NEWSLETTER
HEALTH AND AGEING

THE GENEVA ASSOCIATION

No. 30, April 2014

Public/Private Partnerships: The Role of Private Health Plans Providing Coverage to Medicare Social Insurance Enrolees—U.S.*

By Diana C. Dennett+

Medicare beneficiaries generally have two choices under the Medicare programme: (1) they can choose to receive Medicare covered services under the Medicare fee-for-service programme entitling them to receive health services from any participating Medicare provider in the U.S. or (2) they can choose to enrol in a *Medicare Advantage* plan offered in their community and agree, with some exceptions, to receive their health services from providers (hospitals, physicians and other practitioners) under contract with the *Medicare Advantage* plan.

What is Medicare Advantage? Medicare Advantage health plans provide all the services required under Medicare fee-for-service but, in addition, often provide more services, less cost sharing and provide care coordination that is often missing in fee-for-service Medicare. Medicare beneficiaries can choose to enrol in Medicare Advantage private health plans when they first become eligible for Medicare or during an annual open enrolment period.

Medicare Advantage plans receive a capitated (fixed per-person) payment in exchange for covering hospital, outpatient, physician and home health-care services. The Medicare Advantage programme has grown substantially and now accounts for 23 per cent of total Medicare spending and covers 30 per cent of Medicare beneficiaries. Medicare beneficiaries can also receive their Part D drug coverage through Medicare Advantage plans or through free-standing Medicare drug plans.

How are Medicare Advantage plans paid? To calculate payment for Medicare Advantage plans, the Medicare programme establishes a maximum amount (the benchmark) that it is willing to pay in each county in each state. Medicare Advantage plans annually submit a bid, which is the amount they calculate that it will cost to cover benefits for the average enrolee, administrative costs and profit or margin. The government bases plan payment on the relationship between a plan's bid and the benchmark amount.

Benchmarks are calculated using a statutory formula that results in rates that vary by county. It is in the

Medicare: a primer

Enacted into law in 1965, the Medicare programme was one of the most important pieces of social legislation in the United States (U.S.) during the 20th Century. The Medicare programme was designed to meet the health care needs of individuals 65 years old and older. In 1972, the Medicare programme was expanded to cover persons with end-stage renal disease (ESRD) and eligible persons with disabilities regardless of their age.

The Medicare programme was originally modelled after health insurance as it existed in 1965. At that time, health insurance was commonly divided into two parts: coverage of hospital and other institution services (Medicare, Part A) and coverage principally of physician and other practitioner services (Medicare, Part B).

At its beginning, the Medicare payment structure was "fee-for-service"; in other words, the Medicare programme would pay a fee or an amount to a health care provider in return for a service the provider furnished to a Medicare beneficiary. This fee-for-service model had two inherent limitations: (1) it lacked elements to manage or control costs and (2) it lacked elements that promoted the coordination of health services that a Medicare beneficiary needed.

In 1982, the U.S. Congress expanded the opportunity for managed health care plans known as health maintenance organisations (HMOs). These HMOs were private health plans (not-for-profit and for-profit) that agreed to provide all Medicare services to persons who enrolled in the HMO in return for a fixed payment. Under this payment arrangement, these private health plans assumed the risk of providing health services, which created the incentive to manage costs and care. This private health plan programme has evolved over the past 40 years and currently covers 30 per cent of the Medicare population.

This growth has paralleled broader efforts to expand value-based purchasing in the Medicare programme to reward both private health plans and individual providers of service for greater efficiency and improving the quality of health care.

* With thanks to Mark Joffe, Esq., from the Law Offices of Mark S. Joffe, for his assistance in the article.
+ Executive Vice President, Global Issues, America's Health Insurance Plans.

interest of Medicare Advantage plans to submit bids that fall below the benchmark amount, because they can retain a portion of the difference between the benchmark amount and the bid to provide extra services without additional cost for their members. These extra benefits enhance the marketability of their plans compared to competing Medicare Advantage plans. The Medicare programme also retains a portion of the difference between the benchmark and the bid amount.

The actual amounts paid to plans are adjusted for demographics, such as age, sex and institutional status and the health status of the plan's enrolees. In addition, as discussed further below, Medicare Advantage plans that achieve a high quality rating receive a quality bonus of 5 per cent.

How are the plans regulated? The U.S. government agency that regulates the Medicare programme is the Centers for Medicare & Medicaid Services (CMS). CMS regulates a wide range of Medicare Advantage plan activities to ensure beneficiary protection and facilitate its oversight and payment activities. For example, CMS regulates activities such as *appeals* when a member is dissatisfied with a decision not to pay for a health service that was received. The regulations ensure that members have a right to appeal adverse decisions to an independent entity outside of the Medicare Advantage plan. CMS also regulates such areas as *benefits*, to assure that the Medicare Advantage plan is providing all of the required benefits correctly, and *quality*, to assure that the Medicare Advantage plan has programmes to evaluate and improve the quality of the services that it provides. A significant amount of CMS regulation is focused on *marketing* to assure that Medicare Advantage plans market their plans accurately and not in a misleading manner. *Provider network and contracting* is another regulated area. As health services are generally furnished to members through health-care providers who have contracts with the Medicare Advantage plan, CMS regulates *provider contracting* to assure that Medicare Advantage plans are capable of providing or arranging for all Medicare covered benefits throughout their approved geographic area.

Medicare: a primer (continued)

The Medicare programme currently covers about 50 million Americans who are aged, disabled or have ESRD. The programme is broken into four parts:

1. Part A covers institutional care such as hospital services, skilled nursing facilities, inpatient rehabilitation and home health-care services;
2. Part B covers care furnished by health care professionals, such as physicians, and medical equipment and supplies;
3. Part C is the private health plan choice (known as Medicare Advantage) under which Medicare beneficiaries elect to receive all Part A and B benefits covered under their private plan and may receive additional benefits not covered by Medicare; and
4. Part D, which was implemented in 2006, covers outpatient prescription drugs. Part D benefits are only provided through private health plans—either Part D-only plans (known as prescription drug plans or PDPs) or private health plans, which are now called "Medicare Advantage" plans.

For the most part, Medicare beneficiaries have two choices under the Medicare programme: (1) they can choose to receive Medicare-covered services under the traditional Medicare fee-for-service programme entitling them to receive health services from any participating Medicare provider in the U.S. or (2) they can choose to enrol in a Medicare Advantage plan offered in their community and agree, with some exceptions, to receive their health services from providers under contract with the Medicare Advantage plans.

To facilitate its oversight of plan activities, CMS regulates *data submission and reporting* requires plans to have their own *compliance programmes*, and performs *plan audits*. Plans are required to submit to CMS substantial data to assure payments to Medicare Advantage plans are correct and that the plans are meeting all the regulatory requirements. Because of the large size of the programme, data and reporting requirements are automated to the fullest extent possible.

As just stated, Medicare Advantage plans are responsible for having their own *compliance programmes* to ensure that their staff and contractors meet all applicable requirements.

One element of these programmes is to assure that steps are taken to prevent *fraud, waste* and *abuse*, both within the plan and by subcontractors and health-care providers furnishing services under the plan. CMS conducts a variety of *audits* to assure compliance with Medicare requirements. Such audits can be routine, such as the *financial audits* that CMS annually conducts for one-third of Medicare Advantage plans, or they can be done on an individual basis as the need arises, such as when a significant non-compliance issue comes to the attention of CMS.

Within the U.S., a major, a current public and private initiative is to promote value-based purchasing through rewarding private plans and providers for providing high-quality and efficient services. In the Medicare Advantage

programme, this initiative is illustrated by the five-star system to evaluate and reward a Medicare Advantage plan's high quality. Under the programme, health plans are evaluated on their performance on a set of quality measures.

The quality measures evaluate and compare plans on issues such as how many of the plan's members received specified preventive care services, how well the plan manages health care for members with chronic illnesses, how members rate their plans, and whether the plan complies with timelines for making appeals decisions. The ratings also address Part D (prescription drug) issues.

Plans that receive at least four stars receive bonus payments. Plans that consistently have low star ratings may have their contracts terminated. High star ratings also give Medicare Advantage plans an advantage in competing for members. Each plan's star rating is available to beneficiaries in advance of enrolment. Plans that receive five stars get special recognition on CMS' enrolment website. Those with low star ratings have low performance warnings displayed on the website.

Benefits of the Medicare Advantage programme from the stakeholders' perspectives

To be successful, the Medicare Advantage programme needs to meet the needs of the key stakeholders: the government, private health plans, health-care providers and beneficiaries.

Government perspective: The Medicare Advantage programme allows the government to take advantage of private-sector innovations such as the development of programmes to meet the special needs of persons with chronic conditions or incentive arrangements to promote the delivery of high-quality and efficient health-care services. Also, it allows coordination between government programmes where individuals are eligible for more than one programme such as Medicare and Medicaid (low-income programme).

Medicare Advantage plans contribute to public policy objectives by coordinating care between providers as well as with social service agencies that may have programmes available to the members. For example, a Medicare Advantage plan may provide members social service programmes such as medical transportation, free or reduced-price meals, or programmes that may assist in paying for their health-care premiums or out-of-pocket costs when services are received.

Medicare Advantage plans also help the government improve the quality of care provided to beneficiaries. The plans are highly motivated to ensure beneficiaries receive preventive care and other health-care services. Medicare Advantage plans have implemented innovative programmes, such as providing incentives to their members and providing financial bonuses to their physicians in exchange for obtaining or providing preventive care services or meeting other quality targets.

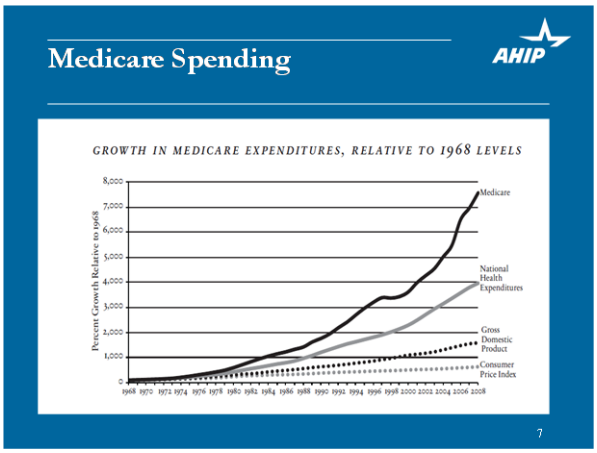
As Medicare Advantage plans are paid on a capitation basis and have an interest in keeping bids low in order to compete, they are motivated to ensure that care is provided in a cost-effective manner. Medicare Advantage plans conduct their own audits to ensure that they only pay for health-care items and services that are medically necessary and appropriate.

Health plan perspective: The Medicare Advantage programme is an opportunity to serve an aging population in the U.S. which is steadily growing. Health plans can offer a product to their

Medicare Costs

In the U.S., significant public policy interest has focused on the Medicare programme, in part, because of its high public costs. In 2012, Medicare accounted for 21 per cent of total national health spending. Traditionally, as shown in Figure 1 below, Medicare programme costs have increased faster than increases in national health expenditures. Moreover, as the U.S. population ages, a greater sense of urgency has been given to how to better manage these rising costs while assuring that beneficiaries receive high quality health care.

Figure 1: Medicare spending 1968–2008



How Is Medicare Funded?

Part A of the Medicare programme (hospital) is funded by a social insurance tax on working —the tax is currently 1.45% for employers and 1.45% for employees and higher amounts for higher income individuals. In addition, general revenues support 75% of Part B of Medicare with an income related premium paid by Medicare beneficiaries providing the remaining 25% of programme costs.

current members who are aging-in to Medicare and giving up employer coverage. The Medicare Advantage programme also gives plans a plan to offer to their employer clients who want to provide retiree coverage in a way that will keep both their employed individuals and retired individuals covered by the same insurer.

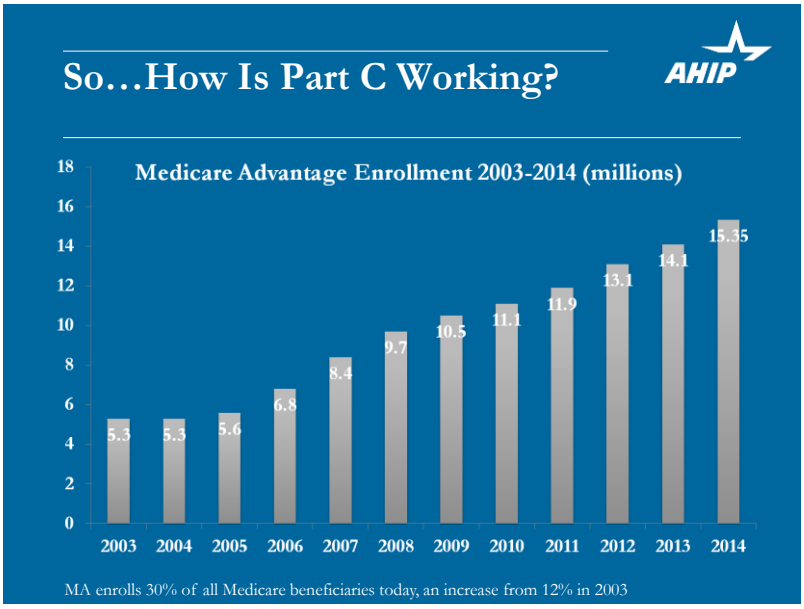
While the Medicare Advantage programme offers private health plans an important opportunity, the attractiveness of that opportunity is dependent on whether private health plans believe the payment rates are financially viable and the regulatory environment is supportive.

Provider (hospital, physician and other practitioners) perspective: As Medicare is an important revenue source to providers, there is a strong interest in participating in the Medicare Advantage plan's network and therefore being eligible to treat members of the Medicare Advantage plan. Some financial arrangements with providers allow for increased payments if the provider can furnish cost-effective services. Other financial arrangements include bonus payments for promoting quality, such as assuring that members received needed preventive care or meeting other quality metrics. Providers need to assure that the amount of payment that they receive meets their revenue requirements. The willingness of a provider to participate in a Medicare Advantage plan's network can vary depending on such factors as relative negotiating strength between the Medicare Advantage plan and the provider and the relative importance of participating in a particular Medicare Advantage plan's network.

Medicare beneficiary perspective: The Medicare Advantage programme frequently offers significant benefits over the Medicare fee-for-service programme because members often are eligible to receive additional benefits at no or little cost, as well as cost-sharing obligations that are lower than those available under Medicare fee-for-service. In addition, many plans choose to offer value-added benefits, such as discounts on items and services that are not covered under Medicare or are not health-care items and services, such as dental and eyeglass discounts or grocery store discounts. Medicare Advantage plans also provide care management services such as discharge planning from hospitals and coordination between primary health-care providers and specialists that makes it easier for beneficiaries to navigate the health-care system.

These benefits have resulted in CMS consumer satisfaction surveys showing that Medicare Advantage members value their health plans—90 per cent say they are satisfied with their plans. As a result, and, as noted by Figure 2 below, these factors have resulted in an increase in popularity of the Medicare Advantage programme, which has grown from 12 per cent of the Medicare population in 2003 to 30 per cent of the Medicare population today.

Figure 2: Medicare Advantage membership growth 2003–2014



Challenges: There are a number of challenges to the success of the Medicare Advantage programme. One of the key challenges has been payment adequacy. The payment methodology over the past 25 years has changed numerous times. The payment changes are generally motivated by either a government interest in ensuring it is not overpaying the plans, budgetary savings needs, or the need to encourage additional plans to participate in the programme. Depending on the methodology, significant payment change can cause some plans to leave the programme or promote an influx of plans participating in the programme. At times, the instability has affected private health plans' continued willingness to participate in the Medicare Advantage or its predecessor programmes. In addition, when the payment changes result in plan decisions to no longer participate; those withdrawals have created instability for beneficiaries who will no longer be able to obtain coverage through their private health plan.

Another important challenge to Medicare Advantage plans has been the consolidation of health-care providers. Hospitals and other health systems have been purchasing provider groups and provider networks. This consolidation gives providers more power in negotiating payment with Medicare Advantage plans. The ability to contract for favourable payment terms with providers is important for Medicare Advantage plans to keep their costs down.

The amount of regulation to which Medicare Advantage plans are subject is also a challenge. As previously noted, the government regulates a broad range of plan activities. Consequently, significant financial and human resources must be dedicated to compliance with the myriad of regulations, and a solid compliance programme is critical for Medicare Advantage plans. These regulations can also constrain health plans from engaging in innovative activities. In addition, the amount of regulation poses challenges for the government in doing the audits and oversight necessary to ensure the integrity of the programme and beneficiary protection.

Lessons learned: Since the implementation of private Medicare options in 1972, there have been a number of lessons learned. The first lesson is that private health plans are better able to provide care coordination. They have also been creative and aggressive in implementing programmes to ensure quality of care. The government has also learned that increased flexibility under the regulations governing the plans is necessary to provide plans with opportunities to implement such creative programmes. Regulations need to be implemented in an efficient and cost-effective manner to balance the needs of the government, beneficiaries, providers and health plans. Another lesson is that enhanced benefits offered by Medicare Advantage plans and their care coordination programmes have made the Medicare Advantage programme very popular with high member satisfaction rates. A final lesson is that stability in the rates paid to the health plans is crucial to the stability of the programme. Payment stability is critical to allowing the health plans to do the business planning necessary to succeed in the programme, providing important and valued options to Medicare beneficiaries, and in giving plan assurances necessary to make long-term investments in quality and compliance programmes. Stability in the participating plans also avoids disrupting beneficiaries by forcing them to make plan changes.