NASI Roundtable Discussion Session

MEDICARE LOW-INCOME BENEFICARIES & STATE BASED PRIVATE HEALTH PLANS

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CONCERNS ABOUT MEDICARE PRIVATE PLANS

SINCE MEDICARE PROSPECTIVE PAYMENT OF PRIVATE PLANS WAS PROPOSED IN 1982

- **Capitated private plans have strong fiscal incentives** to increase revenues and decrease spending on medical services
  - **Skimming of healthier enrollees** – to increase revenues relative to expenditures
  - **Skimping on services** – to decrease plan expenditures
- **Most MA plans today** are operated by the large national health insurers traded on Wall Street such as UnitedHealthcare, Anthem/WellPoint, and Humana

CONCERNS ABOUT MEDICARE PRIVATE PLANS

SINCE MEDICARE PROSPECTIVE PAYMENT OF PRIVATE PLANS WAS PROPOSED IN 1982

- Over 30 years, Medicare has developed detailed policies regarding both **payments to private plans** and **access to and quality of health services** provided to Medicare beneficiaries
- Given the concerns with private plans, Medicare beneficiaries have always been **required to actively chose to enroll in a health services private plan**
- Low-income beneficiaries in **Dual-SNPs** must actively enroll in MA plans

MEDICARE HAS DETAILED REQUIREMENTS AND ENFORCEMENT OF STANDARDS FOR MA PLANS

- CMS **explicit policies in statute, regulations and program manuals** for MA plans that run over 100s of pages
- CMS **explicit data and other information reporting requirements** to monitor plan compliance
- CMS **data management systems** to manage data and audits to insure accuracy of data reported by MA plans for analysis
- Over 200 experience **staff in Washington and regional offices to analyze information from plans** and to identify plans that fail to meet standards
- Policies and staff with experience in **enforcing sanctions on plans that fail to meet standards**

MA PLAN COSTS ARE NOT LESS THAN COSTS IN TRADTIONAL MEDICARE

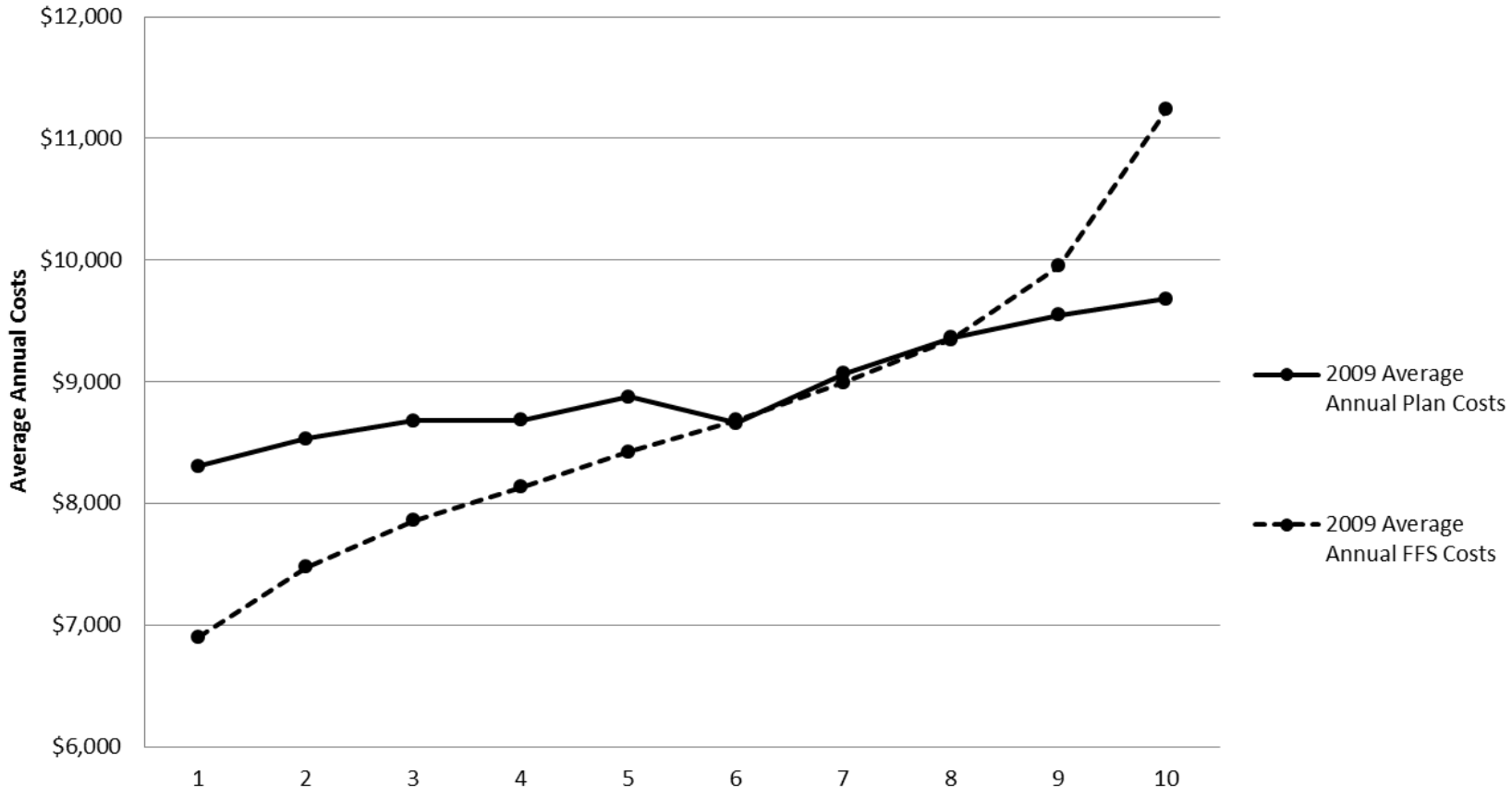
- Evidence from current MA program **is that average MA plan costs are greater than average costs in traditional Medicare in the same county**
  - Findings are from analysis of CMS data on MA plan cost data for 2009 filed on a retrospective basis in June 2010
  - MA plan and traditional Medicare per capita costs are both risk adjusted to a uniform risk score of 1.0
- National average of MA plan costs is **103% of costs in traditional Medicare**

MA Plan Costs Related to Traditional Medicare FFS

Plan Type	2009 Medicare Advantage Enrollees	2009 Average Annual MA Plan Costs	2009 Average Annual Traditional Medicare FFS Costs	2009 Average Annual Plan Costs as Percent of Traditional Medicare Costs
National	**10,260,815**	**$8,933**	**$8,731**	**102%**
Urban	8,300,030	9,057	8,921	102
Rural	1,960,785	8,409	7,927	106
HMO	6,516,710	8,886	9,070	98
Regional PPO	419,647	9,087	8,636	105
Local PPO	899,133	8,749	8,171	107
PFFS	2,425,325	9,100	8,044	113

Weighted By Medicare Advantage Enrollees

MA Plan Costs Related to Traditional Medicare FFS



COSTS OF MA PLANS
RELATIVE TO TRADITIONAL MEDICARE
IN STATES PROPOSING NEW DEMONSTRATIONS

- **MA plans costs to provide Medicare benefits are greater than traditional Medicare costs in 12 of the 13 states** that earlier proposed capitation model
- **Dual SNP plan costs are greater** than traditional Medicare costs in all **but 2 states with appreciable D-SNP enrollment** – California and Tennessee

AUTHORITY FOR MEDICARE – MEDICAID DEMONSTRATION PROGRAM

- CMS program is authorized by **ACA authority for CMMI** –and not by the ACA authority for MMCO
- ACA authority for CMMI is to **"test payment and service delivery models"**
- ACA authority provides that CMMI projects must:
  - **Reduce costs and not reduce quality of care** or increase quality of care without reducing costs
- The CMMI authority provides for **termination of projects** that are not budget neutral or reduce the quality of care
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WHAT DOES THIS SUGGEST FOR THE DESIGN OF CMMI DEMONSTRATIONS

- State private plan programs should be **real demonstrations that follow the policies of the CMMI legislative authority**
  - Plans should be fully qualified Medicare MA plans and be located in **specific, local geographic area**s that can be served by HMO type plans
  - Demos should study care for **specific type of disabled or aged person**
    - Mentally ill, developmentally disabled, physically disabled, HIV-AIDS, over 80 in ltc facilities, over 80 in community, over 65 in community
    - Not just all under 65's or over 65's in a geographic area

WHAT DOES THIS SUGGEST FOR THE OPERATION OF CMMI DEMONSTRATIONS

- Plans should file all current **MA annual bid cost** report data
- Plans should file all current **MA risk adjustment data** with CMS
- State demos should have **limited number of enrollees** – not more than 10,000 – and a clearly defined control group of similar Medicare beneficiaries who are not in the program
  - State demo programs should **not be too big to fail**
- States should submit an **explicit plan to unwind** the demo program if CMS finds the program increases costs and/or reduces quality of care