All Things Medicare Advantage

Michael S. Adelberg and David O. Ault
Faegre Baker Daniels

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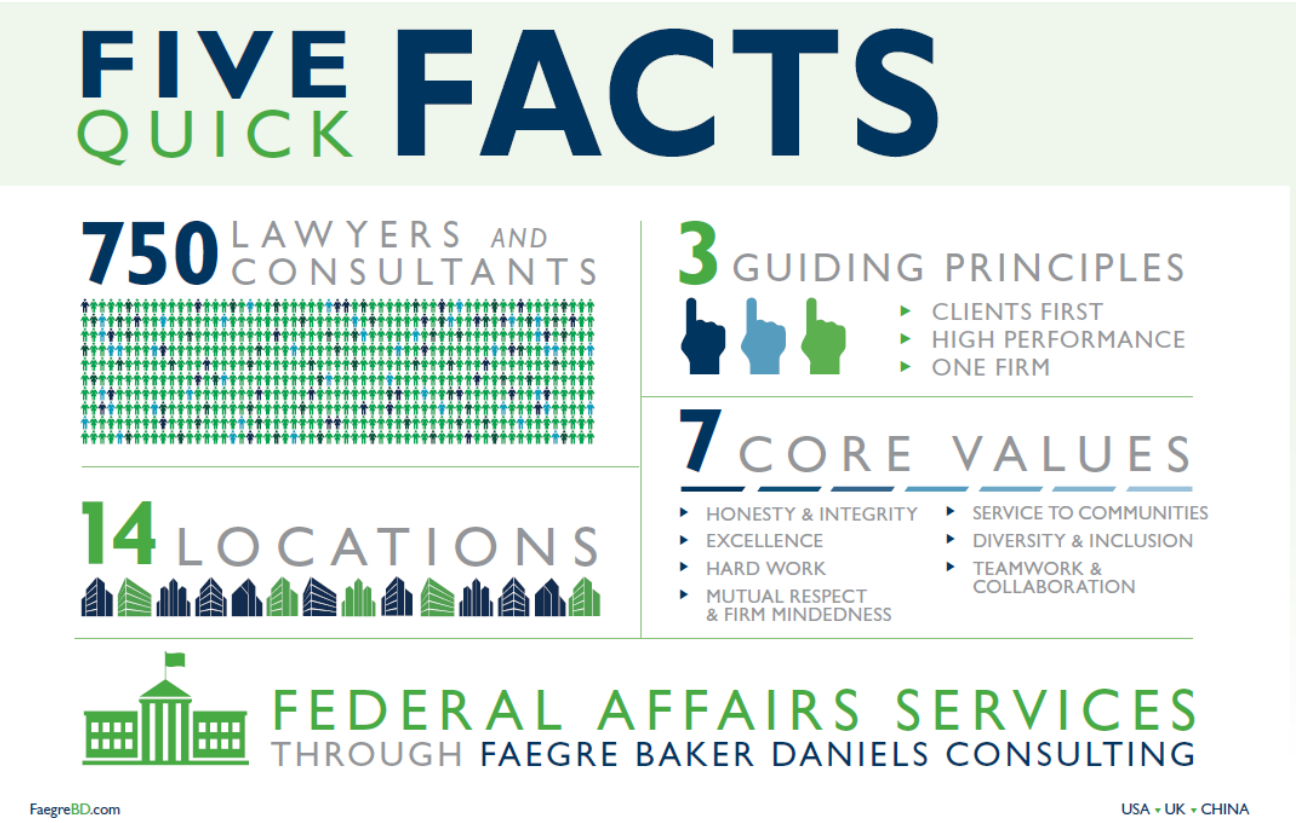
About Faegre Baker Daniels and Today's Speakers



FBD has dozens of specialist attorneys and consultants, including former senior federal and state officials, health plan and association executives, focused on government-run healthcare programs.

Dave Ault is Counsel at Faegre Baker Daniels. Dave spent most of the last decade at HHS, where he held leadership positions working on issues spanning the hospital and health system landscape. During his time with the Office of the General Counsel and Center for Medicare and Medicaid Innovation, he worked on myriad Medicare initiatives, including ACA implementation and value-based insurance models.

Mike Adelberg is a Principal at Faegre Baker Daniels Consulting. Prior to that, Mike held a several senior positions at CMS in the ACA, Medicare and Medicaid programs, including Director of Medicare Advantage Operations. He was also the VP Product Development and Government Affairs for a large health insurer with MA products.

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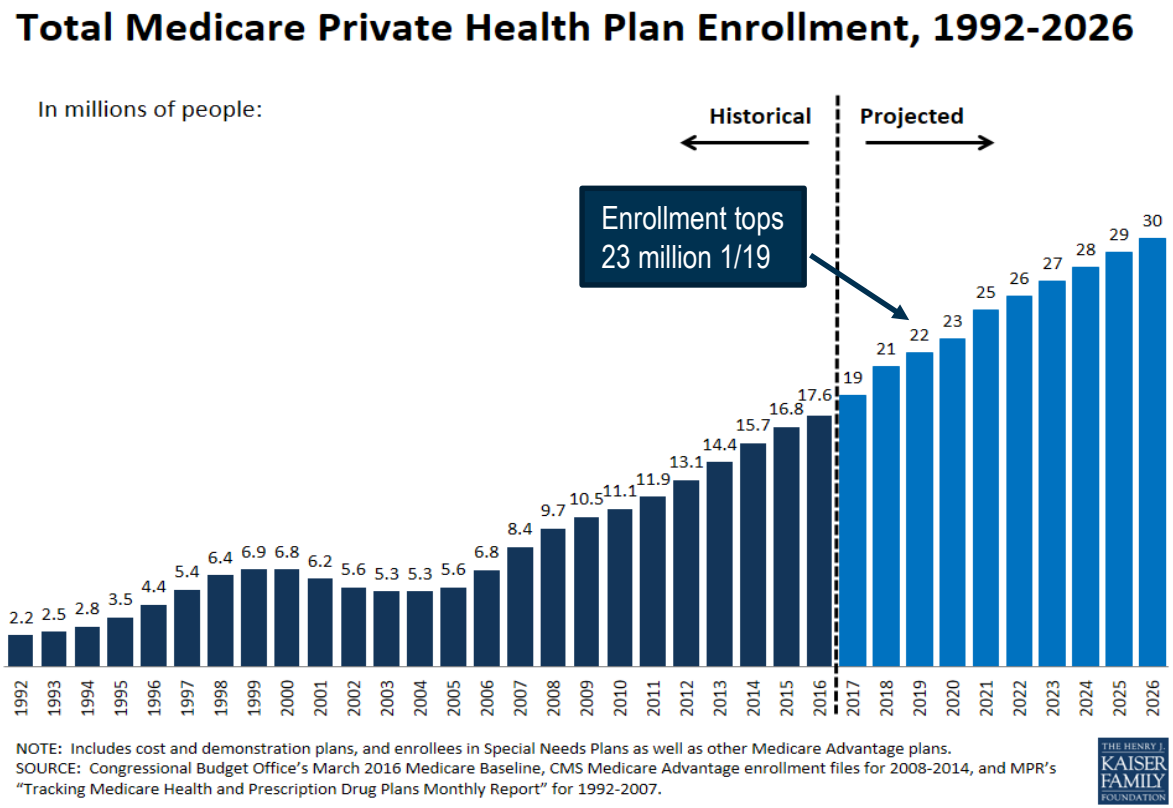
Medicare Advantage Enrollment and Trajectory



In 2016, the Kaiser Family Foundation predicted 30 million in MA plans by 2026. This projection now seems conservative.

This growth has occurred despite a seven-year funding reduction that has brought MA funding even with Original Medicare. MA is now a bipartisan program on stable footing in Congress.

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History of Medicare Advantage (MA), Part I

The Early Years of managed care in Medicare

- Starting in 1972, Medicare began contracting with managed care entities via demonstrations
  - By 1979, 65 HMOs were contracting with Medicare, only one had a risk-sharing contract
- TEFRA (1982) established a capitated payment set at 95% of average beneficiary cost
  - beneficiaries enrolled in risk plans increased from 530,658 (1986) to 4.2 million (1997)
  - Plans were found to have enrolled healthier-than-average beneficiaries
  - enrollees could disenroll midyear, some return to original Medicare when they get sick
- The Balanced Budget Act of 1997 (BBA) establishes new Medicare +Choice program
  - new risk-adjustment payments based on health status
  - annual enrollment period with only one switch allowed outside that period
  - More plan types: PPO, PFFS, MSA
  - M+C plan reimbursement declines through changes in payment formula
  - M+C plans raise premiums and cut extra benefits
- Total number of plans dropped from 407 to 285, enrollment drops 30 percent by 2003.

History of Medicare Advantage (MA), Part II

Medicare Advantage Established and the Bush Years

- In addition to establishing Medicare Part D, the Medicare Modernization Act of 2003 (MMA) creates Medicare Advantage
  - Raised plan payments an avg of 10.9% from 2003 and 2004.
  - Established bidding: per-plan estimated cost of providing Medicare benefits vs. a CMS benchmark; when bid is below the benchmark money spent on extra benefits
  - New Regional PPOs (to bring MA into rural areas) and special needs plans (SNPs) (to focus MA plans on vulnerable populations).
- By 2009, MA in nearly every US county; plans paid 114 % of traditional Medicare; enrollment reaches 11.1 million (24% of benes.).
- Concerns about “land grab” plans and marketing abuses

History of Medicare Advantage (MA), Part III

The Affordable Care Act and the Obama Years

- ACA reins in MA reimbursement over 7 years – near 100% parity with traditional Medicare
- Quality bonus implemented for high quality plans
- Rebates required of MA plans that do not achieve 85% MLR
- Risk adjusted payment lowered per annual "coding intensity" factor
- Despite initial pessimism, MA prospers… By 2017:
  - Enrollment increases 80 percent (33% beneficiaries) enrolled in plans
  - Roughly 50% of plans with 2/3 of MA enrollment achieve quality bonus
- Concerns over risk adjustment gaming and quality bonus gaming
- Affirmative oversight: MA is most strictly regulated insurance market

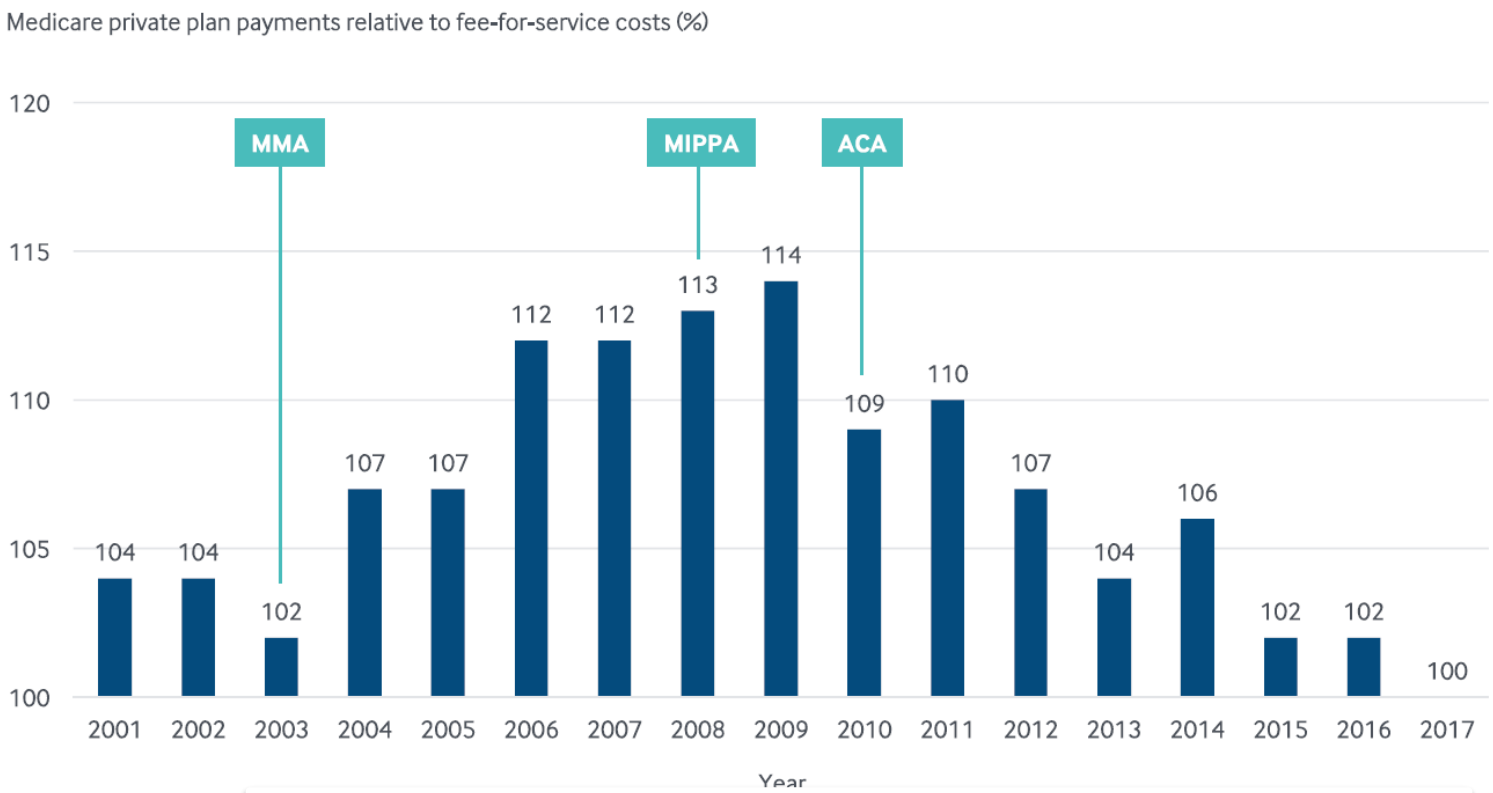
The History of Medicare Advantage, Part IV

MA under GOP Congress and Trump Administration

- Favorable Tweaks from Congress
  - Re-established MA-to-MA switching
  - Made SNPs a permanent program
  - Established new benefit flexibilities for treating chronic illness in MA
  - Congress phases out a popular Medigap plan in 2020 (will benefit MA)
- Regulatory Flexibilities
  - Favorable payment updates (1-2% under Obama; 2-3% under Trump)
  - New benefit flexibilities
  - Marketing Rules lessened and amended
  - Relaxed oversight
- Growth continues: 22M enrolled (36% of beneficiaries) in 2019

Medicare Advantage Plan Payment, Part I

After a period of "over-payment", MA plans are now paid roughly even with the cost of traditional Medicare. Despite this, MA continues to grow and most MA plans are profitable.



Source: *The Evolution of Private Plans in Medicare*, The Commonwealth Fund, 2017

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Medicare Advantage Plan Payment, Part II

MA Organizations are paid according to a complicated formula which is (over-)simplified below

- Base Payment + Quality Bonus (if any) Risk Adjustment +

- Base Payment
  - By county, CMS determines avg cost per traditional Medicare beneficiary
  - This base payment is adjusted annually and CMS has discretion when making this adjustment
  - Counties are grouped in quartiles and certain counties are paid more or less than avg beneficiary cost

- Quality Bonus
  - 5% of base paid to plans that receive at least 4 stars (out of five)
  - All or nothing; roughly half of MA contracts get the bonus
  - In several hundred counties, quality bonus is reduced due "benchmark cap"

Medicare Advantage Plan Payment, Part III

Medicare Advantage Plans receive a per-beneficiary risk adjusted payment based on underlying health risk of each member

- Physicians are essential to appropriate risk adjustment payment

- Demographic risk factors: sex, age, Dual/non-Dual, SNF/non-SNF
- ICD-10 codes rolled up into condition groupings called "HCCs"
- HCCs are calculated two ways
  - MA plans submit HCCs to CMS (through a system called RAPS)
    - MA plan maintains medical records necessary to prove codes
    - As MA plans assign more HCCs, CMS applies a "coding intensity" factor
  - MA plans submit claims to CMS (Encounter Data); CMS assigns HCCs
    - Concerns exist about the accuracy and completeness of the claims
  - CMS is slowly replacing RAPS with Encounter Data (50/50 in 2020)

MA Benefits and the Social Determinants of Health

The Basics of MA Benefits…

- All MA Plans must provide Medicare Part A and Part B benefits
  - But can limit access to benefit through utilization management tools
  - Most MA plans include a Part D benefit
- MA plans must also provide out-of-pocket catastrophic protection
  - Roughly 5% of MA members reach catastrophic limit
- MA plans that "bid" below the CMS benchmark can buy down cost sharing on Part A and Part B benefits or offer supplemental benefits
- Common supplemental benefits
  - Dental, Vision, Hearing
  - Over-the-counter drug, Fitness/Gym membership

MA Benefits and SDOH, Part II

The Medicare Advantage Value Proposition… more benefits per $ than traditional Medicare

Comparison of Medicare options

Original Medicare has a 60-day inpatient coverage limit, with the remaining time paid for by the patient; with no out-of-pocket maximum, this can bankrupt some seniors with serious health requirements.

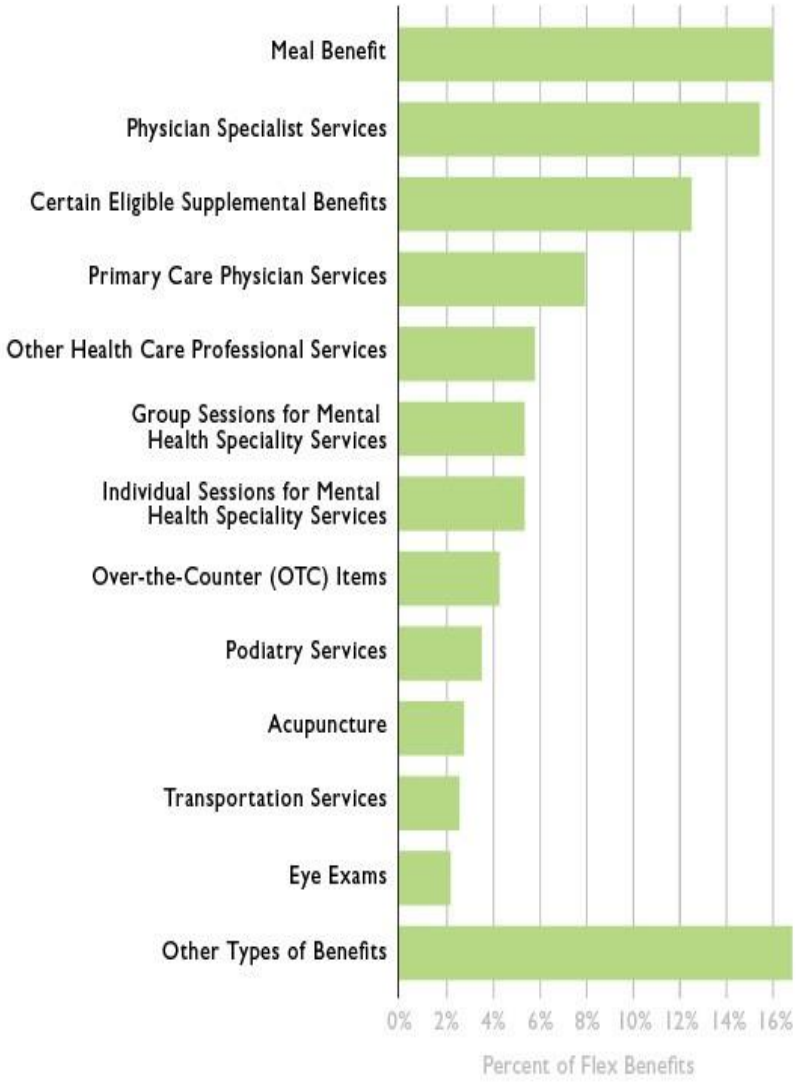
	Network coverage	Supplemental benefits	2019 patient costs					
			Deductible	Out-of-pocket max	Co-pays	Monthly premiums	Est. total annual cost range	
							Good health	Poor health
Original Medicare (Parts A and B)	Most in-network providers	None	~$1.5K (Part A $1,364, Part B $185)	No limit	20% (Part B only)	$135* (Part B only)	$4K-$5K	$13K-$20K
MedSupp	Most in-network providers	None	Varies (typically significantly lower than MA or Original)		Varies (typically lower than MA)	$67-$361 (in addition to Part B premium)	$5K-$6K	$5k-$10k^
Medicare Advantage (Part C)	Varies by plan (PPOs more than HMOs)	May include vision, dental and others (e.g., transportation, meals, OTC benefits, etc.)	Varies (typically similar to or lower than Original)	$6,700 IN, $10,000 OON (often lower depending on plan)	Varies (typically similar to or lower than Original)	Varies** (paid in addition to Part B premium; typically less than MedSupp)	$2K-$4K	$5K-$7K

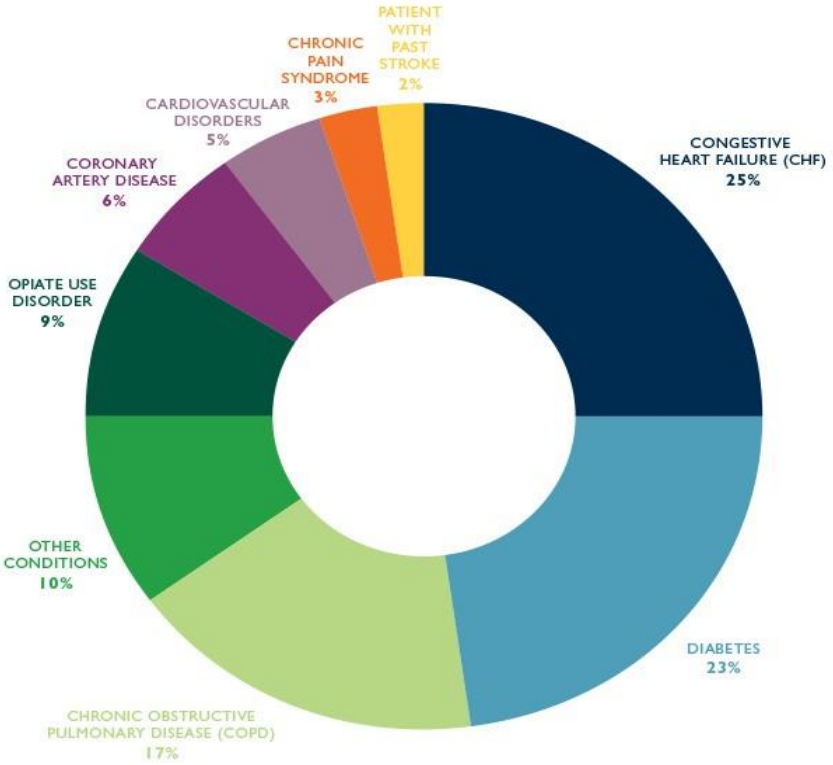
MA plans have lower average premiums than MedSupp, but more limited provider networks and less treatment flexibility.

Attractiveness relative to other Medicare plans: Unfavorable, Neutral, Favorable

Note: *Typical/average monthly premiums — Part B premiums are means tested based on income; **Range from $0-$400 — ~80% of enrollees have at least one choice for $0 premium; ^Increase in costs — driven chiefly by Part D drug costs — seniors in poor health may also choose plans with higher premiums
Source: L.E.K. research and interviews; AARP; CMS; KFF; Gorman Health Group; My Medicare Matters, Medicare Plan Finder

2019 MA Plan Landscape





Roughly two-thirds of condition-specific flex benefits are focused on three chronic diseases: CHF, Diabetes, and COPD. In total, plans are offering flex benefits for 25 chronic diseases.

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MA Benefits and SDOH, Part III

CMS has created new opportunities for MA plans offer new types of benefits…

- Value-Based benefits:
  - Lower cost sharing for services important to treating a chronic disease
    - Example: $0 podiatry for diabetes
  - Lower cost sharing for services received from "high value" providers
    - Example: $0 primary care, but only for PCPs with patients who receive annual physicals more than 90% of the time
  - Lower cost sharing for services contingent on wellness participation
    - Example: $0 pulmonology for COPD patients who complete care mgt reqs
  - Cannot be discriminatory (tied to participation, not results)
- Also permissible: Rewards & Incentive Programs (gift cards)

MA Benefits and SDOH, Part IV

- CMS now permits a much wider range of supplemental benefits
- MA Plans can offer all members new "primarily health related" supplemental benefits that include:
  - Transportation to medical appts and pharmacies
  - Fall reduction interventions
  - Respite and caregiver support
  - Pre-hospice palliative care
- Starting in 2020, supplemental benefits need only have to have a "reasonable expectation" of improving health outcomes
  - But only for members with 15 common chronic conditions
  - New permissible benefits include: long term meals, air conditioning, pest control, and interventions to combat social isolation

MA Benefits and SDOH, Part V

In general MA plans cannot offer benefits that are triggered by the Social Determinants of Health, but there are exceptions…

- MA Plans that participate in the Value Based Insurance Design demonstration can offer benefits based on low-income
- MA Plans that are offering supplemental benefits for one of the 15 common chronic diseases on previous slides, can make that benefit contingent upon a SDOH
  - Example: For members with dementia, MA plan offers dementia-specific benefits, but makes the meals benefit contingent upon low income
- MA Plans can also be configured specifically to serve Medicare-Medicaid "dual eligibles"
  - Offer Medicare and Medicaid benefits in a single plan

MA Benefits and SDOH, Part VI

2019 MA Plan landscape

- Only 153 of roughly 5,000 plans include a flex benefit
- There are 824 flex benefits in these 153 plans
  - 458 are reduced cost sharing and
  - 366 are additional supplemental flex benefits
- Access to some Flex Benefits are contingent upon prerequisites
  - 54% are contingent upon participation in care management program
  - 9% are contingent upon utilizing a high value provider
  - 1% are contingent upon both
  - 36% are not contingent

Quality Program and Ratings, Part I

Star Ratings - Based on Patient Scoring, Not Provider

- Medicare uses a Star Rating System to measure how well Medicare Advantage and Part D plans perform.
- Medicare scores how well plans perform in 5 categories

- Ratings range from one to five stars, with five being the highest and one being the lowest.

  5-star rating: Excellent
  4-star rating: Above Average
  3-star rating: Average
  2-star rating: Below Average
  1-star rating: Poor

- Plans are rated in each individual category. Medicare also assigns plans one overall star rating to summarize the plan's performance as a whole.
- CMS reviews plan performance annually and releases new star ratings each fall; plan ratings change from year to year

Quality Program and Ratings, Part II

- Under a provision of the Affordable Care Act (ACA), star ratings began to be used to adjust payments to MAOs beginning in 2012.
- Rewards are two-part:
  1. Direct bonus payments to the plan operator
  2. Rebates which must be returned to the beneficiary in the form of additional or enhanced benefits, such as reduced premiums or co-payments, expanded coverage, etc.

Plan Rating	Bonus Payment	New Benchmark	Rebate Payment
4.5 & 5 Stars	5%	105% of Benchmark	70%
4 Stars	5%	105% of Benchmark	65%
New Plans	3.5%	103.5% of Benchmark	65%
3.5 Stars	None	Benchmark	65%
3 or Fewer Stars	None	Benchmark	50%
Plans Not Reporting	None	Benchmark	50%

Provider Networks and Requirements, Part I

Medicare Advantage plans must offer a provider network that includes the medical professionals necessary to offer Medicare covered services

- The network is submitted annually and geo-mapped against reqs.
- CMS also requires…
  - Notice when a provider network has a "significant" midyear change
  - Provider directories to be current and accurate (but they aren't)
- CMS has proposed…
  - Requiring MA (and Medicaid) provider directories to be made a available in a common electronic format… to improve oversight and public info
- CMS does not intervene in plan-provider contract and reimbursement disputes, but…
  - CMS does want to receive provider complaints about beneficiary care

Provider Networks and Requirements, Part I

Provider Networks and Requirements, Part II

Providers in MA Networks are required to…

- Abide the terms of the contract they sign with the MA plan
- Abide by the terms of the contract that the MA plan signs with CMS ("flow down" provisions), examples:
  - Support member appeals/grievances processes
  - Hold beneficiary harmless for dollars in dispute
- Depending upon relationship with MA Plan, providers might…
  - Participate in marketing the MA plan
  - Participate in quality improvement and clinical decision making
- MA plans frequently use Medicare as a "reference price", but…
  - Contracts can include bonuses or penalties based on metrics
  - Contracts can include end of year bonuses based on MA plan margin

CMS Oversight of Medicare Advantage

CMS's oversight of Medicare Advantage plans is more comprehensive than health plan oversight in any major health insurance market

- MA Plans are subject triennial program audits focused on:
  - Drug access and formulary
  - Drug and medical service exception requests, grievances and appeals
- Other regular audits
  - Financial Audits
  - Risk Adjustment Data Validation
  - Provider Network Adequecy and Directory Accuracy
  - Marketing Events
  - Call Center
- MA Plan fines have dropped significantly under Trump Administration

Faegre Baker Daniels – Medicare Advantage Team

Mike Adelberg

Principle | Washington D.C.
D: +1 202 312 7464
michael.adelberg@FaegreBD.com

15 years at CMS; Director of Medicare Advantage Operations

VP Product Development & VP Government Affairs at midsized MA plan sponsor

Co-led 23 MA-plan MA Benefit Consortium analyzing new benefit flexibilities for smaller plans

Expert on MA provider networks, benefits, marketing and CMS compliance processes

Dave Ault

Counsel | Washington D.C.
D: +1 202 312 7023
david.ault@FaegreBD.com

Three years at CMMI/CMS leading MA VBID and ACO models; Five years in HHS Office of the General Counsel focused on Medicare and ACA

Expert on CMMI models, valued based care and provider-MAO risk sharing

Tricia Beckmann

Director | Washington D.C.
D: +1 202 312 7009
tricia.beckmann@FaegreBD.com

Led regulatory analysis of benefits for the MA Benefits Consortiums and many other firm clients

Prior experience at CMS, MA/Medicaid managed care plan, and in-house counsel for a national population health company

Expert on MA regulations

Jared Danilson

Partner | Indianapolis
D: +1 317 237 8214
jared.danilson@FaegreBD.com

Steered major insurance companies and their holding companies through numerous high-profile mergers and acquisitions

Advises clients on the strategic design and implementation of captive insurance programs, including risk management, reinsurance arrangements and domicile analysis.

We have ongoing partnerships with actuaries, clinicians and coders, and partner as needed.

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Faegre Baker Daniels – Medicare Advantage Team

Steve Lokensgard

Partner | Minneapolis
D: +1 612 766 8863
steve.lokensgard@FaegreBD.com

Former health system compliance officer

Expert on HHS/CMS compliance processes and compliance plan requirements

Amy Strati

Counsel | Indianapolis
D: +1 317 237 1457
amy.strati@FaegreBD.com

Former Acting Insurance Commissioner and Chief Counsel for Indiana Dept of Insurance

Expert on various Medicare Advantage issues including applications, service area expansions, provider contracting, appeals and marketing

Jay Warmuth

Partner | Minneapolis
D: +1 612 766 8856
jay.warmuth@FaegreBD.com

Former executive at UnitedHealth Group, including senior positions at UHC and OptumRx

Expert on Part D benefit and PBM industry

Aaron Dobosenski

Associate | Minneapolis
D: +1 612 766 8110
aaron.dobosenski@FaegreBD.com

Leads quantitative analyses of Medicare Advantage benefits including data visualization, return-on-investment analyses

Expert on provider compensation and supplemental benefits

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