discussion about how public exchanges are everything health plans had feared, and then some. The risk profiles and medical needs of those who have enrolled are worse than anticipated. Even fewer "healthy" members than forecasted have enrolled to balance out the risk pool. Utilization rates have been high, steering members to appropriate care settings (non-ER) has been extremely challenging, and out-of-network utilization has been equally difficult to control.

In response to these challenges and losses, many exchange plans increased premiums by more than 20% from 2015 to 2016. Many have dropped PPO plans from their exchange menu offerings, stopped advertising their exchange products, and reduced sales commissions for brokers, while others are re-evaluating their provider networks or seeking to renegotiate lower rates. Some are pulling out of selected markets or have ceased expanding into new geographies. A few have publicly questioned the sustained viability of the public exchanges, called for regulatory changes, or threatened to exit the exchanges completely.

In contrast, Centene and Molina have experienced substantial enrollment increases with positive profit margins. Centene grew from 74,500 exchange members in 2014 to 146,100 members in 2015, while Molina grew from 8,000 in 2014 to 266,000 in 2015. With the acquisition of Health Net, Centene's membership increased to 683,000 across 15 states in the first quarter of 2016. Both Centene and Molina raised premiums only by about 4% in 2016.

Success Factors

Two key questions emerge when comparing the experience of Medicaid specialists like Centene and Molina with that of multiline plans:

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1. Was focused targeting of the "churn" of members between their existing Medicaid plans and the subsidized public exchange the winning positioning strategy of the Medicaid specialists?
2. Were the Medicaid specialists operationally more ready for the challenges of administering a public exchange product, including better preparation for member behaviors and utilization management challenges?

The keys to Centene's and Molina's success may well stem from their Medicaid heritage. By positioning themselves as a "Medicaid player," repurposing their insights from working with low-income populations, and applying the same budgetary disciplines that allowed them to succeed in the Medicaid environment, these plans may have had a head start in preparing for exchange member populations. Some of their key strategies include:

- Using existing, low-cost (Medicaid) networks
- Leveraging an operational platform — including utilization management (UM), care management, member eligibility and retention, and claims administration — geared toward Medicaid and narrow networks
- Targeting lower-income subsidized exchange enrollees and positioning themselves for continuity of coverage for the Medicaid-Exchange membership churn
- Offering exchange products in core geographies only
- Focusing on proven member identification, outreach, engagement and behavior change strategies

Anchoring to Medicaid Rates

Generally, health plans were expecting exchange reimbursement rates close to Medicare, but many have found it hard to negotiate with providers for rates significantly lower than commercial. As traditionally Medicaid-focused health plans, Centene and Molina arguably had a different starting point for negotiations with providers, anchoring to Medicaid rates. They had the compelling rationale that their exchange offerings were aimed at providing continuity of health coverage for their Medicaid members, fluctuating between Medicaid eligibility and a subsidized public exchange plan. As such, they were able to begin with their existing Medicaid networks of providers as the foundation. By contrast, most nationals and large commercial plans used their traditionally commercial network as the starting point, where providers were accustomed to rates that may be 1.5x or 2x Medicaid rates — a very different starting point for negotiations.

Operationally Prepared for the Exchange Population

The Medicaid specialists entered the exchange business with their skills already honed for key member-directed levers of medical cost controls: utilization management and member engagement for care management. Key strengths include ensuring that their medical policies and network design adhere to and support the benefit design (as defined by Medicaid), the UM processes adhere to benefit design, and the claims logic upholds the UM decisions. In addition, they could apply member outreach, engagement and behavior change strategies that are time-tested on Medicaid members. Unlike nationals who started from the commercial heritage of highly customizable, broad-network-design products, Medicaid's operational platform was easier to adapt to exchange products.

What Are the Lessons for a More Sustainable Exchange Future?

The ability to "play the Medicaid card" is not available to all. But are there elements of the Medicaid specialist strategies that others can successfully adapt?

- For those with Medicaid business, can they better leverage the existing Medicaid infrastructure, practices and/or brand? Some commercial plans have already aligned their individual and exchange businesses to government programs.
- What opportunities exist to push contracted rates closer to the medical cost realities of exchanges? Even if unable to "anchor to Medicaid rates," are there ways to continue to push for more sustainable rates?
- As exchange enrollment grows, will providers be more receptive to renegotiating lower rates, recognizing that the exchange line of business is a "new norm" for all in healthcare — payers and providers alike?
- Are there further surgical, narrow-network levers to pull (less "opt-in," but rather selecting those willing and able to be true partners)? Which markets allow for such provider partnerships?
- Are the operational capabilities in place to adhere to and uphold narrow network designs? Do the UM processes uphold the benefit and network designs? Does the claims logic uphold the UM decisions?
- How might member management best practices from Medicaid (e.g., outreach, engagement, care planning, triggers for intervention) apply to exchange membership?

Contact

To learn more about our insights on public exchanges and strategies for commercial plans, please contact healthcare@lek.com.

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