EXPRESS SCRIPTS®

PUBLIC HEALTH EXCHANGES

Unmanaged risk. Untapped opportunity.

Sustainable solutions are necessary to help health plans manage unprecedented risk

While plans in the evolving Health Insurance Marketplace ("exchanges") face many unique challenges, one is universal – profitability. Plans struggle to provide compliant, effective healthcare at a sustainable profit. Fortunately, solutions are also evolving to tackle the unprecedented risk associated with this new member population.

Today, effective risk strategies help ensure plans get the credit they deserve in the government's evaluation of their risk. They also address risk management at its source through better care and improved outcomes for members. Express Scripts offers a unique set of capabilities to manage risk, positively impact profitability and provide superior care for members.

Risk is uncontrolled, unpredictable and an ongoing concern for nearly every plan in the exchanges.

An exchange market and population in flux

In healthcare, the new normal is a constantly evolving marketplace. Some brand-name plans are exiting the market and others are joining. Patients with expensive health conditions and no prior insurance account for the vast majority of enrollments. Many patients are receiving proper healthcare for the first time in their adult lives. The power of consumerism, as noted in *7 Ways Healthcare Will Change by 2017*, is evident in the exchanges. Exchange plans can no longer manage risk by relying on tactics such as denying membership based on preexisting conditions or underwriting risk across a pool of employer members.

Plans also face significant membership churn within their exchange book of business through a constant influx of new members and plan shopping. This uncertainty means plans struggle to understand the risk of their new population.

Exchange enrollment, premiums and spending in this nascent market remain extremely fluid. In fact, to cover losses from mandated risk programs, health plans are accumulating debt at almost double the rate we saw in 2011 – borrowing $6.4 billion in 2015 alone[1].

Most plans struggle to accurately and completely document the risk of their patient population.

Plans need both risk adjustment and risk management strategies

To improve the health of this unique population, and reduce risk as a result, exchange plans need effective strategies they may not have used in the past. The marketplace is a learning environment with an unclear lesson plan. And we see many lessons to learn:

- How to manage risk while balancing the cost of care.
- How to work within the confines of essential health benefits while adhering to the many requirements for benefit design decisions.
- How to respond to updates and new regulations, knowing that ACA risk-stabilization programs (risk adjustment, risk corridors and re-insurance) are still in their infancy and are not working exactly as intended. Insurers received only 12.6% of expected risk corridor payouts last year.

Risk adjustment is a concrete solution to align plan revenue with risk. The gap between a plan's documented risk and what the plan actually manages can equate to millions in lost revenue. But maximizing risk-adjusted revenue alone won't help plans win in the market.

Without a comprehensive strategy to effectively manage the cost of care and risk coding – addressing **risk adjustment** and **risk management** – plans will shortchange their profitability and viability in this market.

Risk adjustment

Plans in pursuit of accuracy

Improved financial performance starts with accurately reporting to federal regulators the amount of risk that plans are carrying. While this may sound straightforward, it's anything but. **Typically, 10 to 20 percent of risk goes undocumented.**[2]

Why is accurate risk adjustment a persistent challenge? There are many factors, including these systemic breakdowns:

- **Lack of insight into members.** New market entrants and membership movement across payers prevent health plans from building long-term risk profiles of members. This forces plans to use non-targeted outreach calls or end-of-year chart reviews, which are suboptimal means of closing documentation gaps and managing cost of care.
- **Challenges engaging members.** Many documentation gaps are a byproduct of inconsistent member engagement or behavior. Establishing a minimum of one appointment per year for members with illnesses in the hierarchical condition categories is necessary for risk adjustment, which yields long-term savings, improved care focus and reduces emergency room visits and other high-cost care.
- **Incomplete medical claims.** Often, due to unavoidable circumstances, doctors simply don't code everything plans need to know about your members. When someone visits a doctor for a sinus infection, but doesn't mention their chronic COPD, it makes it impossible for the physician to code properly for an accurate risk adjustment score. In addition, physicians are focused on patient care, not patient coding. Providers, or their administrative staff, may inadvertently choose the wrong code. This results in patients getting the right care, but plans getting the wrong financial result.
- **Delays in receiving claims.** The gap in time from medical care to claim is a healthcare reality. However, a lack of early indication of an undiagnosed patient condition means plans can't effectively implement patient interventions. This can result in inefficient management efforts, higher overall plan costs and decreased patient care.

Accurate risk scoring can be the difference between profitability and a shortfall in risk adjustment payments. Many plans are grappling with this pervasive issue and end up doing more than just leaving money on the table.

Essentially, some plans are putting substantial revenue in their competition's pockets through risk adjustment payouts.

Proper risk scoring can mean a difference of millions of dollars in risk adjustment payments to a given health plan.

Plans must capture risk accurately to ensure higher payouts and remain competitive

	Plan A: Captures all diagnosis codes	Plan B: Misses one diagnosis code
	Risk Weight	Risk Weight
Male, 32	0.22	0.22
Diabetes with comorbidities	1.32	1.32
Asthma/COPD	0.96	0.00
Total patient risk score	**2.50**	**1.54**
Risk adjustment payments received	**$4,550***	**$1,190***

*For illustrative purposes only. Actual risk payouts may differ. Does not include premiums collected. Example assumes a health plan with $400 statewide average premium and 50% market share.

As this example shows, disease states that go undocumented in a given year create drastic variations in risk adjustment scores affecting transfer payments. If the Centers for Medicare & Medicaid Services (CMS) begin to factor pharmacy data into risk calculations, as proposed, this will help. However, uncertainty remains and CMS has no immediate plans to make a sweeping change across risk scores for all disease states. Even if changes happen, plans can't rely on them to fully mitigate coding problems.

The good news is that right now, plans have an untapped opportunity to manage their risk adjustment scores much more aggressively. Using diagnostic tools that put proprietary algorithms and Express Scripts prescription data to work, plans can now see gaps well before medical claims reveal them. This lets exchange plans better capture risk and ensure risk scores are a more accurate representation of reality.

Exchange plans need to ask themselves these questions:

1. How are you supporting your sickest patients who carry the most risk?
2. Do you definitely know who those patients are as early as possible?
3. Are you confident where to focus first?

Best practice:
Using prescription data as a leading indicator for a patient's true risk provides timely and actionable risk intelligence.

Plans that take a more proactive approach to complete and accurate coding will align their risk adjustment transfer payments to the actual risk being managed.

Risk intelligence enables patient intervention strategies

Express Scripts has partnered with HealthScape Advisors to offer **Pareto Intelligence™** ("Pareto") to help plans identify potential coding gaps and bring documented risk in line with the actual risk being managed.

Pareto is a secure, web-based solution that gives medical, pharmacy and actuarial teams timely, actionable risk intelligence for exchange, off-exchange (individual and small group), Medicare and Medicaid lives. Using a consultative, tailored approach based on specific plan needs, Pareto focuses on four areas:

Precision

Plans want to target opportunities that have a high return on closing gaps. Pareto uses clinical and claim administrative data and advanced algorithms to identify coding gaps for each risk-adjusted member.

Prioritization

Once potential gaps are identified, prioritization must occur for maximum use of resources. Pareto's optimization engines prioritize gaps and align intervention strategies to optimize efforts and results. These tools and analytics allow health plans to create user-defined target lists to facilitate any campaign.

Performance

Pareto enables its users to track performance, quantify returns on investment and evaluate the effectiveness of each deployed tactic to inform future strategies.

Profitability

Plans need more than just coding gap identification. Identifying and consulting plans on profitable opportunities is necessary for a holistic view of risk management. Pareto provides a data-driven approach to improving a health plan's financial performance in the risk-adjusted marketplace. From product design, pricing and distribution to sales, marketing retention and acquisition campaigns, Pareto provides actionable insights that inform strategies that improve short- and long-term profitability.

Pareto Intelligence provides objective, targeted analytics that place health plans in the driver's seat to effectively manage their coding improvement activities.

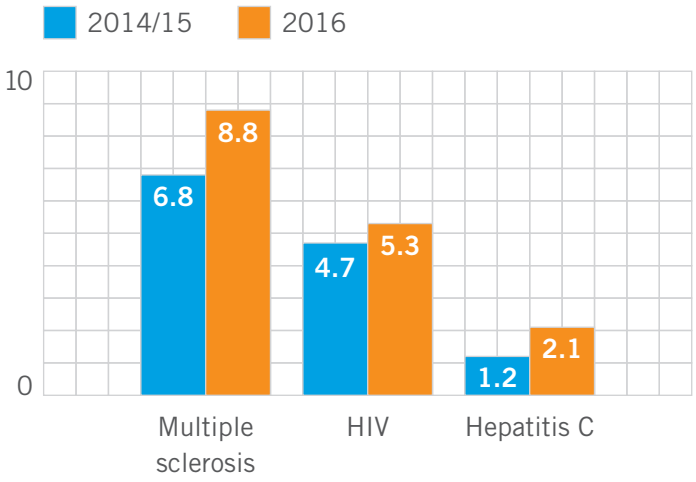
Actionable insights, objective support

Pareto provides actionable insights and meaningful reporting to facilitate all revenue management activities. Beyond software, Pareto and the Express Scripts team of healthcare experts support health plans to achieve complete and accurate coding through the most effective means possible.

Preparing for what's next

The 2018 Health and Human Services Notice of Benefit and Payment Parameters is bringing changes to risk adjustment, including the use of pharmacy claims to validate a member's diagnosis for certain chronic conditions, such as hepatitis C. Not only are hepatitis C and HIV in the top two classes for exchange spending, their risk coefficient weights are increasing over prior years. These changes could result in higher risk scores for some plans, but only if patients are properly documented on medical claims.

Risk coefficient weights



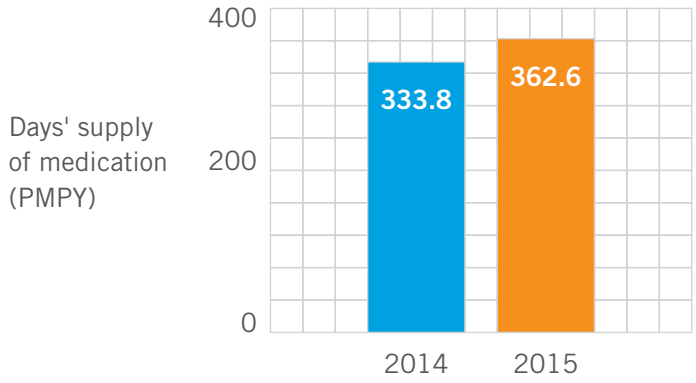
UP TO **75%** **increase** in risk coefficient weights for 2016

Until exchanges stabilize, volatility is today's reality

Risk is not only inherent in the annual adjustment; it's a constant concern for exchange plans. Enrollment and spending in this nascent marketplace remain unpredictable.

Exclusive insights from the Express Scripts *Exchange Pulse*™ report reveal that the exchange population's overall pharmacy spending increased more than 14%, driven primarily by an 8.6% increase in drug utilization.

Exchange drug utilization



8.6% **increase** in drug utilization in 2015

Both the percentage of members using their benefit and utilization per member has increased from 2014 to 2015. So, while exchange members with specialty and other high-cost conditions were first to enroll and use their benefit, the second year of the public exchanges saw many new members just beginning to fully utilize their benefit – especially for traditional drugs.

More members using services more frequently means claims volume and coding opportunities are increasing. What's more, though utilization increases are higher in the exchanges, total spending lags behind the commercial population. This indicates that there is still more growth ahead. And while plan costs are up year-over-year in the exchanges, member cost share remains flat.[3] And for most plans, shifting some of the increased pharmacy costs to the member is not a viable option.

To be proactive, plans need proven solutions for the inherently riskier exchange population. The good news is that even though the exchanges are new, managing risk in pharmacy is not.

Risk management

Controlling risk begins with managing patient health

For over 30 years, Express Scripts has been partnering with health plans to foster a healthier member population, avoid unnecessary spending and mitigate risk. This includes delivering innovative solutions that are proven to:

Improve adherence

When patients skip their medicine or forget to refill their prescriptions, their health suffers and both the patient and plan incur additional medical costs due to nonadherence. Express Scripts leverages predictive modeling to detect future risk for nonadherence and tailor interventions for individual patients.

Identify and prevent safety risks

Express Scripts uses thousands of evidence-based clinical rules to initiate weekly alerts for providers and members for unknown safety risks and to prevent costly short-term hospitalizations and long-term health complications.

94% accuracy in predicting nonadherence in advance – **nearly 9x better than self-reporting** – saving $106M in plan costs[4]

2M therapy changes in 2014 – resulting in **plans receiving more than $321 million** in pharmacy savings[5]

Coordinate care

Express Scripts provides authorized healthcare professionals easy access to patient and population views of prescription data, actionable clinical and member savings opportunities and specialist pharmacist consultation services. This empowers nurse teams with better data and insights for closing potentially costly gaps in care.

Provide specialized care

We give patients access to specialist pharmacists with expertise in conditions such as HIV, hepatitis C, oncology, diabetes and multiple sclerosis. These specialists proactively reach out to patients to offer care and support, explain the dangers of not taking their medications and discuss potential side effects and ways to alleviate them.

60% **more likely to complete therapy** when hepatitis C patients use Accredo[6]

Stop fraud, waste and abuse

Every $1 of prescription drug fraud, waste and abuse results in an estimated $41 of avoidable medical spending. Our investigative service has a proven track record in helping plans to identify and stop prescription drug abuse and physician and pharmacy fraud.

$1.9B **saved** in 2015 in costs associated with fraud, waste and abuse[7]

Reduce prescription costs

Delivering 90-day supplies of medicine directly to a member's mailbox from the Express Scripts Pharmacy℠ produces healthier outcomes, increases adherence and lowers costs for plans and members.

Predict health outcomes

Leveraging access to more than 1.5 billion prescriptions and comprehensive member health profiles, our next-generation healthcare analytics platform accurately predicts patient health outcomes.

Optimize benefit design

Our expert exchange pharmacy consultants help exchange plans design their formulary tiers, drug utilization review process and overall pharmacy benefit more strategically in order to attract and retain new members and manage their risk from the start.

As exchange programs stabilize, changes in the risk adjustment program seem inevitable. Industry insiders are already speculating as to how scoring methodology will change in the coming years and how this will impact plans. Even small changes, such as adding socioeconomic status into the mix, could have drastic impacts. But the fact remains that in any scoring method, plans achieving a healthier, more adherent member population are best equipped to succeed in overall profitability.

Ask us about strategies to help manage your population's risk

To win in the marketplace, health plans must do everything possible to optimize risk adjustment scoring and payments and manage overall patient health. **To arrange for a comprehensive risk consultation at no cost, contact your Express Scripts sales or account team today.** We'll demonstrate Pareto Intelligence in action and show you our other innovative capabilities for managing risk in the public exchanges and beyond.

REFERENCES

1. A.M. Best Special Report: Health Insurers Increase Borrowing Due to ACA Impact, May 2016
2. Pareto Intelligence data, 2014-2016
3. Express Scripts Exchange Pulse report, June 2016
4. Express Scripts data, October 2014-December 2015
5. Express Scripts book of business data, 2014
6. Role of Pharmacy Channel in Adherence to Hepatitis C Regimens; Am J Pharm Benefits, 2013
7. Express Scripts book of business data, 2015

About Pareto Intelligence

an affiliated company of HealthScape Advisors

Pareto Intelligence is an analytics and technology solutions company that supports healthcare plans and providers with revenue, cost, quality and risk-adjusted payment models. Pareto Intelligence was launched by HealthScape Advisors, a management consulting firm specializing in the business of healthcare. That means Pareto's pedigree is deep expertise and a pragmatic approach to executing solutions.

About Express Scripts

Serving more health plans than any other PBM, and 15 million regulated markets lives, Express Scripts is the premier partner for exchange, Medicare and Medicaid health plans. We help plans deliver a tightly managed, rigorously compliant pharmacy benefit while bringing innovative solutions to improve member health and winning strategies to help plans retain and grow lives in all the markets they serve.

Learn more at express-scripts.com/corporate

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