WHITE PAPER

Flexing Their Muscles? Plan Sponsors Weigh in on Medicare Advantage Benefit Flexibility

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Overview

On Friday April 27, 2018, the Centers for Medicare and Medicaid Services (CMS) released its long-awaited guidance on newly established benefit design flexibility for Contract Year (CY) 2019. Following that initial guidance, CMS has continued apace to broaden the options available to Medicare Advantage Organizations (MAOs) in designing benefit packages.

However, despite the steady introduction of expanded opportunities for benefit flexibility and merited industry buzz, early signs and data points suggest MAOs are taking a relatively cautious approach towards incorporating benefit flexibility opportunities. For example, for 2020 plans, CMS has indicated that 500 plans comprising approximately 2.6 million enrollees (11.6% of the 22.2 million current MA enrollees) will have access to a broader menu of supplemental benefits[1].

In order to understand how MAOs incorporated new flexibility options into their benefit design process for the 2020 MA bid year, we reached out to a number of MAOs to solicit input on specific questions regarding benefit flexibility. Among other findings, we found that respondents rank improving clinical outcomes and Star Ratings – and not achieving overall cost savings – as the primary reasons they took advantage of benefit flexibility options. On the other hand, respondents emphasize that benefit cost is a concern, and are worried about the anti-selection that could result from offering innovative new benefits.

We have summarized all the survey feedback we received from MAOs in this white paper, and also include a discussion on CMS's major guidance related to benefit flexibility for MA bid years 2019 and 2020.

In the Beginning: The Birth of Benefit Flexibility[2]

Bid Year 2019 represented a monumental expansion of benefit design flexibility for MA plan sponsors due to CMS's reinterpretation of key areas related to plan benefits. The reinterpretation provided MAOs [1] the opportunity to provide a broader menu of

[1] CMS Press Release accompanying release of 2020 Medicare Advantage Landscape files, available at: https://www.cms.gov/newsroom/press-releases/trump-administration-drives-down-medicare-advantage-and-part-d-premiums-seniors

[2] Wakely's initial whitepaper on the concept of benefit flexibility, published in May 2018 is available below: https://www.wakely.com/sites/default/files/files/content/ma-unleashed_0.pdf

supplemental benefits (relaxation of the definition of "primarily health-related") and [2] the opportunity to offer customized, enhanced benefits to members based on objectively-defined health status (relaxation of the uniformity requirement). Relaxation of uniformity requirements effectively opened many of the initial Value-Based Insurance Design (VBID) model flexibilities introduced in 2017 to the broader MA population.

Benefit adaptions permitted under this newly allowed benefit flexibility included the reduction or elimination of cost sharing for certain services or high-value providers for those with chronic conditions, as well as introduction of benefits that were previously not permissible, such as home safety devices and modifications. A few examples introduced by MAOs for the 2019 benefit year include $0 endocrinologist visit copays for diabetic members, blood pressure cuffs for hypertensive patients, and "Flex/Wallet" benefits – basically a pool of funds to which member-appropriate benefits can be applied.

While additional benefit flexibility is a boon to plans interested in designing benefits tailored to the specific health needs of their members, it comes with new challenges in execution. Actuaries need to consider how to price new benefits that often lack historical data. This may result in "first principles" pricing work using sources ranging from publicly-available public health data to vendor and clinician input. Actuaries also need to consider the likelihood of anti-selection risk as well as potential cost offsets that new benefits may generate (e.g., avoidable emergency room visits or inpatient admissions). In addition to actuarial challenges, benefit flexibility creates operational issues with which MAOs must wrangle. These include member identification and condition-specific claims adjudication, the potential for beneficiary confusion and dissatisfaction, and finding qualified vendors, some of which may be new to the MA market, to administer innovative new benefits.

Despite these challenges, there are strategic reasons for plans to consider taking advantage of new flexibilities as they seek to use benefit design as a lever to reduce cost, improve quality, improve member satisfaction, and improve risk score coding accuracy.

A review of 2019 benefits revealed renewed interest in the MA world from solutions providers and vendors, perhaps more than from MA plans themselves who faced a tight timeline for vetting and developing new benefits. Moving forward, one can expect to see iteration and refinement as plans work through the exploration of new benefit flexibility opportunities.

New Opportunities for Flexibility

CMS's reinterpretation of benefit uniformity and the relaxed definition of "primarily health-related" benefits represented the first forays into allowing plan sponsors more flexibility in benefit design. In the months since this initial guidance, CMS has continued to introduce new avenues of flexibility. We provide an overview of key incremental avenues to benefit flexibility below.

Value-Based Insurance Design

The Value-Based Insurance Design (VBID) program began in 2017 as an initiative to create more tailored healthcare for MA beneficiaries and to encourage utilization of necessary services for chronic conditions. These objectives took the form of reduced cost-sharing and/or additional supplemental benefits for members living with chronic conditions. For the 2020 bid year, CMS introduced an expanded VBID program, which we will refer to as "VBID 2.0." In addition to expanding the program to nation-wide

and also expanding to new targeted conditions, VBID 2.0 allows for the following new flexibilities:

1.) Targeting of enrollees based on socioeconomic status[3] for reduced cost-sharing and/or additional supplemental benefits

2.) Spousal sharing of beneficiary's benefits

3.) Carryover of benefits to next plan year

4.) Additional non-primarily health-related benefits

5.) More robust Rewards and Incentives programs, including rewards up to $600 in annual value and rewards tied to Part D benefits

6.) Opportunity to (partially) satisfy network adequacy requirements via telehealth services

Also introduced as part of VBID 2.0 is the requirement that plans must include "Wellness and Health Care Planning" (WHP) in their VBID application. CMS's stated goal for WHP is to provide enrollees the opportunity to discuss their wishes for care, as well as to tailor delivery and avoid expensive and unwanted care. CMS has been vague regarding the details of how this would operate, simply stating that execution is up to the individual MAO and that there is no "right solution". Ideally, plans would be able to integrate this requirement in their existing administrative systems to improve the timing and efficiency of WHP.

Special Supplemental Benefits for the Chronically Ill

The Bipartisan Budget Act of 2018 created a new category of supplemental benefit intended for the chronically ill, called Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI was further fleshed out in the 2019 Final Call Letter. The intent behind SSBCI, as with the VBID program, is to help MA plan sponsors tailor benefits to populations in most need of additional care. To be eligible for benefits under SSBCI, an enrollee must:

1.) Have one or more co-morbid and medically complex chronic conditions that are life threatening or which significantly limit overall health or function

2.) Have a high risk of hospitalization or other adverse health outcomes

3.) Require intensive care coordination

An important nuance regarding benefits offered under SSBCI is that benefits only need to have a "reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee." This is a significant departure from the requirement that supplemental benefits must be "primarily health-related." Under this looser definition, an entirely new set of benefits are now in play for MAOs, including pest control, subsidies for utilities or rent, and transportation for non-medical purposes. CMS further increased this flexibility for the 2020 bid year, waiving the uniformity requirement and therefore allowing plans to target SSBCI to individual enrollees' specific medical condition and needs.

SSBCI benefits can be contingent on social determinants of health, more specifically low income subsidy ("LIS") eligibility, as *one factor* for establishing beneficiary eligibility, although they cannot be used as the sole determinant.

[3] Socioeconomic status is based on beneficiaries' Low-Income Subsidy (LIS) status.

Other New MA Flexibilities

Telehealth – Telehealth has traditionally been allowed as a supplemental benefit under Medicare Advantage. Effective for 2020 bids, however, plans were permitted to offer telehealth services as a basic benefit so long as specific CMS requirements were met. This change is important to MAOs as it effectively enables telehealth services to be included in the MAO bid, thereby freeing up rebate dollars, which plans can use to offer other supplemental benefits. Also, under the aforementioned VBID 2.0 program, for the first time telehealth services can be used to augment and complement provider networks in order to satisfy network adequacy requirements. CMS guidance does mandate that irrespective of breadth of telehealth options, beneficiaries must have the choice to see a provider in person if desired.

Indication-Based Formulary – Fully effective for the 2020 bid year, CMS is allowing Part D plan sponsors to employ indication-based utilization management strategies. The purpose is two-fold: to give plan sponsors and pharmacy benefit managers (PBMs) greater negotiating power with drug makers, and to give plan sponsors the option of expanding their formularies for members who require specific drugs for treatment while preventing off-label or experimental utilization. MAOs choosing to limit coverage to only specified indications must satisfy requirements around:

1.) Access to therapeutic equivalents

2.) Process for granting exceptions

3.) Existing formulary regulations

4.) Beneficiary notification

The new flexibility in indication-based formularies provides plan sponsors a method to expand their formularies without assuming full risk for alternative uses of the newly-covered drugs.

Part B Drug Step Therapy – Effective in 2019 for new prescriptions[4], MA plans may require members to seek treatment through a Part B drug therapy program before continuing to other therapies as needed. This flexibility can be deployed to ensure members first use a Part D drug before engaging in a Part B step therapy, or vice versa. The intent is to give plan sponsors leverage in negotiations with drug manufacturers and to provide plans with tools to better coordinate care between MA and Part D benefit packages.

Plan sponsors can choose to incentivize enrollees to participate in the coordination program through rewards and incentives and plans participating in this program must offer beneficiaries the ability to take part in drug management care coordination activities.

Rewards and Incentives – Rewards and incentives (RI) have been allowed under the MA program for the past few years. Traditionally, RI amounts were limited to the cost of the service. Beginning in 2020, CMS has expanded the options for MAOs related to their RI programs under both the VBID 2.0 and Part D Modernization Models.

For VBID 2.0, CMS no longer limits RI to the cost of the service, and allows RI up to $600 per enrollee per year. CMS hopes that in removing the cost-based limitation, plan sponsors can

[4] Note that step therapy can only be required for *new* prescriptions. Plan sponsors cannot require beneficiaries already using a specific drug to be subject to step therapy. CMS August 7, 2018 Fact Sheet, available at: https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-prior-authorization-and-step-therapy-part-b-drugs

deploy greater resources toward driving member behavior to engage in programs that will improve health outcomes and lower cost.

Under the 2020 Part D Modernization Model, MA as well as Part D only plans may propose Part D RI programs to encourage enrollees to use Part D covered medications in ways that lead to improvement in health outcomes, medication adherence, or the efficient use of health care resources.

MAO Views on Benefit Flexibility

Wakely polled a number of MAOs, seeking to better understand not just the specific benefits plans are offering under the auspices of benefit flexibility, but also how plans weigh the considerations related to new flexibilities made available by CMS. This section summarizes the key takeaways from our MAO survey effort.

Who Participated in the Survey?

Wakely released a survey to various industry professionals working for MAOs to gain insight into industry perspectives around benefit flexibility. Our goals of the survey were to understand what MAOs are currently doing, what they see as the greatest benefits or opportunities, and why MAOs may not yet be taking full advantage of the range of CMS-provided possibilities.

MAOs responding to the survey were typically established, rather than new organizations, potentially indicating that they may be better positioned to understand and/or take advantage of benefit flexibility.

Most of the responses were from MAOs with between 10,000 and 50,000 beneficiaries and who have been operating for more than five years, and about 80% of responding MAOs have existed at least four years.

Many of the respondents held a senior position within their organization (e.g., C-suite, Head of Marketing/Strategy, etc.), which indicates they are likely in a position to enact strategy or to have extensive Medicare knowledge.

57% of respondents said they took advantage of benefit flexibility in 2020. This may be higher than the national rate, as we suspect MAOs who chose to participate in a survey on benefit flexibility are more likely to have experience in this area. The most frequently reported benefits included items such as enhanced meals, over-the-counter drugs, and bathroom safety devices.

Respondents were asked about their familiarity with various benefit flexibility options. Most responses indicated a good understanding of benefit flexibility programs, however we believe this may also be skewed due to which MAOs opted to participate in the survey. Most respondents were very familiar with uniformity flexibility and the relaxed definition of “primarily health-related” benefits. Respondents were less familiar with SSBCI, and many respondents were unfamiliar with the opportunities for enhanced Part D Rewards and Incentives; no respondents indicated having taken advantage of this particular program.

Benefits and Opportunities for Benefit Flexibility

In order to understand the drivers that encourage MAOs to offer certain flexible benefit options, survey respondents were asked to identify the following strategic considerations as “Very Important”, “Somewhat Important”, or “Not Important” when making benefit decisions:

- Expected Positive ROI/net cost savings
- Likelihood to improve Star Rating measures
- Likelihood to improve clinical outcome

- Likelihood to attract new members and/or retain existing members

Survey respondents identified all considerations as either "Somewhat Important" or "Very Important" (see Appendix A, Table 1). Overall, respondents felt that improving clinical outcomes was the most important benefit, followed closely by the improvement of Star Rating measures. Attracting new members and retaining existing members came in at third in the importance ranking. Respondents indicated that benefits have a positive ROI or net cost savings – while important – was the least important consideration in taking advantage of benefit flexibility options.

We also asked MAOs what conditions they focused on or intended to focus on and what social determinants of health they anticipated attempting to address. By far, the health condition that received the greatest amount of attention was diabetes, with over 90% of respondents identifying it as a condition of focus. Diabetes was followed by congestive heart failure and COPD/Asthma. For social determinants, MAOs' primary focus was on transportation and food security. Both of these categories may represent benefits for which MAOs already have existing vendor relationships due to other associated benefits, making them easier to operationalize. Other social determinate-type benefits of interest to plans included addressing social isolation and providing caregiver support.

Challenges of Benefit Flexibility

We asked survey participants to rank the following potential concerns regarding benefit flexibility opportunities from "Not a Concern" to "Major Concern":

- Cost/Anti-selection of benefit
- Operational issues with administering benefit
- Lack of familiarity with benefit flexibility
- Shortage of time in 2020 planning cycle to vet benefit
- Reintroduction of the health insurer fee in 2020

Overwhelmingly, cost and/or anti-selection were the biggest concern for MAOs (see Appendix A, Table 2). Respondents mentioned not wanting to be "first out of the gate", and voiced significant worry that creating new benefits which had not been thoroughly vetted and tested could be risky. Respondents also mentioned that they would like CMS to share more information on what is and is not working for plan sponsors. Operational issues and a lack of time during the planning process were identified as additional key concerns. A lack of familiarity with various benefit flexibility options did not appear to be a major concern for respondents, although once again our results may be skewed by the MAOs who have chosen to respond to our survey.

Next Steps

Since April 2018, CMS has continued to expand the possibilities for benefit design flexibility. The rapid pace of change has created an environment in which MAOs with the expertise and appetite can innovate to better meet the needs of their beneficiaries, and do so in a more customized, personalized fashion.

Wakely's survey of MAOs illustrated how plans are using benefit flexibility to address their own varied concerns and strategic goals.

On October 1, CMS and MAOs will release 2020 plan benefit package (PBP) details via Medicare Plan Finder and MAO websites. Note that the full PBP details on uniformity flexibility and VBID benefits may not be available in an easily

manipulable format until early 2020. In the coming weeks, Wakely will continue its analysis of benefit flexibility topics with discussion of innovative benefit highlights for the 2020 benefit year.

Please contact Nate Baehr, Robert Lang, or Dani Cronick with questions or to follow up on any of the concepts presented in this paper.

Appendix A

Table 1

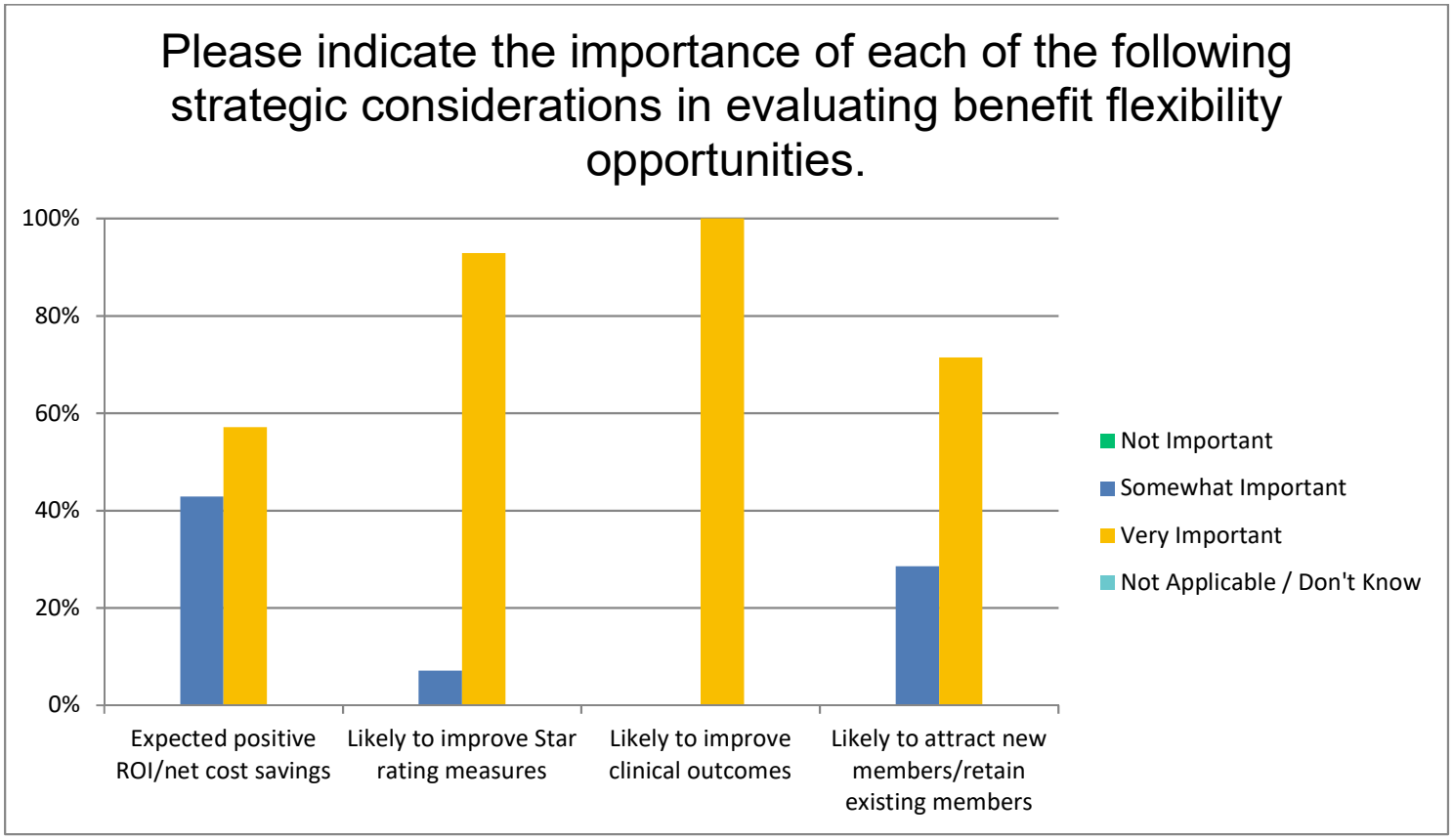
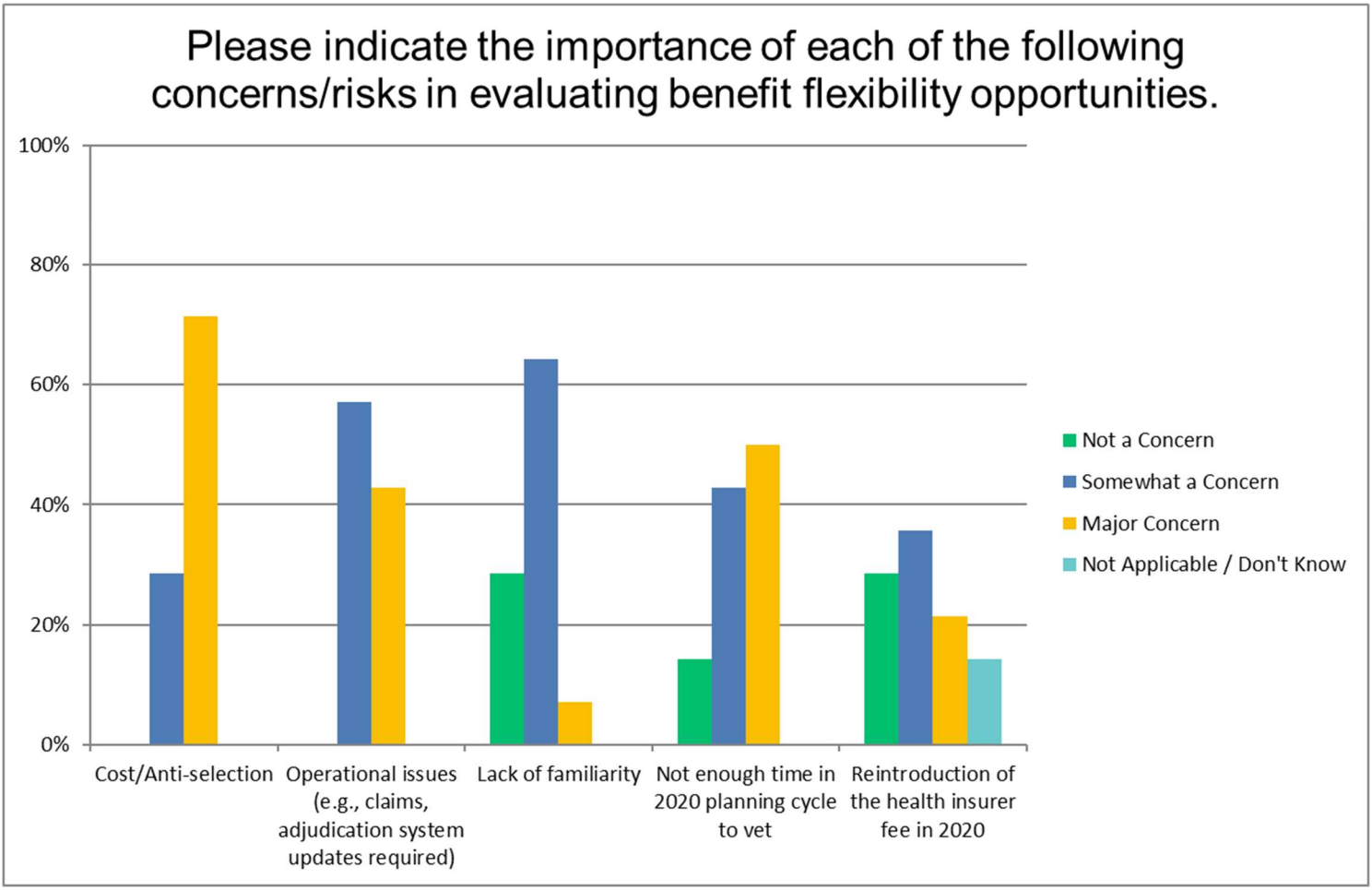


Table 2


Please indicate the importance of each of the following concerns/risks in evaluating benefit flexibility opportunities.
100%
80%
60%
40%
20%
0%
Cost/Anti-selection
Operational issues (e.g., claims, adjudication system updates required)
Lack of familiarity
Not enough time in 2020 planning cycle to vet
Reintroduction of the health insurer fee in 2020
Not a Concern
Somewhat a Concern
Major Concern
Not Applicable / Don't Know