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Amplifying Transformation:

Addressing Medicare Advantage's Disadvantages

Market Corner Commentary
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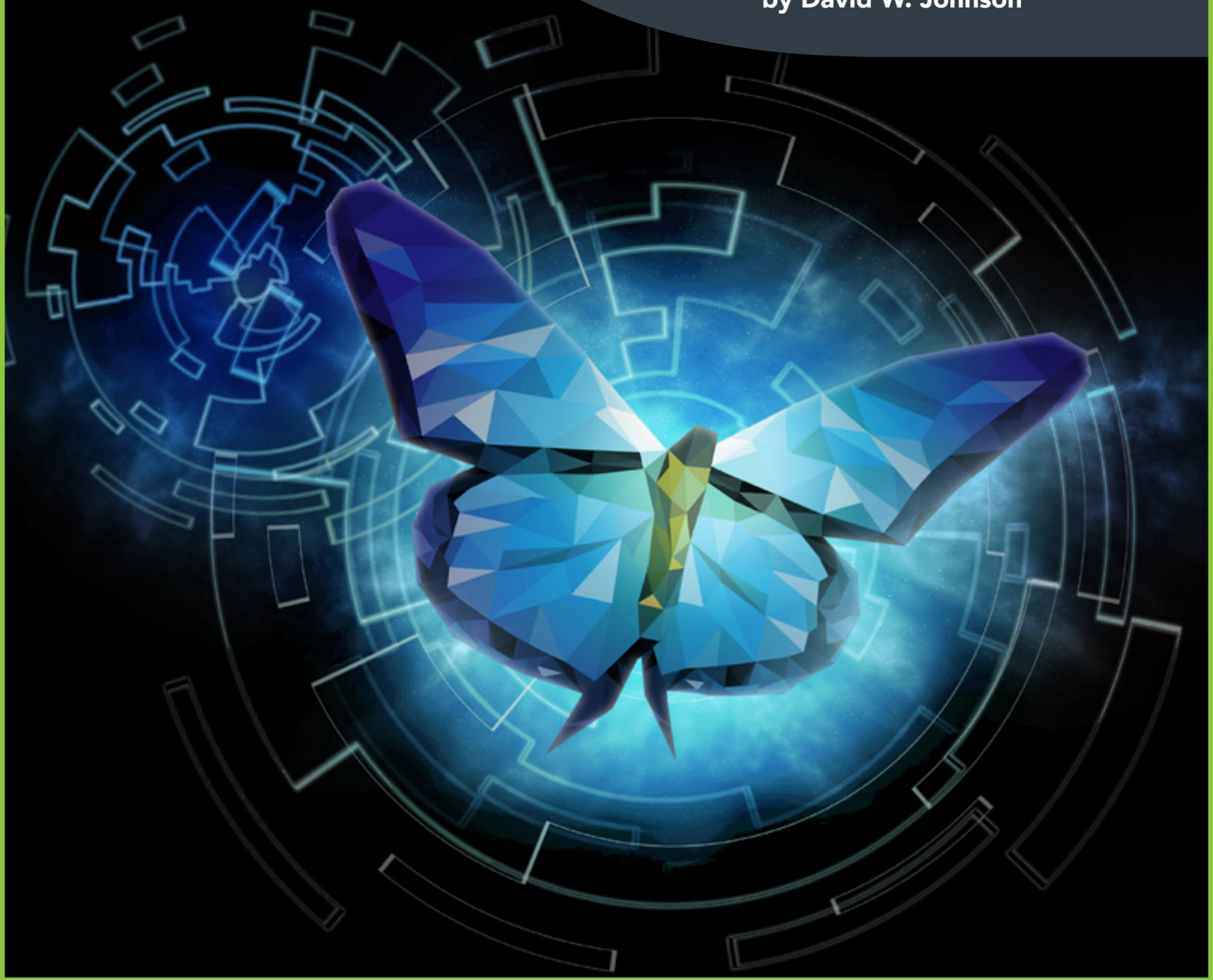


The U.S. healthcare system will not change the way it delivers care until it changes the way it pays for care. Perverse incentives riddle fee-for-service payment (FFS) and lead to overtreatment, fragmented delivery and runaway medical inflation. Incremental attempts to reform care delivery through value-based payment reform and provider education (e.g. the "Choosing Wisely" initiative) have not changed practice patterns in meaningful ways.

The system's unforgivable failure to coordinate care, manage chronic disease and promote health increases human suffering and treatment costs. In stark contrast, high-performing Medicare Advantage (MA) programs accomplish these objectives through focused medical management.

MA works because its payment and performance incentives reward comprehensive and holistic care delivery. It shifts the government's care management risk to MA health plan sponsors. In this sense, MA represents successful public-private partnerships that advance value-based reform.

To achieve its potential as a transformative force, however, MA must address major structural flaws in its payment mechanisms and regulatory oversight. The depth and pace of market-led transformation toward value-based healthcare delivery depends, in large measure, upon improving MA's ability to appropriately and transparently shift care management risk to MA plan sponsors.

MA'S TRANSFORMATIVE POTENTIAL

Full-risk contracting arrangements, including MA, are the disruptive force challenging conventional healthcare business models. Under full-risk contracting, payers and providers need new capabilities to improve patient-centric health outcomes. MA plans that cannot manage their members' care within fixed revenue parameters lose money.

CMS provides funding within pre-defined parameters to MA plan sponsors. Commercial health insurers develop, market and admi MA plans that compete for members in the public marketplace. Custo select MA plans with the benefits they want at prices they're willing to pay. Successful MA plans attract members, meet their health needs efficiently and receive high quality scores.

MA is gaining sufficient critical mass in many markets to stimulate vertical integration of care payment and delivery. A third of Medicare beneficiaries are now enrolled in MA programs. That percen could grow to as high as 50% by 2025[1] as record numbers of baby boomers age into Medicare beginning next year.

Properly executed, MA has the scale to transform U.S. healthcare delivery by aligning payment incentives with desired health outcome objectives. A recent study by Avalere[2] found compelling evidence that MA plans manage the health of sicker Medicare beneficiaries more cost-effectively than traditional FFS Medicare. Key findings from the Avalere study include the following:

- Medicare Advantage had a higher percentage of beneficiaries with chronic conditions who enrolled in Medicare due to disability (36% versus 22% FFS) and are dual-eligible/low-income beneficiaries (23% versus 20% FFS) than FFS Medicare.
- Medicare Advantage beneficiaries had a 57% higher rate of serious mental illness (9% versus 5% of FFS) and a 16%higher rate of alcohol/drug/substance abuse (7% versus 6%of FFS) than FFS Medicare beneficiaries.
- Utilization of costly healthcare services was lower for Medicare Advantage beneficiaries, including 23% fewer inpatient stays (249 versus 324 per 1,000 beneficiaries in FFS Medicare) and 33% fewer emergency room visits (511 versus 759 per 1,000 beneficiaries in FFS).
- Average annual Medicare Advantage beneficiary costs were not significantly different from average costs for FFS Medicare beneficiaries. But annual spending per beneficiary on preventive services and tests was 21% higher in Medicare Advantage ($3,811 versus $3,139 in FFS Medicare) whereas FFS Medicare had 17% higher spending on inpatient costs ($3,477 versus $2,898 in Medicare Advantage) and 5% higher spending on outpatient/emergent care services ($2,474 versus $2,359 in Medicare Advantage).

- Medicare Advantage outperformed FFS Medicare on several key quality measures, including a nearly 29% lower rate of all potentially avoidable hospitalizations (17% versus 24%in FFS), 41% fewer avoidable acute hospitalizations, 18%fewer avoidable chronic hospitalizations, and higher rates of preventive screenings/tests, including LDL testing (5% more) and breast cancer screenings (13% more).
- Relative to FFS Medicare, Medicare Advantage beneficiaries in the clinically complex diabetes cohort experienced a 52% lower rate of any complication (8% versus 17% of FFS) and a 73% lower rate of serious complications (2% versus 6% of FFS).

By any measure, these are impressive results. The Avalere study summarizes the results of its analysis as follows:

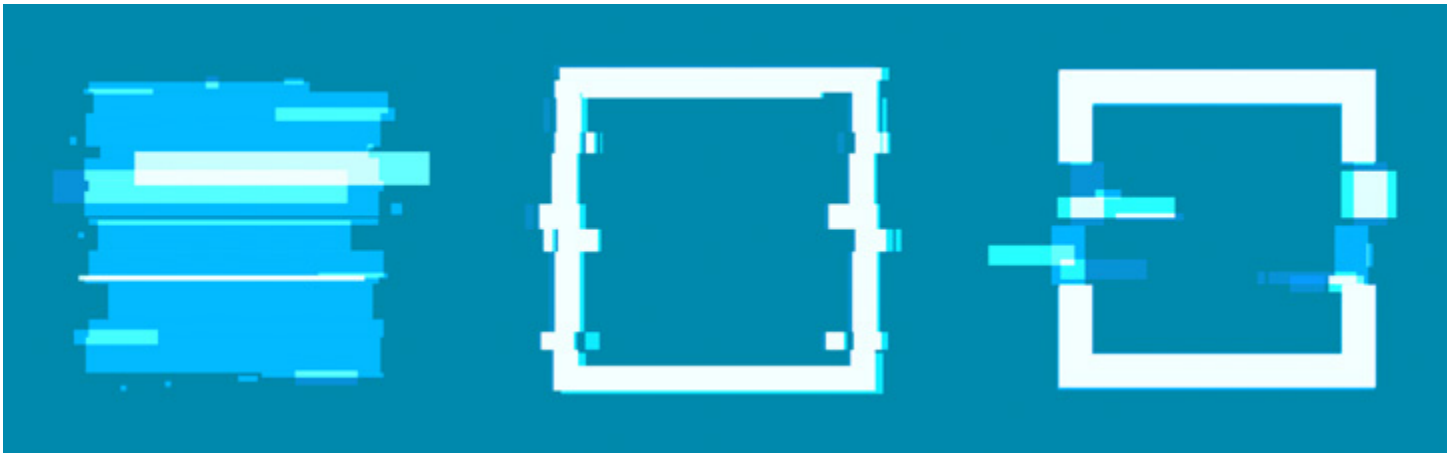
These results indicate that, compared to FFS Medicare, Medicare Advantage provides more preventive services and utilizes interventions designed to better manage chronic conditions, which may avert preventable complications and result in lower overall costs. This was especially true among the most clinically complex and dual eligible/low-income beneficiaries.

Despite Medicare Advantage beneficiaries having more social and clinical risk factors, they had similar costs to those in FFS Medicare overall, indicating that Medicare Advantage's focus on coordination of care may lead to more efficient treatment patterns and care delivery. Medicare Advantage has inherent incentives to coordinate care and deliver preventive services that do not exist in the FFS Medicare program.

The study findings show that Medicare Advantage beneficiaries with chronic conditions experience better outcomes, fewer adverse events at similar or lower costs, and suggests a better quality of life for beneficiaries with chronic conditions in Medicare Advantage.[2]

The marketplace sees enormous investment potential in MA companies. Founded in 2017 by health tech entrepreneurs Ed and Todd Park, Devoted Health is a nationwide Medicare Advantage company offering customer-focused, relationship-based, easy-to-use health plans that deliver the right care at the right time. In October, Devoted raised $300 million in private equity financing led by Andreesen Horowitz with a company valuation of $1.8 billion.

Given its potential, it is imperative that MA become an effective and efficient vehicle for redistributing resources in ways that improve outcomes, lower costs and enhance health. For this to happen, MA must correct several structural deficiencies.



MA'S STRUCTURAL FLAWS

MA plans require two core competencies to succeed financially. The first is the medical management of the plan's enrollees. As described in the Avalere study, everything good in MA results from the active management of MA plan enrollees. Enhancing MA plans collective ability to manage members' health is America's last, best hope for transforming healthcare delivery.

The second core competency is managing revenue flows in and out of the health insurance plan. Everything bad in MA results from the design and application of CMS payments to MA health plans. "Fixing" these flaws would dramatically improve MA's performance and speed health system transformation.

The following 4 structural flaws distort the proper functioning of MA plans:

- Risk Adjustment
- Baseline Variation in FFS Payment Rates
- Contracting Friction between MA Plans and Providers
- Release Mechanism for High-Cost Enrollees

Let's address them individually.

Risk Adjustment

Risk adjustment is the mechanism through which CMS calibrates the payments it makes to MA plans for the expected care cost of MA plan enrollees. CMS employs a complex formulary employing demographic and diagnostic information for each beneficiary. Sicker enrollees generate higher monthly payments for MA plans.

The marketplace is always smarter than central planners. MA plans have become adept at identifying additional diagnoses that increase monthly premiums separate and apart from the enrollee's true health status. For this reason, risk scores are 8% higher and have risen 1.5% faster for MA enrollees than for traditional Medicare enrollees.[3]

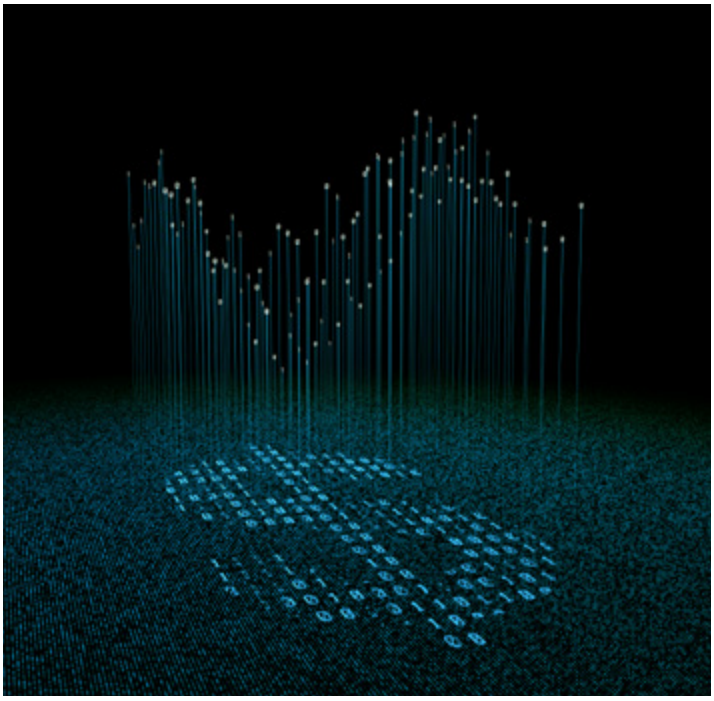
Higher payments for specific beneficiaries inflate MA plan revenues and profits. In a February 2017 Health Affairs article[4], Richard Kronick projects this "coding intensity" could increase MA spending by more than $200 billion over 10 years.

In a textbook example of coding intensity gone rogue, the U.S. government just filed suit against Anthem for inflating enrollee diagnoses that netted an additional $112 million in MA payments for 2015 and $102 million for 2014. Anthem conducted retrospective chart reviews at a cost of $18 million to justify the additional payments. In the same vein, the Justice Department is pursuing a $3+ billion whistle-blower claim against UnitedHealth Group for excessive risk-adjustment payments between 2010 and 2015.[5]

Gaming payment is antithetical to value-based reform. In competitive markets, prices send powerful signals between

buyers and sellers regarding purchasing preferences and perceived value. Tactics like retrospective chart analysis that emphasize revenue optimization shift managerial attention away from value creation. They break the direct connection between pricing and value-based care delivery. They create unnecessary system waste.

CMS could eliminate much of diagnosis gaming by assuming the demographic and diagnostic characteristics of MA and traditional Medicare populations are equivalent. Even better, CMS could move away from risk adjustment all together and apply experience ratings to specific MA populations. Experience ratings assign premiums based on the actual healthcare use of similar populations. The larger the populations, the more accurate the assessments.



Baseline Variation in FFS Payment Rates

Traditional Medicare FFS calculates an average inpatient case rate sufficient to cover operating and capital costs for efficient facilities. Medicare adjusts this base rate for geographic variation in labor and non-labor costs as well as treatment complexity based on the primary diagnosis, coexisting medical conditions and complications. Then Medicare adds payments to compensate hospitals for medical education and indigent care costs. It also makes allowances for high-cost, outlier cases.[6]

The complexity of Medicare's payment formularies makes them vulnerable to manipulation and results in remarkable payment variation across the nation. For example, the 2016 per-capita cost in Miami/Dade County was $14,133. That figure was 76% higher than the 2016 per-capita cost of $8,054 for Seattle/King County.[7]

Physician practice patterns are the primary factor driving FFS payment differentials exhibited in Miami and Seattle. Medicare patients get more care in Miami (much of it unnecessary) than in Seattle. These payment differentials exist despite Seattle's higher cost of living.[8]

County-specific Medicare FFS payment serves as the baseline for setting MA payment rates. All other things being equal, Miami's Medicare's per-capita payment rates to MA plans in Miami will be 76% higher than per-capita rates to Seattle-based MA plans. This distorts MA plan pricing in two ways that favor highly reimbursed markets like Miami:

- More revenue per-capita enables MA plans to offer richer benefit packages, including zero premiums, to entice Medicare beneficiaries to enroll. At 65%[9], Miami has among the nation's highest percentage of Medicare beneficiaries enrolled in MA plans. It also has a disproportionately high number of MA health plan offerings.
- High per-capita FFS payments correlates with high levels of overtreatment and waste. That means the MA plans in Miami not only receive higher per-capita payments, they also have more opportunity to increase profitability by eliminating unnecessary, wasteful treatments.

No good deed goes unpunished. It's unfair that more efficient healthcare markets like Seattle receive lower per-capita payments for generating the same or better care outcomes. Lower payment levels also make it harder for Seattle-based MA plans to generate profits by eliminating unnecessary healthcare expenditures. It's a lose-lose proposition.

Medicare should decouple MA plan per-capita payments from FFS-driven payment formularies and replace with national, experienced-based rates. Over time, this would shift payments from higher-premium markets to lower-premium markets and result in more effective and efficient care delivery across MA plans throughout the country.

Friction Between MA Plans and Providers

MA plan ownership is highly concentrated among three commercial insurance companies. UnitedHealthcare, Humana and Blue Cross affiliates accounted for 57% of nationwide MA enrollment in 2017. Eight companies and affiliates accounted for 77% of enrollment.[9]

Commercial MA plans typically contract with providers on an FFS basis for specific treatments. The plans manage their members' care efficiently to generate higher profits. Better care management keeps medical expenditures low.

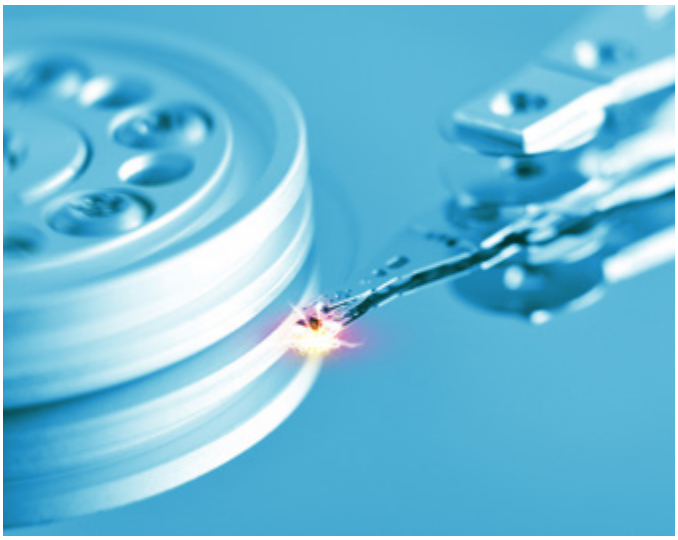
This payment model can become problematic when dominant MA plans exert price-setting pressure on providers. More commercial insurers offering MA plans levels competition within markets and establishes more balance in payer-provider price negotiations.

Moreover, several American counties have only one MA plan sponsor. Many markets would benefit from more competition among MA plan offerings. Incentivizing greater competition in underrepresented MA markets should be a strategic priority for CMS.

In a troubling report, the HHS Office of Inspector General found that MA plans and independent reviewers overturned more than 75% of payment denials appealed by providers between 2014 and 2016. This is a very high percentage but represented only 1% of MA plan treatments.

Denial appeals are costly and time consuming for providers to pursue. The small appeals percentage suggest that disproportionate numbers of providers forego payment rather than appeal. The OIG worries that persistent denials may influence provider care-delivery practices in material ways.

A Medicare Advantage organization that inappropriately denies authorization of services for beneficiaries, or payments to



healthcare providers, may contribute to physical or financial hare and also misuses Medicare Program dollars that CMS paid for beneficiary healthcare.

MA plans that contract with providers using sub-capitated rates for specific services (e.g. behavioral health services) align payment with desired outcomes in the same way capitated MA do for MA plans overall. More sub-capitated arrangements will improve plan performance by focusing those providers on value creation.

Concern with fair provider payment will grow as MA plans increase enrollment. Unfair payer and provider pricing power distorts market function and destroys value creation. The best way to address unfair payments by MA plans is to create more competitive MA marketplaces for both payers and providers. This will enable value-oriented health companies to differentiate, win customers and gain market relevance for the right reasons.

Release Mechanism for High-Cost Enrollees

MA enrollees have the right to convert back to traditional Medicare at any time. This creates an incentive for MA plans to shift the financial risk of caring for their highest-cost enrollees by nudging them to convert their health insurance back to traditional Medicare. Typically, these high-cost enrollees require significant acute-care interventions.

I have found no study that documents this cost shift from MA to traditional Medicare is occurring, but its potential is worrisome. The existence of this "release mechanism" creates a perverse incentive to place the company's financial well-being above that of chronically sick enrollees. Given MA's organic growth, eliminating this ability of MA programs to shift financial risk constitutes prudent regulatory policy.

ADVANTAGE, MEDICARE ADVANTAGE

In his first inaugural address with the nation on the verge of civil war, President Abraham Lincoln appealed to "the better angels of our nature" in making the case for keeping the union together. Despite Lincoln's plea, the war came and exacted an enormous cost on the nation. The nation's "better angels" disappeared
as the North and South armies fought ferociously to establish dominance.

Today powerful incumbents struggle to preserve healthcare's fragmented status quo against societal demands for value-based care delivery. This war rages with no end in sight. Its enormous cost is measured in lost resources, unnecessary suffering and economic loss.

At issue is whether Medicare Advantage will be the driving catalyst for disruptive industry transformation. To realize this potential, MA must amplify its medical management capacity (our better angels) and diminish the financial maneuvering (our lesser angels) that compromise its effectiveness.

The future of U.S. healthcare and the health of the U.S. economy hang in the balance. Another president with ties to Illinois, Ronald Reagan, famously quoted the Russian proverb "Trust but verify" in describing his approach to negotiating nuclear disarmament with his Soviet counterparts.

Employing President Reagan's sensibility, CMS must enhance MA's regulatory framework, trust the marketplace will evolve toward efficiency and verify that MA plans deliver value for customers. In that way, Medicare Advantage will truly provide advantage to the American people.

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David Johnson is the CEO of 4sight Health, a healthcare advisory company working at the intersection of strategy, economics, innovation and capital formation. Dave wakes up every morning trying to fix America's broken healthcare system. He is a frequent writer and speaker on the need to transform to a pro-market healthcare system. His expertise encompasses health policy, academic medicine, economics, statistics, behavioral finance, disruptive innovation, organizational change and complexity theory. Dave's book, ***Market vs. Medicine: America's Epic Fight for Better, Affordable Healthcare***, is available for purchase on www.4sighthealth.com.