INSURANCE

Medicare Advantage plans for dual-eligible enrollees set to get Senate scrutiny

By Simar Bajaj Sept. 26, 2023

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The Senate has set its eyes on regulating insurance plans for some of the most vulnerable patients in the U.S. — the 12.5 million people eligible for both Medicare and Medicaid.

"They're a complex group of people with a lot of chronic conditions — mental illness, frailty, disability," said Jose Figueroa, an internal medicine physician and health policy expert at Brigham and Women's Hospital. Over a third of these dual-eligible beneficiaries have less than a high school education, and about 90% make less than $20,000 per year.

Just around 15% of beneficiaries are eligible for both Medicare and Medicaid, but they account for a third of these programs' spending — around $440 billion — and still don't receive better health care, Sen. Bill Cassidy (R-La.) pointed out in a JAMA viewpoint published earlier this month. "The root cause of worse outcomes despite spending more money is a lack of coordination of care," Cassidy wrote.

This is partly because most dual-eligible patients have to navigate a bifurcated healthcare system with two sets of benefits. Around three million patients are enrolled in dual-eligible special needs plans (D-SNPs) that are designed, in theory, to coordinate care, but the majority of these plans integrate Medicare and Medicaid benefits only minimally.

"People are not fragmented," said Arielle Mir, vice president of health care at Arnold Ventures, a philanthropy that advocates for health care policy reforms. "But the systems we have in our society, in our public programs, are really fragmented. And it makes getting care confusing, burdensome, and potentially dangerous."

Cassidy has thus been leading a bipartisan group of five other senators on the Finance Committee to reform D-SNPs and better integrate care between Medicare and Medicaid. In November, the senators sent out a request for information about the health care shortfalls dual-eligible beneficiaries face, and in May, they released draft legislation for stakeholder comment.

The final version of the bill is expected to be introduced in the Senate later this year, although it might take until 2025 before the bill moves forward and actually has a chance of being passed, according to Michael Cheek, president and CEO of the SNP Alliance, the trade group representing insurers. Beyond states being knee-deep in Medicaid disenrollments and the House of Representatives not yet having a companion bill, Cheek emphasized that "as drafted, this bill would be a huge coster," making passage politically unlikely.

Still, experts interviewed by STAT said that time is ripe for reforming how dual-eligible plans are financed and deliver care. For one, despite these patients being particularly vulnerable, insurers find them highly profitable, with D-SNPs earning 16.7% margins in 2020, nearly double that of the Medicare Advantage program as a whole. And, as insurance companies receive higher payments for dual-eligible beneficiaries, compared to typical Medicare patients, dozens of "look-alike" plans have also popped up over the past decade, enrolling dual-eligible beneficiaries but with no care coordination. "We currently have a system that seems to be more profit-oriented than mission-oriented," said Figueroa.

Phasing out D-SNPs with bare minimum integration

There are three levels of D-SNPs based on the plan's level of care coordination, ranging from the poorly integrated coordination-only plans to the fully integrated dual-eligible special needs plan, or FIDE-SNPs. Both are required to contract with state Medicaid programs and abide by various other regulations, but coordination-only plans don't have to cover any Medicaid services, such as behavioral health or long-term care. "You just have some statutory regulations to say you're helping them coordinate care with the Medicaid side," said Figueroa, as opposed to the FIDE-SNPs where plans are required to provide both Medicare and Medicaid benefits under a single entity.

What that difference looks like in practice is that poorly integrated plans have "a perverse incentive to not necessarily care about what happens on the Medicaid side" and even pawn payment responsibilities onto Medicaid to bolster their margins, according to Figueroa.

As one example, a coordination-only D-SNP might refuse to pay for a patient's wheelchair "because they say, 'That's not a Medicare-covered service; that's on them — that's on the Medicaid side,'" said Mir from Arnold Ventures. While coordination-only plans aren't responsible for duals' entire spectrum of care, they still receive the higher payments associated with caring for this sicker population.

On behalf of D-SNP insurers, Cheek said, "I don't think that there are specific issues with coordinated plans," arguing that cost-shifting is a more general issue and that coordination-only plans "play a role in states and regions where more integration isn't feasible." In fact, he noted that FIDE-SNPs are offered in only 12 states right now and aren't easily scalable.

University of Pennsylvania health policy expert Eric Roberts, however, is more optimistic about how the draft legislation would bolster FIDE-SNP's growth. Specifically, the legislation would require every state to develop an integrated care model for dual-eligible patients but exclude coordination-only plans from this "integrated" category. The legislation isn't prescriptive on what exactly states must do to meet the requirements, but "converting coordination-only D-SNPs into FIDE-SNPs would be a plausible path forward," Roberts said.

Dangers of look-alike plans

The draft legislation also seeks to crack down on "look-alike" plans, which predominantly enroll dual-eligible beneficiaries and thus receive similarly high risk-adjusted payments as D-SNPs. However, these look-alike plans don't have to contract with state Medicaid agencies, deal with any additional oversight, or coordinate care in the slightest, according to Laura Keohane, health policy expert at Vanderbilt University School of Medicine.

Perhaps as a result, these look-alike plans have been growing rapidly, Figueroa and Roberts showed in a recent Health Affairs study, from 20,000 dual-eligible enrollees in 2015 to 220,000 enrollees in 2020. This rise is at least partially due to the aggressive marketing strategies of brokers and agents, Figueroa suggested, targeting populations with lower English proficiency and health literacy in places like flea markets, dollar stores, food banks, and low-income housing communities. Their study — partly funded by Arnold Ventures and the National Institutes of Health — showed that look-alike plans were more likely to enroll beneficiaries who were older, Hispanic, and from disadvantaged communities, and that a third of all patients in look-alike plans were poached from genuinely integrated plans.

The Centers for Medicare and Medicaid Services has started to regulate look-alike plans, refusing to contract with plans that enroll over 80% dual-eligibles. That ceiling, Figueroa said, may not be effective because plans could just go right underneath. To a certain extent, this has already started because the number of plans with 50-80% dual-eligible enrollees is now almost as large as the number of look-alikes. Cassidy's draft legislation proposes a more stringent ceiling at 50%.

Improving the evidence and health policy

Crafting legislation for duals is challenging because the evidence base is particularly murky, according to Keohane. With D-SNPs run by private insurance companies, data have historically been inaccessible or incomplete when released for research use. Do coordination-only plans cost-shift onto Medicaid? Are FIDE-SNPs better than coordination-only plans? How about look-alike plans? "Common sense would term that way," Keohane said, and the available evidence points toward integrated plans increasing the use of home and community-based services while reducing nursing home stays, emergency department visits, and hospitalizations. But it's still impossible to say for sure.

Mir agreed that more evidence is needed to fill in some of the gaps. But she also emphasized that the problems with D-SNPs are more structural. Cost-shifting and look-alike plans aren't anomalies, but simply a case of the system "operating according to the rules," Mir said.

Reforming the plans for dual-eligible beneficiaries is thus both "a challenge and an opportunity," according to Roberts, because any missteps could make a bad situation worse but the right reforms could mean higher-quality, integrated care to more duals.

"The D-SNP model is not going away; it's permanently authorized," said Roberts. "The question now is, can we improve upon it?"

About the Author

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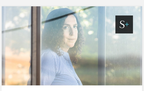

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