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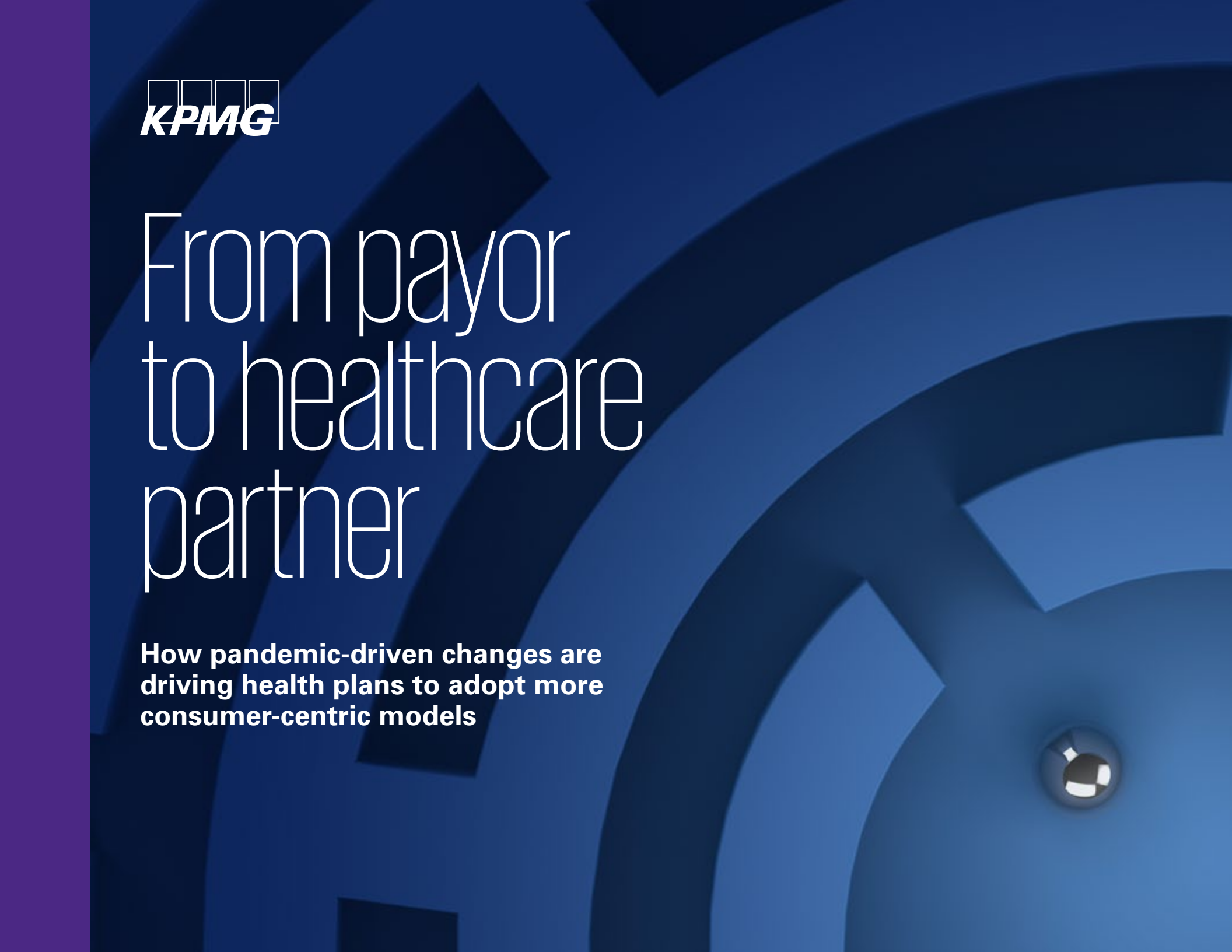
From payor to healthcare partner

How pandemic-driven changes are driving health plans to adopt more consumer-centric models



From payor to healthcare partner

On the surface, the health plan sector has been minimally disrupted by the pandemic. Healthcare utilization and claims activity were at historic lows in the first half of 2020 due to canceled elective procedures and routine care. As a result, payors realized record profits. However, sky-high profits mean that payors' medical loss ratios (MLRs) failed to reach minimum standards set by the ACA. CMS reports that more than 11.2 million people qualified for ~$2.5 billion in MLR rebates from health insurers in 2020,[1] and KFF estimates that 2021 rebates will total $2.1 billion for 10.8 million members.[2] Potential rebates in 2022—as well as premium levels—will be largely impacted by several factors: how much pent-up demand for care is rescheduled, whether forgoing care has had a negative impact on the health status of certain populations, and the percentage of the American public that is vaccinated and how soon.[3]

Claims were low enough in 2020 to result in profitability for insurers, and profits were not significantly offset by the fact that many payors paid in full for COVID-19 testing and provided waivers on cost sharing for COVID-19 treatments.[4] Outsized profits resulted in MLRs that reached double-digit percentage point drops among large payors like UnitedHealth and Cigna, 3 percentage point decreases in the group market, and 4 percentage point drops across Medicare Advantage plans. (In contrast, although Medicaid saw a drop of 7 percentage points, most plans still met the 85 percent minimum MLR thresholds even without accounting for potential adjustments.[5])

Looking forward, payors that invest profits into new clinical- and quality-driven capabilities will be able to offer their enrollees personalized experiences that align with the larger shift toward consumerism in healthcare. The industry has already been forced by the pandemic to take several steps in this direction and the resulting changes – more widespread use of virtual care, shifts from inpatient to outpatient services, a greater focus on connectivity and wellness, and more – will likely be permanent. This paper goes into greater detail on the six trends to watch in 2021, as well as on how payors can capitalize on these trends to become "healthcare partners" with their enrollees and forge a more consumer- and quality-centric role in the emerging post-pandemic healthcare system. ●

Becoming a healthcare partner means forging a more consumer- and quality-centric role in the healthcare ecosystem.

Top six trends to watch in 2021

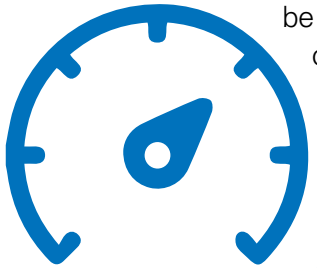
1. **Increased member utilization of elective procedures**
2. **Enrollment shifts due to unemployment and aging Baby Boomers**
3. **Greater scrutiny of government insurance products**
4. **Reevaluation of telehealth programs in a post-pandemic world**
5. **Greater demand for wellness services and health equity**
6. **Payors become consumer-centric healthcare partners**

The transition from payor to healthcare partner

Acting as healthcare partners, payors can guide consumers through the entire patient care experience and drive better health outcomes and lower cost of claims, and, ultimately, increase customer loyalty. In recent years, payors have been threatened with disruption of these customer relationships by the potential market entry of non-traditional players with consumer engagement expertise. However, that threat may have been overstated, as is evidenced by the dissolution of the Amazon, Berkshire Hathaway, JP Morgan partnership aimed at lowering the cost of health insurance. The following is a closer look at the top six trends to watch in 2021 and actions payors can consider as they seek to become consumer-centric healthcare partners.

Trend #1: Increased member utilization of elective procedures

Over the course of 2021, utilization of healthcare services is expected to rebound and increase by ~1–10 percent. The percentage range reflects the lack of clarity around whether certain canceled elective procedures will ever be rescheduled. As of October 2020, specialty physicians such as dermatologists and urologists, as well as adult primary care physicians, were exceeding their pre-pandemic baselines.[6] However, pulmonologists and behavioral health provider visits were substantially below their baselines.[7]



Further, recent studies show that the resumption of elective and routine care varies by demographics.[8] In the early stages of the pandemic, rates of postponing care were relatively consistent across age groups. However, as time went on and medical practices reopened, elderly patients were more likely to reschedule nonemergency visits and procedures than younger adults. If this trend continues, there may be more significant declines in medical spending among the commercially insured than among Medicare members.[9] On the other hand, if deployment of vaccines continues on its current trajectory and unemployment decreases, commercial health plan members will likely schedule or reschedule higher-end care.

As healthcare partners, what should payors do?

Health plans have an opportunity to engage and educate their members with assessments of the trade-offs between risks of postponing or avoiding necessary care and potential COVID exposure. By helping members navigate a healthcare environment that has become increasingly complex due to COVID-19, payors will enhance their role as healthcare partners and, thereby, increase member loyalty and potentially help stabilize the volatility in utilization experienced over the past year.

Trend #2: Enrollment shifts due to unemployment and aging Baby Boomers

The dramatic increase in unemployment in 2020 resulted in approximately 14.6 million people losing employer-sponsored insurance (ESI)* coverage.[10] All in all, this could represent as much as an 8 percent reduction in total ESI coverage.[11]

Job losses and economic instability have negatively impacted commercial health plans' premium collection,[12] and have driven more individuals to the Affordable Care Act Exchanges (Exchanges), as well as to Medicaid.[13] At the same time, the growing number of aging Baby Boomers is fueling a steady increase in Medicare Advantage enrollment.

Federal and state exchanges: The Biden Administration's recently enacted American Rescue Plan Act allocates $34 billion in health plan subsidies to Americans who buy their insurance on the Exchanges through 2022, with some industry experts predicting that the subsidies may become permanent.[14] The provision—which extends ACA subsidies to higher-income individuals who didn't previously qualify and increases subsidies to lower-income people who already qualified[15]—will likely result in coverage for about 2.5 million uninsured Americans between 2021 and 2023 (800,000 in 2021, 1.3 million in 2022, and 400,000 in 2023[16]), according to the Congressional Budget Office.[17] And, if enhanced subsidies are made permanent, the ACA marketplace could grow by 5.1 million members, according to a recent Urban Institute analysis.[18]

The Biden administration is also offering the 2021 Marketplace Special Enrollment Period (SEP), an extra three-month enrollment period that started on February 15[19] and was recently extended even further to August 15.[20] To support this initiative, CMS has allocated $50 million for an education campaign to attract individuals and families to the healthcare.gov site, the largest campaign since the ACA was launched.[21] And HHS recently announced that, for the 2022 plan year, CMS will make $80 million of grants available to Navigators in Federal Marketplaces. This funding represents an eight-fold increase from the previous year.[22] These are strong signals from the new administration that they are committed to steering people to the Exchanges and improving access.

Going forward, early enrollment statistics show signs of continued momentum and growth in the federally facilitated individual and small group market. Even after accounting for the loss of Pennsylvania and New Jersey coverage from Federal enrollment numbers (both states transitioned from the Federal Exchange to state-based Exchanges), there was a 7 percent increase in ACA plan selections during the late-2020 enrollment period.[23] And, according to a recent announcement from HHS secretary Xavier Becerra, there have already been more than 1 million enrollments during the special enrollment period.[24]

Payors are already trying to improve their market positioning by focusing more on Exchange products. In late 2020, 30 insurers entered the exchange market for the first time, and 61 expanded the areas they serve within states.[25] In early 2021, the number of new payors on the Exchanges increased by 11 percent year over year,[26] and, in Florida alone, five insurance companies increased their on-exchange plan count by 25 percent or more.[27]

* As upper-bound ESI losses are the only available estimate, it is likely that roughly half of workers who have lost jobs with ESI have been furloughed or temporarily laid off and continued to be covered by ESI.

Trend #2: Enrollment shifts due to unemployment and aging Baby Boomers *(continued)*

Medicaid: Medicaid plans stand to realize significant growth this year, as more of the unemployed move toward Medicaid instead of commercial plans. Further, more individuals are now eligible to apply for Medicaid as some states that opted into Medicaid expansion under the ACA have expanded their income eligibility criteria for adults from 100 percent to 133 percent of the federal poverty limit.[28] Acknowledging that groups and communities of color have been hit much harder by the pandemic, the American Rescue Plan is designed to combat systemic racism in the healthcare system by ensuring equitable distribution of vaccines and supplies and expanded healthcare services that address healthcare inequities.[29]

Medicare Advantage: With the aging of the population, there has been continued growth in Medicare and expansion of the share of Medicare represented by Medicare Advantage (MA) plans. As of December 2020, the MA population totaled 24.8 million lives, which represents 39.5 percent of the overall Medicare population.[30] Analysts project that the percentage of Medicare represented by MA will reach nearly 50 percent by 2030.[31] Currently, there are 3,550 MA plans available for individual enrollment nationwide, which represents a 13 percent increase over 2020.[32] For example, Centene has announced plans to increase its MA footprint by 30 percent and Cigna has said it will expand its MA footprint in five new states and 67 new counties, both in 2021.[33] While the growth of this market is already significant, the possibility that the Biden administration will lower the minimum age for Medicare could increase the addressable population even further.

As healthcare partners, what should payors do?

In the coming year, payors have a significant opportunity to grow enrollment by focusing on the evolving needs of individuals and families within their marketplaces and providing additional education and outreach opportunities regarding current on-exchange, Medicaid and Medicare product offerings, as well as how to transition between products as life circumstances warrant. Payors will want to gain some certainty around member churn as the economy fluctuates. To this end, data analytics can help predict patterns of migration between employer-sponsored health plans, the Exchanges, Medicaid, and Medicare, and, thereby, help with risk prediction to protect medical loss ratios.[34]

Trend #3: Greater scrutiny of government insurance products

With expansion into federally facilitated marketplace exchanges and other government plans like Medicare Advantage and Medicaid products, health plans must be prepared for additional oversight and regulatory reviews and audits from CMS and the states. In addition to the aforementioned MLR Examinations, other potential audit areas could include Federal Market Conduct Examinations, FFE Compliance Reviews, audits of Medicare Parts C and D organizational/coverage determinations, appeals and grievances, as well as Part D formulary and benefit administration. Although some of these programs may have been postponed or scaled back during the public health emergency, payors should expect increased scrutiny under the Biden administration.

As healthcare partners, what should payors do?

It is critical for payors to ensure that evolving policies align with proposed and anticipated regulations; that supporting documentation of procedures and processes are up to date; and that methods of assessing new regulations, updating policies and informing stakeholders are in place. Government payors emphasize oversight of important beneficiary protections, so a sharp focus on requirements may provide opportunities to not only meet but exceed expectations through consumer-centric policies and procedures. It is important to undertake staff training on upstream and downstream implications of new policies and ensure that departmental responsibilities and accountabilities are clearly defined. Further, payors should conduct risk assessments of external vendors to ensure their policies and procedures are in line and work with providers on managing utilization and bringing down costs.

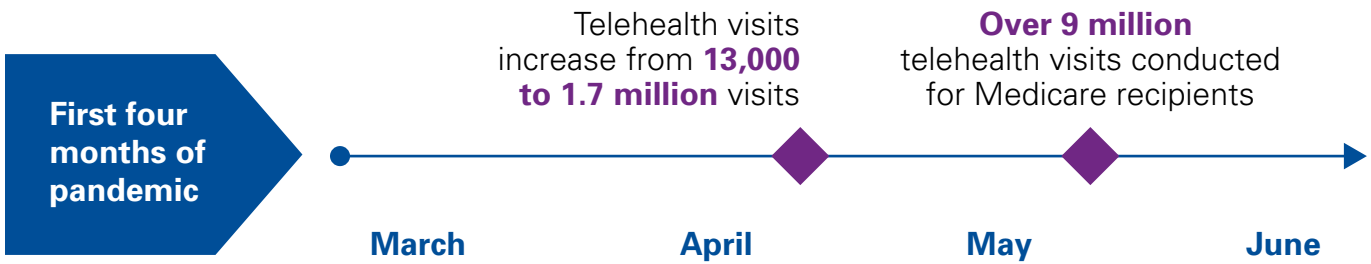
Trend #4: Reevaluation of the use of telehealth programs in a post-pandemic world

Since the pandemic began, consumers have increasingly relied on virtual health services not only to inquire about COVID-19 symptoms, testing and treatment, but also to keep regular check-up and chronic care appointments with their physicians. Many of the barriers to widespread telehealth usage were removed for the length of the public health emergency by legislative authority granted to HHS under the Coronavirus Preparedness and Response Supplemental Appropriations Act, as well as the Coronavirus Aid, Relief and Economic Security (CARES) Act.[35] Public health insurance programs were required to cover and reimburse for telehealth appointments regardless of where the service was received. Many state governments expanded telehealth in Medicaid programs, relaxing restrictions around provider licensing and online prescribing. And commercial insurers had the option to voluntarily cover telehealth by reducing or eliminating cost-sharing, broadening coverage for services, and expanding patient access to in-network telehealth providers.

Private insurers that followed this path during the pandemic reported a 4,000 percent increase in claims from the previous year.[36]

As healthcare partners, what should payors do?

Since virtual health services are likely here to stay, payors should work closely with federal and state governments on regulations that ensure both widespread access to telehealth and appropriate levels of payment and reimbursement. Payors may choose to acquire or ally with providers and extend virtual access to their patients. At the same time, it is critical to focus on reducing risks related to service overutilization; financial losses due to service and payment parity; inaccurate measurement of effectiveness and quality of care; and other forms of fraud, waste and abuse.



Trend #5: Greater demand for wellness services and health equity

2021 may be the year when access to health and wellness is available to all individuals regardless of racial and socioeconomic status through programs designed to promote health equity.

The time is ripe to engage patients in playing a more active role in staying healthy as many have already become accustomed to regularly taking their temperatures, remaining vigilant for potential COVID-19 symptoms, considering weight and comorbidities as higher health risk factors, and generally being more forthcoming about disclosing their health risks. Further, there is a need for specific wellness services due to some of the fallout from the pandemic, e.g., the increase in anxiety, depression and stress; the enduring reluctance to visit hospitals and doctors' offices for nonemergent procedures and visits; and concerns about boosting resistance to infectious disease by avoiding preventable illnesses.

Although it has long been known that less affluent communities bear greater health risks, the pandemic shed a spotlight on the need to advance health equity by addressing social determinants of health (SDOH) – economic stability, neighborhood and physical environment, education, food, and community and social factors. Greater understanding of these other sources of health risk can help payors improve actuarial underwriting, benefit design, member risk stratification, and closing gaps in care. Many payors are offering relief through not only benefits packages, but also through their charitable organizations as part of their Environmental, Social and Corporate Governance (ESG) programs. Medicaid managed care contracts are now required by the states to screen for SDOH needs and link members to community resources. Currently, 27 states screen for social determinants, 37 states help beneficiaries to access social services, and 35 states make social services referrals.[37]

As healthcare partners, what should payors do?

As healthcare partners, payors have numerous tools at their disposal to help members stay healthy and to drive health equity. For example, given widespread concerns about mental health and the decreasing stigma around treatment, many health plans are using data analytics to target patients in need with offers of more robust mental health benefits, such as free helplines, mental health coaching, stress management classes, and meditation apps. For those members concerned about their underlying medical conditions and overall ability to ward off illness, health plans can offer incentives for meeting self-care goals or for using wearable technologies to monitor their health.

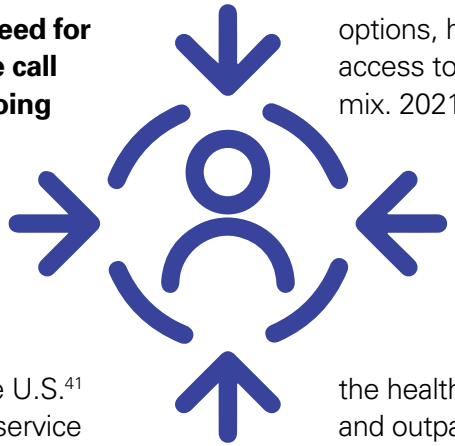
Payors are in a prime position to play a major role in supporting and supplementing SDOH initiatives as well. Payors can partner with providers, social services agencies, community-based organizations (CBOs), governments, and foundations on identifying SDOH needs, connecting patients with resources in their communities and analyzing the impact of SDOH interventions across patient populations. Further, SDOH ties in with the shift from fee for service to paying for quality and value, as payors are increasingly responsible for managing patients' healthcare costs over time. To this end, many payors are collecting data on members and beneficiaries to pinpoint the social needs with the potential to have the greatest impact on healthcare outcomes and costs. However, to derive real value from this data, there must be consistency across the payor sector around data elements and value sets used to measure SDOH.

Trend #5: Greater demand for wellness services and health equity *(continued)*

Although smaller carriers and Medicare Advantage plans are currently increasing their wellness benefits, the largest health plans have been offering these benefits for some time. Some representative examples include United Healthcare's Life in Motion program, wherein members who track their walking and meet predetermined goals can gain financial rewards deposited into their flexible spending accounts or prepaid debit cards[38]; Aetna's workplace-based wellness services that include biometric screening and health awareness campaigns and workshops[39]; and Cigna's Your Health First program through which members with chronic conditions like diabetes, asthma and heart disease can work with health coaches and learn how to better manage their conditions and avoid complications.[40]

Trend 6: Payors become consumer-centric healthcare partners

Although many of the trends above speak to the need for payors to become more consumer-centric, here we call out two other drivers of consumerism: (a) the ongoing progression to value-based care; and (b) vertical integration across the care continuum.



(a) Progression to value-based care: Becoming a more consumer-centric healthcare partner goes hand in hand with the long-awaited push toward value-based care – a move that many hope will ultimately curb health spending growth in the U.S.[41] Providers — especially those heavily reliant on fee-for-service reimbursement— took a huge financial hit in 2020 when they were forced to halt services to help stem the spread of the virus. As a result, there may be a greater appetite for value-based care arrangements with payors where providers are paid a certain amount per patient monthly whether the patient seeks care or not.

(b) Integration across the care continuum: Shifting care away from inpatient settings to less costly outpatient settings, including retail options, has been underway for many years. Now, expanded access to telehealth has been added to the outpatient provider mix. 2021 will likely see an evolution of this trend, given patients' preferences for the convenience of home-based care and continued reticence to enter healthcare facilities and provider offices based on fear of infection.

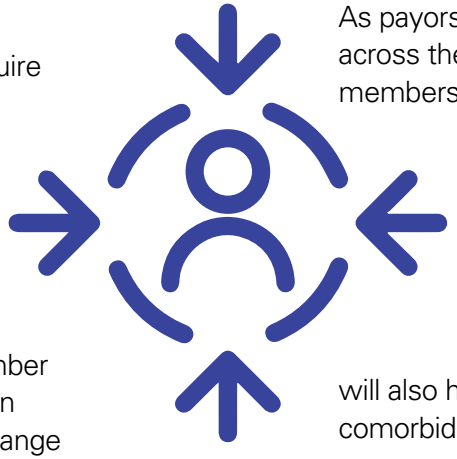
The pandemic has highlighted the need for greater convergence between previously siloed players in the healthcare supply chain, e.g., continuity between inpatient and outpatient care, cooperation between the government and the private sector, partnerships between competing pharmaceutical companies, and services that combine the healthcare and pharmacy benefit. Regarding the latter, we expect to see more momentum behind this trend as retail health settings – from CVS/Aetna to Walmart and Kroger's – expand their primary care models to include higher levels of care.

Trend 6: Payors become consumer-centric healthcare partners *(continued)*

As healthcare partners, what should payors do?

Mid- and large-sized health plans are continuing to acquire physician practices and build risk-based programs to effectively manage their members' utilization, improve access, and increase services and capabilities provided within a network. With a healthcare partner model, measures of quality and value must shift. Instead of measuring transactional value, e.g., sales, claims, and renewals, health plans should focus on demonstrating health outcomes, member satisfaction, retention rates, and reduction in appeals. In other words, value should be viewed as a mutual exchange and a way to optimize long-term financial impacts over time. As primary care providers and specialists merge or partner and services are more tightly integrated, payors will need to develop new reimbursement models for covering global care. As payors oversee and coordinate how all these pieces come together, there will be benefits not only for patients, but also for their own bottom lines.

As healthcare partners, payors should support sharing of patient records and a seamless consumer experience. Such an approach will not only ensure that communication between disparate providers is facilitated, but also help individuals have more informed discussions with their healthcare providers and help avoid adverse events that drive some hospital admissions and readmissions.



As payors and providers increasingly share patient data across the care continuum, payors can proactively monitor members' chronic conditions to better predict their needs and communicate with them in a more timely manner.[42] Payors can play a role in ensuring that patient records for care received in a retail setting are integrated with care received in traditional settings and via telehealth encounters to lower the risk of duplicative or contraindicated care decisions. Access to a complete and longitudinal electronic health record will also help reduce clinical errors by ensuring all test results, comorbidities, medication regimens and previous procedures are accounted for. Of course, payors must at the same time take more proactive steps to up their cyber-security and privacy measures, and to communicate those measures to members. ●

Conclusion

Although 2020 wasn't as challenging for payors as for hospitals or specialty physician practices, the sector will go through a great deal of change in 2021 and beyond. The need to achieve convergence with providers and other stakeholders in an integrated, consumer-centric ecosystem is only going to increase.

Viewing enrollees as consumers requires payors to shift their role to healthcare partners – partners that will meet enrollees where they are and help them to be informed and engaged consumers by guiding them through rescheduling of elective procedures, offering new products on the federal exchanges and through Medicare Advantage and Medicaid, working with federal and state governments to ensure that telehealth waivers are maintained even after the pandemic is over, fostering wellness and advancing health equity, furthering the progression of value-based care, and ensuring continuity of care.

Payors are not immune to the shift to consumerism happening across all industries. Ultimately, the most successful payors will use their new roles as healthcare partners to help their members stay healthy—and loyal—in the years to come.

How KPMG can help

KPMG's payor strategy services help payors leverage customer data and disruptive technologies to increase brand loyalty through enhanced customer experience. As payor operations focus on customers, they can provide them with more value and a streamlined experience across channels.

KPMG understands the technical, clinical, and business components of the equation and can help healthcare organizations create a stronger alignment between business, financial, and IT strategies to facilitate growth in a proactive, rather than reactive, manner. KPMG Healthcare IT professionals can accelerate speed-to-value to optimize IT costs through technology-enabled business transformation, service consolidation, outsourcing or insourcing, labor optimization, and reduction of third-party IT spend, while managing risk, compliance, data integrity, governance, and controls.

KPMG often starts its consulting engagements with a facilitated workshop to thoroughly understand a client company's current state process maturity and to align stakeholders on business needs, vision, guiding principles, and strategy in order to achieve a future state. The execution of these sessions through U-Collaborate provides validation and specification for the project approach. U-Collaborate is a powerful facilitation methodology to enable stakeholder alignment, as well as accelerated design and mobilization across functions, business units, or the enterprise. This methodology has been leveraged more than a thousand times in multiple countries, with each event session customized for the client.

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