THREE REASONS MEDICARE ADVANTAGE (MA) IS A VIABLE FRAMEWORK FOR AMERICA'S HEALTH SYSTEM: A STRATEGIC PERSPECTIVE

July 8, 2019

Medicare is the federal program that provides health insurance coverage to 59.7 million Americans: 51.7 million are seniors 65 plus and 8.6 million who are disabled. It is the second biggest category of federal spending behind social security program and its fastest growing: every day, 10,000 Baby Boomers age into Medicare. As a result of projected enrollment growth, average annual spending growth in Medicare (7.4%) is expected to exceed that of Medicaid (5.5%) and private health insurance (4.8 %).

Since the 1970's, seniors have had an option to use traditional fee-for-service Medicare or opt for a private managed care alternative. In 2003, in the Medicare Modernization Act, the fundamental strategy for Medicare Advantage was authorized: seniors would have an alternative to traditional fee-for-service Medicare wherein private insurers would compete to offer coordinated health while assuming financial risks for results. The federal government would pay plans a capitated rate and encourage them to compete for enrollees based on supplemental benefits and service delivery.

After 16 years, it's fair to say Medicare Advantage has worked reasonably well. Here's why:

MEDICARE ADVANTAGE IS POPULAR AMONG SENIORS

- Enrollment in Medicare Advantage plans is increasing: there are 21.84 million enrollees in 2019 (34% of total Medicare enrollees), up from 11.1 million in 2010. The Congressional Budget Office (CBO) projects that Medicare Advantage enrollment will to continue to grow to 42% by 2028. 80% of enrollment is thru individual policies; 20% are in union-sponsored plans.
- Satisfaction among MA enrollees is high: in 2019, the average MA plan enrollee satisfaction index was 795 out of 1000, higher than in any prior years and above satisfaction levels of seniors with traditional fee-for-service Medicare.
- Seniors have multiple choices. There are 2,734 Medicare Advantage plans in the U.S.—up from 2,007 in 2007. 62% of these feature a HMO provider network and a menu of supplemental services. Nearly two-thirds (62%) of all Medicare Advantage enrollees are in HMOs and 31% are in local PPOs in 2019**.** In addition, 2.9 million are enrolled in Special Practice MA plans that cater to dual eligible and those who have complex conditions requiring institutional care. for Medicare and Medicaid; live in long-term care institutions or otherwise require an institutional level of care.

MEDICARE ADVANTAGE IS A PLATFORM FOR INNOVATION IN CARE MANAGEMENT

The basic design principles in Medicare Advantage plans are these:

- Offer programs and services that reduce demand for hospitals, physicians and prescription drugs. The primary driver for most health costs among seniors is chronic disease: diabetes, depression, heart disease et al. Access to routine primary care is foundational, but insufficient. MA plans offer dentistry, vision and hearing assistance, a prescription drug benefit, telehealth and a cadre of popular supplemental benefits important to seniors including over the counter remedies (51.4%) including transportation services (31.9%), caregiver support (17.6%), bathroom safety devices (3.7%) and others. Seniors like the program.
- Keep MA premiums affordable and predictable. The federal government pays MA sponsors a fixed capitated payment for each enrollee. In addition, seniors pay a monthly premium for additional services that extend beyond Medicare's standard coverage like dental care and others. Premiums for MA plans have decreased gradually since 2015: the average in 2019 is $29/month/enrollee or $40 per month if the plan includes a prescription benefit (offered by 88% of MA plans). MA plans limit enrollees out-of-pocket costs to $5059 for in-network services or $8649 for in and out of network services. So, for most seniors, knowing how much they'll pay provides a sense of security.
- Incentivize hospitals and physicians to share financial risk. Medicare Advantage rewards providers in three ways: MA plans channel enrollee (patient) volume to specified providers, MA plans share clinical and administrative data with providers so each organization can respond and MA plans share savings with providers. Unlike the mixed results from Medicare's accountable care and bundled payment programs that have not produced significant savings in Medicare spending overall nor shared savings for 3 in 4 provider participants, MA has produced steady savings for Medicare.

It's a formula that works. Medicare Advantage sponsors use technology to keep their administrative costs low. They leverage telehealth, digital tools and call centers to customize enrollee interactions. They contract with narrow networks of hospitals and physicians to keep their premiums low and leverage with network providers high. They channel referrals to hospitals and specialists aggressively based on the efficiency and effectiveness of the provider's performance and they garner support from state and federal regulators effectively. And long before "social determinants of health" became standard fare, MA plans were addressing food insecurity, hopelessness and social isolation, unsafe housing, clean air and other risk factors in their care management strategies.

Competition among MA plan sponsors is intense. That's why major players are doubling down on new models: Humana's Bold Goal initiative, United's integration of financing and delivery vis a vis Optum Health, Aetna's consumerization vis a vis its merger with CVS and upstart sponsors like Clover Health.

MA lends itself to innovations that are hard to implement in most conventional organizations. That's why it might be adaptable to other populations beyond seniors.

MEDICARE ADVANTAGE IS A SAFE BET FOR POLITICIANS

The federal government controls the purse for MA plans. Unlike Medicaid, which is jointly funded by

states and CMS, MA plans gets the majority of their funding through the DC budgeting process which is inherently challenging. But, to date, it received favorable treatment by the government's bean-counters and wonks. It's understandable.

Medicare Advantage offers a safe haven for politicians. It's fundamentally a private sector solution to a public problem. Every senior 65-plus has an opportunity to enroll: it's their choice. And it has proven to reduce Medicare spending and outperform fee for service Medicare for quality of care and enrollee satisfaction.

Nonetheless, there's political risk: Medicare Advantage sponsors is dominated by large investor-owned insurers, especially the big ones: 9.7 million of the 21.8 million enrollees (54%) are in plans sponsored by United (4.7 million), Humana (3.3 million) and CVS Aetna (1.7 million). Of the 10 largest sponsors of Medicare Advantage plans, only one is provider sponsored (InovaCare, 235.6 thousand) and that's through its joint venture with Aetna. Industry studies indicate provider-sponsored MA plans have smaller enrollment, fewer supplemental benefits and, in some markets, higher premiums. Thus, many provider sponsored MA plans partner with insurers in offering an MA plan.

MY TAKE

Medicare Advantage is no panacea. It has its detractors. Recent studies indicate MA attracts healthier seniors resulting in alleged overpayments to plans. Critics also argue that insurers and other sponsors earn excess profit by restricting specialty care and negotiating discounts to providers that do not cover their costs.

But, on balance, the performance of MA plans since 2006 when first implemented has been favorable: it controls Medicare costs for seniors by managing their care. By contrast, alternative payment models, like the Medicare Shared Savings (ACOs), bundled payments and primary care plus, are a work in process. Savings from these to Medicare have been modest and the costs to set-up and operate higher than expected.

In the Democratic Presidential debates, the federal budget deficit has received scant attention. That's unlikely to be the case in the general election where Medicare spending will be a central theme.

Medicare Advantage may be the framework through which a growing number of Americans interact with the health system. It's plausible to think its design features extend beyond services for seniors.

Paul