Executive Highlights

We spent late January in the shadow of the Capitol attending the 5th Annual National Forum on the Business of Medicare Advantage and Compliance in Arlington, VA. At the conference, we took a deep dive into the world of health insurance programs, particularly Medicare and Medicare Advantage (MA). For background, MA is a health insurance program that provides Medicare benefits through non-governmental HMOs. Currently, there are about 450 MA contracts (run by just under 200 different organizations), and about 25% of seniors (14 million people) are enrolled in an MA plan. For more details on how MA works and on how it differs from Medicare, please see the Appendix.

This was a tiny meeting with about 40 people (many of whom work for health plans and systems) in attendance to learn strategies for how plans – particularly Medicare Advantage (MA) plans – can adjust to the series of reforms being implemented under the Affordable Care Act (ACA). We gained a deeper appreciation for how difficult a task this will be for health plans and systems. There is so much uncertainty about exactly how the Affordable Care Act [ACA] will impact health insurance companies and even more ambiguity about what additional reforms might be implemented. Below, we synthesize our learnings from the conference, and hypothesize how movement in the insurance industry might impact the pharmaceutical arena and people with diabetes.

- **The 2012 Harris Poll** (n=2,000 US adults) found that people generally prefer price controls on pharmaceutical and device companies over alternative strategies for addressing healthcare costs. This was unsurprising, given that the answer to most questions asked in the form of “do you want to personally pay more for X?” will be no. In the 2012 Harris Poll, 54% of respondents preferred reduced payments to pharmaceutical companies and providers rather than increased cost sharing (40%) or restricted access or benefits (7%) to address increasing healthcare costs. Additionally, the third most popular strategy to keep Medicare financially sound was paying pharmaceutical companies less for prescription drugs (with 47% of respondents either strongly or somewhat favoring this strategy). We fear that the government had such poll numbers in mind when it passed policies, such as competitive bidding for diabetes supplies, and we wonder if consumers understand the financial implications of such policies for pharmaceutical companies (e.g., less resources for innovation).

- **In a conversation with Dr. Adam Kaufman** (General Manger, dLife, Westport, CT), he hypothesized that the rise of managed care and the focus on quality will benefit pharmaceutical companies by increasing medication adherence, at least in the short run. However, he thinks that it is possible that as payors develop closer ties with their members, using price (via co-pays, co-insurance, etc.) to make them more aware of the cost-effectiveness of drugs, payors will play a larger role in picking which drugs are used. We agree. He also believes that managed care plans will work to reduce barriers to initiation of insulin. Although he feels this will hurt the oral drugs, we aren’t sure since this is multi-factorial question. Recently, a number of patients have delayed going on insulin due to incretins. However, over the long-term, cost pressures might drive earlier insulin initiation and, therefore, could reduce payments for some oral incretins. Yet, patients who go on insulin sooner may also continue to take oral medications. Additionally, we think more people with type 2 diabetes going on insulin earlier could increase their average life expectancy, which might augment the average “lifecycle” of all drugs.
Dr. Kaufman said a good Medicare Advantage (MA) plan could be better than Medicare for people with diabetes. Under many healthcare models (sometimes described as acute-care models, since acute illness and injuries are what they address best) a healthcare provider is only paid when a patient is sick. Thus, the system has little incentive to be concerned about a patient’s behavior when she is well (e.g., if she is taking her medications). In contrast, an MA plan is paid the same amount for a patient (a value adjusted for the patient’s medical risk) no matter the patient’s final medical costs to plan. MA plans, therefore, have incentives to reduce costs by preventing sickness and coordinating care. For example, in most MA plans a patient’s PCP serves as a “gatekeeper,” referring them to specialists. The hope is that the PCP will help coordinate a patient’s care among specialists. Such a system could be particularly useful for people with diabetes, given the many specialists they must see. However, if this process is poorly executed, a patient may have difficulty in quickly getting specialty care – a problem sometimes associated with managed care plans in general.

Several speakers emphasized the growing consumerism in the health insurance market. Dr. Kaufman highlighted how many insurance companies are shifting their marketing campaigns from targeting employers to individuals. For example, UnitedHealth is piloting retail stores to sell health insurance plans. This shift could be in response to the introduction of state-based health insurance “marketplaces” (the new name for “exchanges”). Dr. Kaufman suggested that payors might be replacing the marketing clout of pharmaceutical companies: the anecdotal evidence indicates that those companies are engaged in less direct-to-consumer (DTC) marketing than they used to. On the consumer side, Ms. Debra Richman (Senior VP, Healthcare Strategy and Business Development, Harris Interactive, New York) corroborated Dr. Kaufman’s position, stating that consumer behavior in healthcare is beginning to mirror that seen in other industries such as consumer goods and financial services.

- For background, the marketplaces are intended to provide a single place to shop for individuals and small businesses buying their own coverage. To make it easier to compare policies, information on plan benefits will be standardized. Additionally, plans will be divided into four types (bronze, silver, gold, and platinum) based on their level of benefits. Though most people will continue to get insurance through their employers, the marketplace format might affect those plans’ marketing strategies.

- Speakers seemed to agree that MA plans are facing a very difficult period because plans may face decreasing revenues and increasing regulations. Some policy analysts believe that the cuts in reimbursement and the increased regulations from the Affordable Care Act [ACA] (see below for details) will result in MA plans having higher premiums and lower enrollment. Ms. Sue Rohan (VP, Health Care Service Corporation, Chicago) showed data from the Centers for Medicare and Medicaid Services’ (CMS) Office of the Actuary forecasting that MA enrollment will be 50% lower in 2017 than it would have been if healthcare reform had not been passed. She warned that plans must focus on “surviving” the next few years. Similarly, Dr. Timothy Schwab (CMO, SCAN Health Plan, Long Beach, CA) characterized that MA is facing a downward trajectory for the coming years. Ms. Rohan and Dr. Schwab both offered some hope with phrases like “the [market] will swing the other way” eventually. Unfortunately, neither provided strategies for how plans can survive or how the industry can reverse this trajectory. We note, however, that a Kaiser Family Foundation study (http://www.kff.org/medicare/upload/8323.pdf) found that despite the implementation of some regulations and the reductions in reimbursement, MA enrollment grew by 10% in 2012 and that at $35 the average premium paid by MA enrollees in 2012 was $4 less than it was in 2011. The report did not state how MA plan’s bottom lines are fairing.
For background, according to the Kaiser Family Foundation, MA plans cost taxpayers an average of 14% more a year than traditional Medicare in 2009 (for more details see the report at http://www.kff.org/medicare/upload/2052-12.pdf). Under the ACA these excess payments are to be reduced to 2%, and reimbursement reductions began to take effect in 2012. The Congressional Budget Office estimated that ACA’s payment policy will save taxpayers $132 million over 10 years. Healthcare reform also limits the cost sharing that can be imposed on enrollees for certain services (e.g., no cost-sharing for some preventive care services).

- **Given that this conference targets an audience that represents non-governmental insurance plans, we were surprised that several speakers supported a single-payor system.** In response to a question on the impact of having an increasing number of payors (primarily due to state-based health insurance marketplaces), Mr. David Lipschutz (Center for Medicare Advocacy, Willimantic, CT) simply responded, “We need a single-payor system.” Another panelist, Ms. Susan Roberts (CEO, The RobertsGroup, Tampa Bay, FL) also said a single-payor system was a “good idea.”

- **A frequently discussed proposal to reform Medicare was increasing the eligibility age from 65 years to 67 years of age.** According to Dr. Leonard Kirschner (President, AARP Arizona, Phoenix), increasing the age from 65 to 67 would not have a substantial impact on the country’s healthcare spending. Additionally, he was concerned that to save money, people delay seeking needed care as they approach the eligibility age. He fears that raising the age will exacerbate this problem and that Medicare will pay for the potential medical consequences. Ms. Rohan noted that increasing the age would result in society paying additional subsidies to some plans, which are based on a person’s risk factors, including age. However, Mr. William Boyles (Editor and Publisher, Consumer Driven Market Report, Washington) reminded the audience that increasing the age not only reduces the number of years Medicare covers a person, it also increases the number of years people pay into the program. Personally, we feel that the age should be lifted to adjust for people living longer, and we have seen some estimates of such a change reducing Medicare’s costs by about 5% over the next 20 years. Though this reform would not be a panacea for Medicare’s financial woes, we think it is an important and logical first step, and we would assume that people would be given several years notice – or a decent warning – on when this policy would start.

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Detailed Discussion and Commentary

ENGAGING MEMBERS AS CONSUMERS FOR BEHAVIOR CHANGE: DIABETES IN THE STAR RATINGS

Adam Kaufman, PhD (General Manager, dLife Healthcare Solutions, Westport, CT)

During his presentation, Dr. Kaufman described two trends he is seeing in the Medicare Advantage market – rising healthcare consumerism and a growing focus on quality – and how they might impact plans’ relationship with people with diabetes. Describing how consumerism in healthcare is increasing, Dr. Kaufman noted that United is piloting the use of retail stores, and many insurance companies are shifting their marketing campaigns from targeting employers to individuals. He hypothesized that payors might even be replacing pharmaceutical companies’ marketing presence, as he (based on observation) believes pharma is now performing less direct-to-consumer (DTC) marketing. On the quality front, Dr. Kaufman noted that the trend of an increasing focus on quality care is particularly good news for people with diabetes. Prior to healthcare reform plans, payors had little financial incentive to invest in preventative services for long-term complications. However, the ACA tied STAR ratings to the magnitude of bonus payments a contract receives and how the Centers for Medicare and Medicaid Services (CMS) represents it to potential members. According to Dr. Kaufman, about 20% of the STAR rating measures relate to diabetes, including A1c (disappointingly, plans are graded against an A1c threshold of 9.0%) and receipt of eye and kidney screenings. Thus, the ACA provides insurance companies with the needed financial incentive to perform – and even promote – the preventative services and programs. In a conversation we had with Dr. Kaufman, he hypothesized that the rise of managed care and focus on quality will (at least in the short run) benefit pharmaceutical companies by increasing medication adherence. However, he thinks that it is possible that as payors develop closer, more influential relationships with their members and use price (via co-pays, co-insurance, etc.) to make members aware of the cost-effectiveness (in the plan’s opinion) of medications, payors will play a greater role in picking which drugs are winners or losers. In particular, he believes that managed care plans will work to reduce barriers to insulinization, potentially compressing the oral antidiabetic market.

- **Rather unbelievably, about 75% of attendees (predominantly insurance company employees) indicated that some people on their teams are not aware of the type 2 diabetes epidemic.**

- **According to Dr. Kaufman, about 20% of STAR measures are diabetes related.** These measures include whether people with diabetes received an eye exam and a kidney function test, and whether their blood glucose and cholesterol are under control. We were surprised and disappointed to learn that CMS’ current definition for glucose control is an A1c less than 9.0%. Unfortunately, more than 50% of MA plans have less than 75% of their members with diabetes at an A1c less than 9.0%.

- **Currently, none of the STAR measures directly relate to preventing obesity or type 2 diabetes, but Dr. Kaufman believes CMS might be moving in that direction.** In a conversation we had with Dr. Kaufman, he explained that a contract’s rating is impacted by whether it tracks its members’ physical activity and – a recent addition – BMI. Contracts are currently not incentivized to have their members’ BMIs below a certain level or physical activity above a threshold, but Dr. Kaufman believes the addition of tracking BMI suggests that CMS is moving in that direction.
Dr. Kaufman highlighted increasing consumerism in healthcare as the first of two trends in Medicare Advantage. He noted UnitedHealth is piloting the use of retail stores to sell health insurance plans in a similar manner to how Apple sells computers (for more details see http://www.bloomberg.com/news/2013-01-04/unitedhealth-retail-stores-sell-insurance-with-a-smile.html). Similarly, Humana is partnering with Walmart, and Aetna is increasing its presence at Costco. Additionally, he highlighted how many insurance companies are shifting their marketing campaigns from targeting employers to individuals. He hypothesized that payors might even be replacing pharmaceutical companies’ marketing presence, as he (based on observation) believes pharma is performing less direct-to-consumer (DTC) marketing.

The other trend Dr. Kaufman noted was an increasing emphasis on quality care and outcomes, which he believes particularly benefits people with diabetes. Prior to healthcare reform, plans had little financial incentive to invest in preventative services for long-term complications. Companies had little confidence that people with diabetes would still be in their plans long enough to realize the benefits of investing in programs to promote eye exams and glycemic control. If members switched plans, other companies would reap the financial benefit of the first’s investment. The ACA changed this by tying STAR ratings, and therefore bonus payments and positive representation to potential members by CMS, to diabetes-related measures. Thus, insurance companies now have a financial incentive to perform – and even promote – preventative services to their members with diabetes.

dLife has been working to help insurance companies, including Humana, connect with their members with diabetes and improve service utilization and outcomes. For about the past two years, dLife has collaborated with Humana on MyDiabetesPath, a multi-channel, multimedia, eight-week instructional program on how to track medications, diet, exercise, and blood glucose. Medicare Advantage members enrolled in the program receive recipes, fitness regimens, information on insulin management, expert Q&A, and access to an online support community. Though the program is designed to take eight weeks, members always have access to the MyDiabetesPath website.

The MyDiabetesPath program resulted in improvements in several measures and helped with Medicare STAR ratings in a pilot study (n=18,000; baseline characteristics not provided). Compared to a control group, the MyDiabetesPath participation arm had a 9% higher rate of A1c screening, a 7% improvement in LDL screening rate, a 7% increased rate of receiving an eye exam, and a 6% higher rate of monitoring kidney disease. The exact impact MyDiabetesPath had on the contract’s STAR rating was not stated.

Questions and Answers

Dr. Leonard Kirschner (President, AARP Arizona, Phoenix, AZ): I was a Medicaid director in Arizona. Medicaid advisors are having a meeting in Phoenix on Friday. Obesity is epidemic in our Hispanic and Native American populations and reaching those populations with education programs has proven to be a daunting task. Do you have any thoughts?

A: We do a fair amount of work on consumer segmentation. At a minimum the segments of age, language, and gender are very important. Medicaid has a higher prevalence of type 1 than type 2 because of the younger population. We speak to people with diabetes and we think it is important to talk to that population. We speak about depression in relation to diabetes, but we would not approach people with depression who do not have diabetes. Outside of that we have learned that the problem of feeling alone is very prevalent in all of these communities. It tends to help if people have the opportunity to speak to
people who had the same experience. You have to find a way to address these problems and provide information that is relevant to them.

Q: How willing are plans to pay for these kinds of solutions?

A: When these solutions are tied to other benefits there is a much greater willingness. There is a lot of interest driven by plans on the quality measures.

Q: Do you have data on your ROI?

A: There is a direct correlation between the STAR ratings and our improvements in quality outcomes. We have some data on claims reduction though it is not as strong yet.

Q: There is a large population of gastric bypass surgeries. A lot of people who have this surgery are prediabetic since they are obese. I would like to get your thoughts on if these surgeries prevent diabetes in such people.

A: There is some exciting data, though it is still pretty early, showing that you can reverse a lot of the problems associated with type 2 diabetes with the surgery. It is believed this occurs in two ways: the weight loss itself and in some of the gut hormonal changes itself. Behavior change is hard. Losing weight is hard. Surgeries are challenging. However, I have not seen studies on preventing the development of type 2 diabetes. The results I just mentioned were from studies assessing the impact of surgery on people with diabetes.

Comment: A lot of people who are obese will likely develop diabetes, which is why a lot of plans are willing to pay for gastric bypass for some members.

Q: The country faces economic issues because of our dysfunctional sick care system. People can move and pick different plans and diabetes is a lifetime condition. It therefore is important to consider who pays the cost and who reaps the benefits. So if you are paying money to prevent complications, they might go to another plan who will see the benefit of your spending.

A: One of the things I point out is that, for the reason you are describing, from a diabetes standpoint it is important to have good quality measures that people rely on. Unfortunately, from a cost/benefit standpoint, it is hard to show a plan the cost effectiveness of reductions in long-term complications. Developing blindness can be a 20-year endeavor. So we do get some of that pushback. Where I think you see it even more is with programs that are intensive case management programs that are hard to do and are highly expensive in terms of resources – our program is relatively low resource compared to these.

HARRIS POLL TRENDS AND PREDICTIONS

Debra Richman (Senior VP, Healthcare Strategy and Business Development, Harris Interactive, New York, NY)

Referring to the 2012 Harris Poll’s (2,000 US adults and 484 seniors) results, Ms. Debra Richman affirmed Dr. Adam Kaufman’s (General Manager, dLife Healthcare Solutions, West Port, CT) earlier assertion that the healthcare market is rapidly moving towards consumerism. According to Dr. Richman, consumer behavior in healthcare is beginning to mirror that seen in other industries such as consumer goods and financial services. She told the health plan managers in the room that patients are most concerned about healthcare being affordable – followed by quality – and that most (54% of the US adults surveyed) prefer reduced reimbursement to pharmaceutical companies and providers versus paying more for their healthcare (20%), paying higher taxes for healthcare (20%), or restricting access
or benefits (7%) to address increasing healthcare costs. Similarly, among seniors surveyed, the most popular strategy for reducing out-of-pocket Medicare costs was increasing controls on the prices charged by drug and diagnostic companies. The third most popular strategy among US adults surveyed for keeping Medicare financially sound in the future was paying pharmaceutical companies less for prescription drugs (with 47% of respondents either strongly or somewhat favoring this strategy). Those surveyed also expressed willingness to have more restricted coverage of brand name prescriptions in order to lower healthcare costs, with 26% of respondents either extremely or very willing to face those restrictions. When patients were forced to make tradeoffs between benefits, they tended to favor cost-related benefits (e.g., low co-pay for generic drugs) over access-related items (e.g., choice of hospitals), a trend that appears to hurt prescription drug coverage since many such benefits (e.g., coverage for a wide selection of brand name drugs) were of below average importance to surveyed patients. It appears that employers might be acting on these preferences; nearly two-thirds of surveyed employers (n=276) imposed changes to their prescription drug coverage over the past year, and the majority of changes made increased the cost of brand name drugs relative to generic. We believe these statistics demonstrate the need for increased education on the cost of developing innovative new drugs, but also the need for pharmaceutical companies to think creatively on ways to reduce their costs making lower prices sustainable or to reduce the out-of-pocket cost for patients.

- According to the Harris Poll, adults (n=2,000) feel that health insurance premiums are a greater financial burden than prescription drugs, hospital bills, or doctor bills. Of those surveyed, 44% labeled health insurance premiums as either a major or moderate burden, while 31% identified prescription drugs as such and 34% characterized hospital and/or doctor bills as being a major or moderate burden. We note that the proportion of US adults who identified prescription drugs as a major financial burden was quite similar to that of health insurance premiums (16% vs. 17%, respectively). Additionally, the cost of prescription drugs were the most likely to be described as “not a burden at all.” We are curious what the correlation was between a person’s use of generic vs. branded prescription drugs and their characterization of the financial burden prescription drugs represent, or between the number of prescription drugs they are on and the financial burden the drugs pose.

<table>
<thead>
<tr>
<th>Financial Burden</th>
<th>Prescription drugs</th>
<th>Hospital bills</th>
<th>Doctor bills</th>
<th>Health insurance premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major burden</td>
<td>16%</td>
<td>12%</td>
<td>12%</td>
<td>17%</td>
</tr>
<tr>
<td>Moderate burden</td>
<td>15%</td>
<td>23%</td>
<td>22%</td>
<td>26%</td>
</tr>
<tr>
<td>Minor burden</td>
<td>18%</td>
<td>30%</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Not a burden at all</td>
<td>51%</td>
<td>36%</td>
<td>40%</td>
<td>32%</td>
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- Surveyed adults (n=2,000) were willing to have more restricted benefits, including more restricted coverage of brand name prescriptions, to reduce costs, but expressed unwillingness to trade off access to primary care and preventative services. Among those surveyed, 26% said that they were either extremely (9%) or very (17%) willing to have more restricted coverage for brand name prescriptions in order to save money, whereas only 11% were extremely/very willing to face more restricted coverage for preventive procedures and 13% were extremely/very willing to restrict their choice of primary care physician.

- When adults under 65 (n=2,052) were forced to make tradeoffs between benefits, they tended to view cost-related benefits as more important than access-related items – a trend that does not favor prescription drugs or medical devices. Of the six benefits which were scored as having “above average” importance were having low co-pays for generic drugs and having reasonable co-pays for brand name drugs. In contrast, of the eight benefits characterized as having “below average” importance to patients, four related to access to drugs and medical devices.
These included: unrestricted access to cutting-edge drugs, unrestricted access to cutting-edge medical devices and procedures, access to all brand name drugs at low cost-sharing levels, and coverage for a wide selection of brand name drugs (the third least important benefit to patients, before choice of hospitals and access to prestigious institutions).

- **A substantial proportion of the adults surveyed (n=2,000) expressed concerns about the cost of their prescription medications through a variety of actions.** Of those surveyed, 31% stated that they discussed the cost of a prescription drug with either their doctor or pharmacist; 29% asked their doctor or pharmacist about a less expensive alternative for a drug; and 26% asked their doctor for free samples of a medication they prescribed. About 17% took a medication less often that their doctor recommended. Similarly, 12% took a lower dose of a prescription than their doctor recommended. Ms. Richman did not address if these actions were taken only in response to the drug’s cost or if they could represent poor adherence. However, 13% of those surveyed did not fill a prescription because they decided it was less important than other medicines they were taking, and the same percentage had to change medications because their plan no longer covered the medication they were taking. In contrast, 11% of respondents stated that they paid more out of pocket to get a better drug.

- **The 2012 Harris Poll found that among surveyed adults (n=2,000), one of the most popular strategies for keeping Medicare financially sound in the future is to have Medicare pay pharmaceutical companies less for prescription drugs.** About 47% of respondents said that they either strongly (17% of respondents) or somewhat (30%) favor the implementation of this strategy. In contrast, only 23% of respondents said that they either strongly (9%) or somewhat (14%) opposed this strategy. Other popular strategies included: requiring only higher income seniors to pay Medicare premiums (with 49% strongly/somewhat in favor), reducing hospital fees for seeing Medicare patients (49%), and reducing nursing home charges for Medicare patients (47%). The least popular strategies (all with only 9% of respondents strongly/somewhat in favor of) were reducing Medicare benefits, requiring all seniors to pay higher Medicare premiums, and requiring seniors to pay a larger share of Medicare costs out of their own pockets.

- **About two-thirds of the surveyed employer health benefit decision makers who offered prescription drug benefit coverage (n=276) imposed changes to this coverage over the past year.** The majority of these changes increased the cost differential between brand name and generic drugs. The most common change (which 30% of respondents implemented) was lowering co-pays for generic drugs and the second most common (24%) was increasing co-pays for branded drugs. In addition, 19% of people added a deductible for branded prescription coverage. However, there were some decision makers who increased prescription drug coverage; 19% of respondents had added a prescription drug benefit and 15% switched to offering no co-pays for some preventative drugs.

**Questions and Answers**

**Q:** Have you done similar surveys on political leaders?  
**A:** Yes, the results were very partisan. Democrats were for reform and Republicans were against reform. However, when we did not brand the components as being part of ACA and just asked people would you like “X” then there was a lot of bipartisan support for the components.

Comment: People hate the law but love everything in it. It is interesting to see the schizophrenia of the answers.

**Q:** Is there any data on the awareness of what the process will actually be? We still field calls every day saying, “Obama is paying for my healthcare.”
A: It is hard to do research when people have not done something yet. We can ask questions about cost and benefits but it is hard to gather information on peoples’ experience when they have not done them yet. The level of understanding is very low, but it is increasing probably as a result of there being a lot of media coverage. Consumers very much prefer employer-based benefits over the exchanges though – well over 80%.

Q: What was the general awareness of the fees and taxes? My sense is that there is very little awareness from any groups. I think that there is going to be sticker shock. I do not think that employers have any comprehension of that. That type of an additional tax is going to be a surprise to many.

A: I agree.

PANEL: MEETING THE NECESSARY COMPLIANCE REQUIREMENTS

William Boyles, MA (Editor and Publisher, Consumer Driven Market Report, Washington, DC); David Lipschutz, JD (Center for Medicare Advocacy, Willimantic, CT); Susan Roberts, (President and CEO, The Roberts Group, Tampa Bay, FL)

Mr. Boyles: Kaiser spent about $6 billion to set up their current IT system, where all members are fully connected to all their providers, and pharmacy, etc. 24/7. This what you are also starting to see in Europe. Inside KP is an amazing book; I am actually sending it to people telling them to read it. When Kaiser got the total connectivity set up they found out a lot of things, including if you give statins to a stroke patient going into the ER, whether they were on statins or not, it reduces the mortality rate by 50%, and this is for a population of 8-10 million people. This was the largest study done on this topic. It was something they just discovered because they had the technology in place to measure it. Kaiser has made about 12 major clinical discoveries just by having the technology in place. You have to believe that this is something everyone is going to be doing in the next five years. As you have the Mayo Clinic aligning with United forming these huge data consortiums, it really is a result of what Kaiser has been doing. What is happening in Europe supports that. We are either going to take this large provider formation or, which is more likely in my opinion, there is going to be a medical cliff. All of a sudden we are going to realize this is happening – and I have not said this publicly before – IT deficit is the largest cause of death worldwide. It is causing tens of millions of people to die each year. It is something that has to be documented and measured. I think that we are on the edge of how we do things, and it is going to be really good and save a lot of lives.

Mr. Lipschutz: A lot of patients express frustrations about not being able to see the best specialists or there not being many specialists within their plan. [...] I want you to know that we will be watching. We will be trying to ensure that Medicare Advantage plans’ beneficiaries are being served as expected.

Ms. Roberts: The current health environment is highly regulated and is becoming more complicated all the time. More and more regulators and overseers, demanding more accountability, transparency, quality, and performance. Regulators are becoming a lot better at detecting program non-compliance and poor performance. Some of the effects of healthcare reform are that it is now easier to prosecute healthcare fraud. It also created mandatory compliance programs and initiated a race between plans against the new enforcement environment. It is now a competitive disadvantage not to have an effective compliance program and to “self-police” operational compliance status.

Mr. Boyles: Recently I realized that with the opening of the exchanges we will have a tripling of payment sources. What impact will having to rival the state exchanges and these many different payors have?
Mr. Lipschutz: We need a single payor system.
Ms. Roberts: I agree; I think that is a good idea.

Dr. Leonard Kirschner (President, AARP Arizona, Phoenix, AZ): You are even using the wrong name, the system is so complicated. The name is now “marketplace.” “Exchange,” apparently, had a negative connotation.

Mr. Boyles: Is having so many different payors something that is so below the radar that we do not know what is going to happen but is going to be a train wreck?
Ms. Roberts: I think that you are right; the light at the end of the tunnel is a train.

Mr. Lipschutz: That is what I figured. The number of national chains forming ACOs [Accountable Care Organizations] tripled once Obama got elected. So I was wondering has that translated yet into the number of plans reaching out to you?

Ms. Roberts: I think that we are probably on the edge of that. I think that many of those companies had filed those plans but had not moved on them until after the election.

Mr. Boyles: Are you seeing any changes in the nature of hearings occurring on The Hill?

Mr. Lipschutz: I think many people are very concerned about what is going to happen in the next few months. I think that wise decisions are rarely made in a panic. I think that a lot of the Medicare reform proposals that are getting the most traction would shift cost onto beneficiaries and would do nothing more. They would do nothing about rising healthcare costs. The things that are being talked about most are further increasing Medicare premiums, and raising the age of eligibility, which has gotten less attention lately...

Dr. Kirschner: [Sarcastically] Doesn’t increasing the age make sense? Think about how much money you would save on the trust fund. [Laughter.]

Mr. Lipschutz: Why don’t we move it to 90 years and make it an award for living long.

Ms. Sue Rohan (VP, Health Care Service Corporation [HCSC], Chicago, IL): You will end up spending the money you think you would save in the exchanges in subsidies.

Mr. Boyles: Except, when you are talking about raising the age to 67 years old, you are also extending the period that people are contributing in – people forget that. It is completely a bogus argument to say that we are living longer so we will move it to 67. The money is in the extra revenue brought in, not what you do not spend.

PANEL: VIEW FROM THE HILL

Elizabeth Jurinka (Health Legislative Assistant, Senator Ron Wyden Office [D-OR], Washington, DC); Susan Stoner (Health Legislative Assistant, Senator Mike Crapo Office [R-IA], Washington, DC)

Q: Let’s talk about where we are in Washington now. We went through the fiscal cliff in December, but we have kicked the can down the road. Give us a ballpark of this eleven months as we deal with health policy on the Hill, starting with the debt ceiling and sequester.

Ms. Jurinka: We have kicked the can down the road. My boss would have liked to see things play out a little differently. It is an interesting signal about where Washington is in terms of making decisions. I
know that what my boss would like to see is a more substantive discussion on entitlements. I feel very fortunate to be up here with Susan; we work very well together. I do not know if that is an anomaly in Washington, but it does exist. I know that both of our bosses would like to see a discussion on entitlements. If we continue down this road, does sequester become a valuable option, or do you have death by a thousand cuts rather than changes that make a better system, or is there a third option? I do not think that the path forward is particularly clear. We will probably have a sense if something is going to happen in March. Open season for the under-65 population starts in October. There are silos created for the under-65 versus over-65 populations and not looking at them holistically.

Ms. Stoner: If anyone asked me what would have happened in December, I do not know if any of us would have believed that the current outcome would have occurred. Coming from the business world, I would have to say that the challenges legislatures face is confusing to the business world and vice versa. We had talked about how bad it would be to go over the cliff including for the healthcare reform bill and quite honestly none of those things have happened. The leadership in the Senate, House, and White House is completely the same as it had been. It seems like for the meantime we put the ball off and things seem to be going OK right now; healthcare stocks continue to rise. I am not a tax policy expert, but the tax policy expert in my office tells me that you can’t talk about the tax code in the middle of the year. When you are trying to find as much money as we are, and the tax code is not on the table, it is hard to avoid all of the sequester being implemented. I think the SGR [Medicare’s sustainable growth rate] has been fixed until the end of the year. I have to tell you that there has been quite a bit of grumbling on the Hill. We are hurting industry and we are not fixing the problem. That is a hard pill to swallow. To be honest, I think that there is a consensus that it does not matter who you are, if you are in Medicare they are coming for you and it does not matter what deal you think you have made. We need to do entitlement reform, because at a certain point we are going to cut it so much that it will not be there any more. We are cutting off our noses to save our faces at this point.

Q: What do you think would be the appetite in Congress for some sort of bridge between Title 18 [Medicare] and Title 19 [Medicaid]?

Ms. Stoner: The gang of eight is made up of four Democrats and four Republicans. I sat through those meetings. Any changes to the benefit structure of Medicare to the help of the industry is not very interesting to some colleagues on the other side of the aisle. I think that their concern is that if you are changing the program and the benefit structure, then it is not a good thing. The industry may not be ready for it. Especially in the next two years, I don’t know if there is a lot of interest in doing that. We really did try. We tried to change the eligibility age and there was a lot of pushback. There were many reasons for why. Now we see that is part of the liberal plan, so things are changing.

Ms. Jurinka: I think it is a great question. I think that if we had all day I am not sure if we would come to an answer. Oregon did a statewide ACO that they call CCOs [Community Care Organizations]. Calling it an ACO was too politically divisive due to the ACA so they called it a CCO and broke the deadlock, a lesson I wish that Washington would learn from. The state is truly transforming the way they are delivering care. The state guaranteed a 2% decrease in per capita spend and that if that was not achieved that the waiver would expire.

I would pose some counter questions to Susan. What is the role of the federal government versus the role of the state? People were thinking that this would go too fast, my boss not being one of them. The question is, would this be giving more authority to the states? I do not think we are there yet, in terms of Congress being able to have that conversation. I think that there is a real need for identifying who these dual-eligible [eligible for both Medicare and Medicaid] patients are, what they need, and who is responsible for financing them. Are the feds going to be paying more? Are the states going to be responsible for part of
that money they would have been spending? I think that those things are being discussed by some members but not more largely.

Q: It is widely known that a large portion (~8%) of Medicare is spent on a patient’s last month of life. Most people do not want to die in hospitals. Is the concept of talking to people about the last year and months of life now the political third rail? Can we not design a system where clinicians speak to patients about how they want to die? Or do we just not want to go there because of Sarah Palin’s characterization of “death panels”?

Ms. Jurinka: When I first started working for Senator Wyden, I was coming from the House side, and we had a conversation about end of life care. I told him some of the statistics that you just said. He said, “Liz that is great, but we do not talk about money in this context.” Currently, people feel like it is one or the other – that they have to forego curative treatment to be in hospice. The point is that it does not have to be all or nothing at that phase of life. This idea of options is just as important at the end of life as it is before. In AMA news, there was an article about a lack of appreciation in the clinical community about the difference between an advanced directive and a DNR [do not resuscitate]. That was a very frightening article for me to read. There are a number of meetings I have been in with my boss and other members where their uncle or loved one has been in this situation and they want it to be different. We know what the numbers are, but I would caution about when to talk about them in this context. I do think that people are willing to talk about the quality of life that they want patients to have.

Ms. Stoner: This goes back to the business perspective versus the legislature’s perspective. As Americans we like life, and that is not a decision my boss ever wants to legislate. I would put a lot of money on this Congress not having that conversation. People know that they will lose their seat to have this conversation. Insurance companies and the business world might be able to have that conversation. However, that is not one that we can have beyond “we love life.”

CHAIRPERSON’S WELCOME AND OPENING REMARKS

Bruce Fried, Esq (Partner, SNR Denton, Washington, DC)

Mr. Bruce Fried, one of the conference’s chairpersons, predicted that 2013 will be another rollercoaster of a year for Medicare Advantage (MA), and that the industry is facing more questions than it has answers. More specifically, he highlighted the uncertainty on whether a full sequester will happen in March and what impact it occurring would have on MA. He expressed uncertainty about what impact the opening of enrollment on insurance “marketplaces” (the new name for “exchanges”; see http://assistantquote.com/its-a-health-insurance-marketplace-not-an-exchange/) will have on MA – enrollment is to begin on October 1, 2013. He expressed doubt over whether the federal government, states, and industry will be ready for this opening of enrollment. He also raised the question: how will MA be impacted by Accountable Care Organizations (ACOs), the Medicare demonstrations on reimbursement models, and the expansion of Medicaid programs?

As a reminder, Medicare is set to face a ~2% budget cut under sequester. This budget cut would also impact Medicare Advantage (MA), since the amount a contract is paid is impacted by Medicare spending. Though 2% is relatively small compared to the 8% defense would suffer under sequester it is certainly not insignificant for MA plans, which (according to Mr. Fried) have narrow margins.

LEADING INDUSTRY EXPERTS SHARE THEIR REACTIONS AND THOUGHTS ON HOW MEDICARE ADVANTAGE WILL MOVE FORWARD AND WHAT THIS WILL MEAN FOR REIMBURSEMENT RATES
During this panel on the specific of Medicare Advantage's future, Dr. Leonard Kirschner, former Director of Arizona's Medicaid program, stated that predictions he had seen on the impact raising Medicare's age from 65 to 67 years old suggest that doing so would not have a substantial impact on the country's healthcare spending. He continued to explain that there is evidence that people often delay seeking care when they are approaching 65 years old in order to save money. As such, Dr. Kirschner expressed concern that raising the age would extend this delay and further exacerbate the problem.

THE FUTURE OF MEDICARE ADVANTAGE

Sue Rohan (VP, Health Care Service Corporation, Chicago, IL)

In one of the last presentations of the conference, Ms. Sue Rohan presented startling data on the future of MA to the remaining audience of about five people, highlighting that the Centers for Medicare and Medicaid Services' (CMS) Office of the Actuary predicts that MA enrollment will be 50% lower in 2017 than it would have been if healthcare reform legislation had not been enacted. Similarly, the Congressional Budget Office – which she emphasized is nonpartisan – anticipates that MA enrollment will be 35% lower (representing about 4.8 million people) in 2019 than if healthcare reform had not been enacted. She encouraged the audience, however, by reminding them that MA is still competitive thanks to its focus on coordinating care and having good provider access. She warned them though that in order to remain competitive, MA plans must remain affordable and high quality. Unfortunately, Ms. Rohan did not provide attendees with actionable strategies for doing so.

WHERE IS MAPD GOING?

Timothy Schwab, MD (CMO, SCAN Health Plan, Long Beach, CA)

Dr. Timothy Schwab stated that the insurance market follows a sine curve – up and down, up and down – and that things are clearly going down for MA and probably for the beneficiary (he did not clarify why the beneficiary will be worse off). He continued to state, though, that he is “stupid enough to believe that clearer heads will prevail” and that the market will turn around (however, he did not provide details on how this might occur). Trends he sees MA facing in the next five years include: decreasing reimbursement and increasing regulations. He admitted that nobody know the impact of ACOs, and highlighted that one of the problem’s with the current five-star focus is that if the Centers for Medicare and Medicaid Services (CMS) wants all seniors to be enrolled in five-star plans then it will lose the grading curve, and the STAR system might lose its meaning. He concluded, however, by complementing the STAR system, saying that it has caused all health insurance leaders, for the first time, to think about quality – even the CFO.
Appendix

BACKGROUND ON MEDICARE ADVANTAGE

Medicare Advantage (MA) is a health insurance program that provides Medicare-eligible people with their Medicare benefits through a non-governmental HMO instead of the original government-run Medicare plan. Currently, there are about 450 MA contracts, run by just under 200 different organizations; about 25% of seniors are enrolled in a MA plan. When a person enrolls in an MA plan instead of Medicare, the Centers for Medicare and Medicaid Services (CMS) pays the plan a “bid” (stipend) each month, which is adjusted for a person’s health risk factors to limit the incentive to avoid unhealthy people. Depending upon the MA plan, members might have to pay the company a premium in addition to the Medicare premium. Every MA plan must cover at least all of the services Medicare covers, so a plan should not be able to lower costs by limiting access to a service (though they can provide these services in a better or worse manner than Medicare). A key strategy an MA plan can use to reduce costs below Medicare – and thereby make money – is to provide these services more efficiently and effectively, and to reduce a person’s need for such services.

If a plan’s bid for a county is below a benchmark derived from Medicare’s cost in that county, the plan receives a percentage of the difference between the bid and the benchmark, called a rebate. The Affordable Care Act (ACA) introduced a revised rebate system in which plans with better pre-determined performance and outcome measures (over fifty selected by CMS) receive more money than those doing poorly. Performance on these measures is then summarized by a single five-star rating system (where five stars represents excellent performance and one star indicates poor performance). By 2014, a 4.5- or 5-star plan will receive 70-75% of the difference between its bid and the benchmark, while a plan with three or fewer stars will receive only 50-75% of the rebate. All bonus payments are required to be reinvested into the plan so that it can provide additional benefits to its members in the future. Additionally, if a plan has fewer than three stars for three or more years in a row, CMS publicly labels the plan “poor” or “below average” and contacts its members reminding them how to switch plans. In contrast, if a plan has five stars, it is allowed to enroll new members at anytime, not just during the normal enrollment period.

-- by Hannah Deming and Kelly Close