

“If You Were Only More Generous, You’d Save Money”: Cost-Offsetting for Non-Medical Benefit Investments

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A Little About Me...



- 7 years at Faegre Drinker; Healthcare Strategy Practice Lead
 - Advisor to several DC trade associations
 - Advisor to medical and dental plans
 - Co-lead consortium of 32 health plans innovating their benefits
- 25 years in/around the federal healthcare programs, including
 - 15 years at CMS; Director of Medicare Advantage Operations; Director of (ACA) Insurance Programs Group and Exchange Policy & Operations Group
 - 3 years as VP for Product Development and Gov't Affairs for large medical plan
- Quoted in *NY Times*, *Washington Post*, *NPR.org*, *Kaiser Health News*, etc.
- Published in *American Journal of Managed Care*, *Health Affairs*, etc.
- Presented twice at the SOA's annual Health meeting.



About Faegre Drinker

Faegre Drinker is an AmLaw Top 50 law firm with more than 1,300 experienced attorneys, consultants and professionals in 22 locations across the United States and abroad.

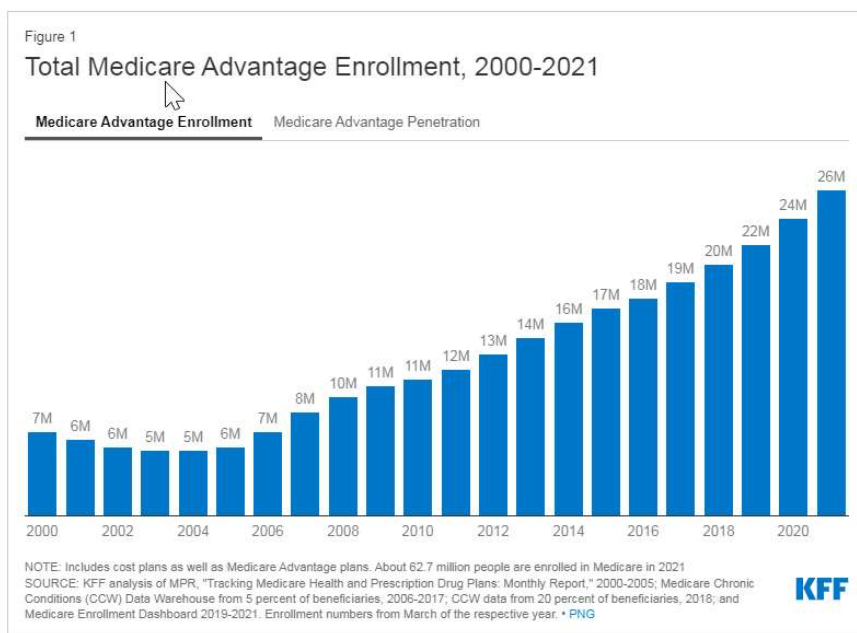
We have broad legal and consulting teams focused on

- Health Care,
- Insurance,
- Government Affairs and Lobbying.

Note: The content of this presentation is intended for information only and is not to be considered legal advice.



Growth Within Medicare Advantage



Over 4 in 10 (42%) of Medicare beneficiaries are now enrolled in Medicare Advantage, and MA is expected to continue to grow.



Medicare Advantage Value Proposition

Beneficiaries receive Traditional Medicare benefits covered under Part A and B.

- Beneficiaries often receive supplemental benefits that are not covered by Traditional Medicare, including dental, vision, hearing, and fitness benefits.
- Additional telehealth benefits are considered a basic Part B benefit starting in 2020

MA plans provide catastrophic protection not available in traditional Medicare

Comprehensive medical and prescription drug coverage can be simplified into a single plan.

- Most MA plans include a Part D benefit

Trade-offs:

- Closed provider networks (sometimes narrow networks)
- Medical management techniques, e.g., prior authorization, step therapy, coverage denials



MA Benefit Packages and Bid Process

Medicare pays Medicare Advantage Organizations based on a bidding process:

- Plans submit “bids” based on estimated costs per enrollee for services covered under Medicare Parts A and B
- Bids are then compared to benchmark amounts that are set by a set formula that vary by county/ region.
- When the bid is lower than the benchmark (nearly always the case), plans use the additional funding to provide extra benefits to enrollees
- Buy down cost sharing on A, B, or D benefit
- Add supplemental benefits
- Payments to plans are then adjusted based on enrollees’ risk profiles.



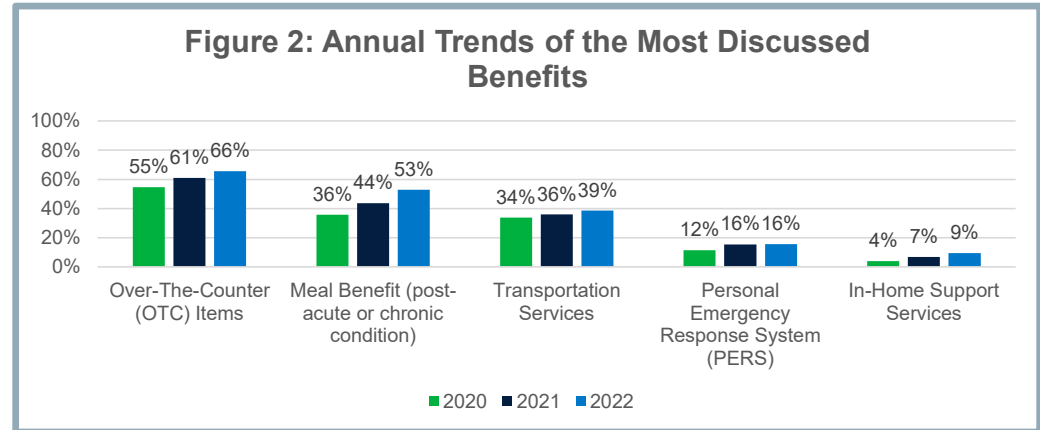
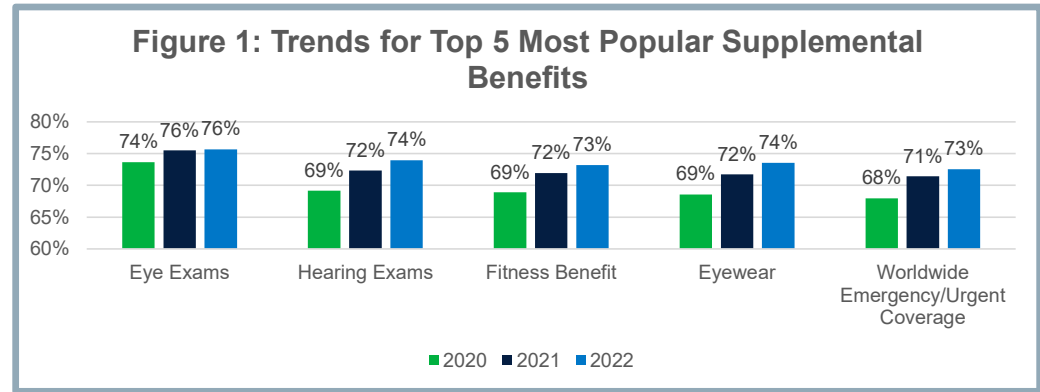
Supplemental Benefit Trends

Supplemental benefits have been increasing in popularity year over year

- Figure 1: The top five most popular supplemental benefits and their trend over the past three years

Due to CMS policy and market evolution, plans are experimenting with innovative benefits

- Figure 2: Five benefits that have been widely discussed among health plan circles that have seen recent increases



*Plan count limited to HMO/ HMOPOS, Local PPO, and Regional PPO



Benefit Uniformity Reinterpretation

For Plan Year 2019, CMS reinterpreted the benefit uniformity requirement to provide new flexibility for MA plans to target benefits at specific populations based on:

- **Health status or condition**
 - Need methodology for identifying every member with selected condition
- **Geographic segment**

Benefit variations may take one of two forms:

- Reduced cost sharing
- Additional supplemental benefits

MA plans must treat all “similarly situated” members similarly.

- Benefits cannot be discriminatory in their application (e.g., cannot tie reduced cost sharing to achieving an outcome).



“Primarily Health Related” Reinterpretation

For Plan Year 2019, CMS announced the reinterpreted scope of the “primarily health related” supplemental benefit definition to consider an item or service as primarily health related if it meets one of the following:

- is used to diagnose,
- compensate for physical impairments,
- acts to ameliorate the functional/psychological impact of injuries or health conditions,
- reduces avoidable emergency and healthcare utilization.
- Services used for cosmetic, comfort, general use, or social determinant purposes are still considered not primarily health related.

New benefits resulting from the reinterpreted scope include Adult Day Care Services, Home-Based Palliative Care, In-Home Support Services, or Support for Caregivers of enrollees.



SSBCI

The Bipartisan Budget Act of 2018 looked to expand the types of supplemental benefits that may be offered by Medicare Advantage (MA) plans to chronically ill enrollees or Special Supplemental Benefits for the Chronically Ill (SSBCI).

- SSBCI allows MAOs to target chronic conditions that meet the statutory definition. Conditions must be:
 - Life threatening or significantly limit the overall health or function of the enrollee;
 - Have a high risk of hospitalization or other adverse health outcomes; and
 - Requires intensive care coordination.
- SSBCI do not need to meet the “primarily health related standard” but only have to meet a lower “reasonable expectation” standard. Permissible benefits include:
 - Food/produce, transport to non-medical sites, pest control, social needs, etc.
- SDOH can be secondary qualifier for a SSBCI
- SSBCI use is growing but still uncommon



Other Benefit Flexibilities

- COVID PHE Midyear Benefit Enhancements – For the length of the COVID public health emergency, MA plans can offer additional benefits midyear as long as...
 - Benefit addresses member needs exacerbated by the PHE
 - Members are advantaged by the benefit and can opt out
- VBID – A collection of benefit flexibilities available only through a separate application process, that include:
 - hospice carve, Part D rewards, low-income as a “qualifying condition” for benefits, beneficiary rebates tied to plan success
- High Value Provider – tying benefits or lower cost sharing to a subset of network providers based on provider’s performance



Cost Offsetting

- Actuaries have long estimated utilization changes based on benefit changes, e.g., changes to drug copays, new prior auth requirement
- Cost offsetting is another type of utilization estimate
 - When a new benefit is introduced, it can favorably impact utilization
 - Example: \$0 transportation to dialysis clinics should lead to an increased dialysis utilization and reduced emergency dialysis (hospital) episodes of care – this can be reasonably modeled a net cost-saver
- Cost offsetting is permitted when it is...
 - Prudently applied and consistent with actuarial principles
 - Supported by claims experience, modeling, or academic studies
 - CMS VBID Model includes offsetting



The Importance of Cost Offsetting

- There is no public accounting of the scope of cost offsetting in the MA and other health plan markets
- But consulting actuaries suggest that they are seeing more cost offsetting across the MA planscape
- The case for cost offsetting incrementally improves each year...
 - More experience with new benefits
 - More studies, including cost off
 - Improved quality and access to MA claims data
- High business need for cost offsetting in competitive MA markets
 - Offsetting frees up bid dollars for buying more benefits



Happy to Continue the Conversation



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