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Correspondence Memorandum

Date: October 4, 2021

To: Group Insurance Board

From: Rachel Carabell, Senior Health Policy Advisor
Arlene Larson, Federal Health Programs & Policy Manager
Office of Strategic Health Policy

Subject: Medicare Advantage Request for Information (RFI)

This memo is for informational purposes only. No Group Insurance Board (Board) action is required.

Background

In October 2017 the Department of Employee Trust Funds (ETF) released a Request for Proposal (RFP) to solicit bids to provide a group Medicare Advantage plan to Medicare retirees enrolled in the State of Wisconsin and Wisconsin Public Employers Group Health Insurance Program (GHIP). Based on the RFP results, the Board awarded a contract to UnitedHealthcare (UHC) starting March 21, 2018, for a group Medicare Advantage plan with members eligible to enroll effective January 1, 2019. The current UHC contract extends through December 31, 2023. The Board is scheduled to decide whether to extend UHC's contract for two more years through December 31, 2025, at its November 17, 2021, meeting.

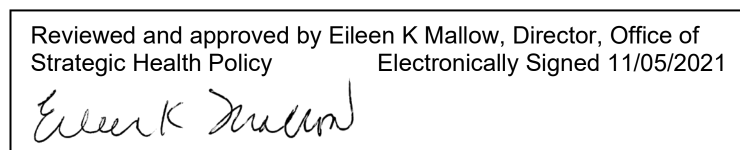
To assist with determining whether to extend the current UHC contract or release another RFP, ETF released a Request for Information (RFI) in February 2021 to determine if and how much the Medicare Advantage marketplace had changed since the evaluation of the original RFP in 2017. In reviewing the results of the RFI, staff determined that the Medicare Advantage market has not significantly changed. Based upon this and other findings discussed in a separate memo (Ref. GIB | 11.17.21 | 12B), ETF would not recommend conducting another RFP at this time.

RFI Background

The RFI was released on February 15, 2021 and responses were due April 2, 2021. The RFI provided background information on current GHIP offerings for Medicare enrollees and summary information on Medicare enrollment. It asked vendors to respond to questions on the following topics:

- The vendor, its Medicare Advantage products, and covered lives.
- Market trends and experience offering group Medicare Advantage plans.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy Electronically Signed 11/05/2021



Board	Mtg Date	Item #
GIB	11.17.21	12A

- Provider network design and capacity.
- Benefit design and program offerings.
- Premium, rating, and contracting.
- Star Rating for federal quality measures.

To ensure ETF received expansive content, ETF allowed organizations to submit two versions of their response: an unredacted version and a redacted version. The redacted version allowed the vendors to strike out confidential and/or proprietary information. Staff reviewed the unredacted versions. ETF will not release the unredacted versions publicly, as allowed by state law.

Plans Responding
Seventeen health plans received advanced notice of the release of the RFI. ETF received 10 responses from vendors. Table 1 lists the vendors that responded to the RFI.

Table 1: Responding Vendors and GHIP Participation Status

Vendor	Participation Status
Aetna	No
Anthem	No
Dean	Yes
HealthPartners	Yes
Humana	No
Medica	No
Network	Yes
Quartz	Yes
UHC	Yes
Willis Towers Watson*	No

**Does not meet RFI requirements*

Willis Towers Watson, a group insurance broker, proposed an individual marketplace for retirees. This model does not meet the requirements of the RFI and is omitted from the summaries below and instead is discussed at the end of this memo.

Table 2 provides a summary of the current Medicare Advantage offerings in Wisconsin by responding vendors. It illustrates that most vendors do not have significant Medicare Advantage enrollment in the group market in Wisconsin. Only the three national vendors have significant group market enrollment: Aetna, Humana, and UHC.

Table 2: Medicare Advantage Covered Lives in Wisconsin

Vendor	Group Market	Individual Market
Aetna	14,925	10,130
Anthem	612	72,511

Vendor	Group Market	Individual Market
Dean	-	24,178
HealthPartners	805	2,415
Humana	6,157	63,869
Medica	427	8,639
Network	-	66,318
Quartz	-	21,228
UHC	46,748	176,106

Vendor Responses
In this section, ETF will share a summary of noteworthy information gathered from the RFI.

Future Financial, Market, Regulatory, and Product Changes (Question 3.2.5)
The RFI asked vendors what financial, market, regulatory or product changes they expected over the next three years that could impact rates, accessibility, benefits, claims or the general market.

Vendors are optimistic about future growth in Medicare Advantage but some expressed concern about the potential for future federal funding cuts, given the looming financial crisis for Medicare, which is currently projected to deplete its assets by 2026.

Several vendors expressed concern about federal changes regarding prescription drug pricing in the Medicare Part D program that could shift costs to a vendor and noted that for each of the several Part D pharmacy legislative proposals, costs shift slightly for plan sponsors and other payers. Another vendor stated that overall member savings will not be uniform and will impact individuals differently. Enactment of this rule has been delayed until 2023.

Vendors mentioned that they are monitoring federal legislation for the potential to add additional benefits and benefit flexibility for Medicare Advantage plans which could impact care and premiums.

Some plans, especially national vendors, mentioned an increasing use of data and working with providers to provide better care and thus increase their Medicare Advantage plan star ratings. They further discussed movement to value-based care payment arrangements, proposed federal pricing transparency rules, and regulatory changes related to technology such as telemedicine and remote patient monitoring. Some plans indicated they are advocating for increasing access to generic drugs and biosimilars and site neutral payments for services.

Provider Network (Questions 3.3.1, 3.3.2, and 3.3.6)
The RFI asked vendors to identify the provider network structure they offer (e.g., regional HMO, nationwide PPO, etc.) and describe the group market in Wisconsin in

which they operate. The vendors were also asked to describe how their networks differ for their Medicare products and their non-Medicare products.

Four plans indicated they offer a nationwide, passive PPO, which means that member cost-sharing is the same whether a member uses a network provider or a non-network provider as long as the provider had not opted out of Medicare, and they agree to bill the plan. Five plans indicated they offer a regional HMO which means coverage is generally not available for non-network providers. Some plans also offer a more traditional PPO which means coverage is available for non-network providers, but at higher cost-sharing.

Almost all of the plans responded that their Medicare networks and commercial networks are very similar and overlap significantly. However, there may be differences to meet Centers for Medicare & Medicaid Services (CMS) network requirements or because certain providers do not accept Medicare assignment or other reasons. Plans indicated that communication with members through multiple mechanisms is the key to handling differences in the networks when a member transitions from a commercial product to a Medicare product.

Innovative Approaches to Provider Reimbursement (Question 3.3.7)
The RFI asked vendors to describe any innovative approaches to provider reimbursement they have implemented.

There is a wide spectrum of innovative approaches to provider reimbursement and the maturity of these approaches varies significantly. The more mature models incorporate:

- Quality into their reimbursement,
- Down-side and upside risk,
- A large portion of their membership receiving care under value-based contracting arrangements, and
- Collaborate with providers by sharing data and other tools to enhance coordination and improve outcomes.

Vendors use a variety of mechanisms to structure these arrangements, including Total Cost of Care models, accountable care organizations, patient-centered medical homes, and centers of excellence, among others. Other vendors use bundled payments or episodes as the basis for reimbursement which incentivizes providers to better manage care through some risk-sharing but only for specific conditions or procedures.
Less mature models are focused only on cost, have a smaller percentage of their members under value-based contracting arrangements, and/or are using pay for performance or other non-risk-based arrangements

Most Popular Benefit Designs (Question 3.4.1)
The RFI asked vendors to identify the most popular benefit designs for their Medicare Advantage members. Popular benefit designs identified:

- Copays rather than coinsurance,
- Passive PPO, where the member can use non-network providers at the same benefit level as network providers,
- Zero dollar ($0) premium plans,
- Pharmacy coverage included,
- Coverage of hearing aids, dental, routine vision, and podiatry services,
- Gym membership programs, such as SilverSneakers, and
- Supplemental benefits for meals, transportation, and personal care.

The Board's Medicare Advantage plan will offer the supplemental benefits of meals, transportation and personal care following an inpatient stay for a limited time period, beginning January 1, 2022.

<u>Supplemental Benefits (Question 3.4.5)</u>
The RFI asked vendors to identify the supplemental benefits they currently provide, in addition to what is covered under traditional Medicare. Below is a list of allowable supplemental benefits and the number of plans indicating they offer these benefits:

- Gym membership – 8 plans
- Routine eye exam and/or eyewear allowance – 7 plans
- Routine hearing and/or hearing aid allowance – 6 plans
- Dental coverage – 4 plans
- Meals limited to post discharge – 4 plans
- Telehealth/virtual care – 4 plans
- Over-the-counter medications – 4 plans
- Transportation – 3 plans
- Nurselines – 3 plans
- Acupuncture – 3 plans
- Incentive rewards – 2 plans
- Travel benefits – 2 plans
- Lifeline alerts – 2 plans
- Discounts for dental, vision, hearing, weight management or pharmacy – 2 plans
- Massage – 2 plans
- Concierge services – 2 plans
- Coaching – 2 plans
- Personal care – 1 plan
- Podiatry – 1 plan
- Chiropractic – 1 plan

<u>Recommended Changes (Question 3.4.2)</u>
The RFI asked vendors what changes they would recommend the Board make to current Medicare plan offerings and identify the current program's strengths and weaknesses. Responses highlight the struggle with offering multiple choices and the challenge of communicating the complexity of them. The responses also highlight the challenge of managing costs and offering the benefits members prefer.

Specific program strengths identified include:
- Plenty of plan choices available including plan options with national and international coverage.
- Low cost-sharing among all plan options.
- Current coverage for travel vaccines, hearing aids, routine vision care, and foot orthotics.
- Ability to re-join the plan during open enrollment after leaving the plan.

Specific program weaknesses identified include:
- Multiple carriers and plan complexity – confusing for members and the potential of members not getting lowest premium rates.
- Complex pharmacy benefit that is confusing to members.
- ETF’s Medicare Some offering is complex and hard to understand. In a Medicare Some contract, the subscriber includes some family members who have Medicare and some who do not. The subscriber may select up to two health plans where one is either Medicare Advantage or Medicare Plus, and the other is any other plan.

Changes recommended include:
- Provide more affordable options.
- Add supplemental benefits that promote increased access to care, such as transportation and that support medical management such as preventive dental and meals after an inpatient stay.
- Carve Medicare retirees out of the plans for active employees and pre-Medicare retirees. Some vendors think this would allow for more focus on the Medicare population and make it easier to communicate benefit differences.
- Do not allow retirees to re-join the plan after leaving (consistent with other employers).
- Allow all health plans to offer Medicare Advantage and allow HMO and PPO options.
- Add small differentials in cost sharing for more expensive care, such as specialty, outpatient hospital, urgent care, high-cost radiology, and skilled nursing facilities.

<u>Prescription Drug Coverage (Question 3.1.5 and 3.4.3)</u>
CMS allows for two Medicare Advantage options. Plans can offer Medicare Advantage Only (MA-Only) plans that cover Medicare Part A (hospital) and Part B (physician) services and supplemental benefits. Plans can also offer Medicare Advantage with Prescription Drug (MAPD) plans which cover Medicare Parts A and B services, supplemental benefits and Part D (prescription drug) coverage. The Board currently contracts with UHC for an MA-Only plan. Prescription drug coverage is offered through Navitus Health Solutions, the Board’s pharmacy benefits manager.

The RFI asked plans to identify their enrollment in MAPD and MA-Only plans. As shown in Table 2, most nationwide enrollment is in MAPD plans.

Table 3: Nationwide Enrollment in MAPD and MA-Only Plans

Vendor	MAPD Plan Enrollment	MA-Only Plan Enrollment
Aetna	1,975,626	836,168
Anthem	1,645,981	1,279,265
Dean	8,068	16,564
HealthPartners	41,826	10,740
Humana	4,570,405	284,555
Medica	51,511	54,012
Network	63,715	2,613
Quartz	20,595	3,748
UHC	5,791,933	716,760

The RFI also asked vendors if they would recommend the Board move to a MAPD model and to address the financial and clinical benefits of integrated medical and pharmacy benefits.

Vendors strongly recommended moving to a MAPD model with the following reasons cited:

- Allows for better risk adjustment capture which could potentially increase payments from CMS,
- Better management of provider-administered drugs,
- Better care management, particularly for chronic conditions where prescription drugs are an integral part of treatment,
- Simplified administration for members and plan sponsors, including simplified billing, enrollment and communications (for example, explanation of benefits);
- Shifts risk to the vendor and allows for better management of costs since the vendor is at risk rather than employers,
- Real-time prescription drug data which allows for better monitoring, medication compliance and management of contraindications,
- Gives plans a more holistic view of the patient,
- Allows for integrated reporting between medical and pharmacy benefits,
- Better identification of gaps in care, and
- Better communication with providers.

As part of the next RFP for Medicare Advantage, ETF anticipates asking plans to submit proposals for both MAPD and MA-Only plans so the two approaches can be evaluated.

Rate Setting Approach (Question 3.5.1)

The RFI asked plans about their approach to rate-setting. Vendors that provided substantive responses generally indicated that they would use the group’s claims and enrollment experience if the group is large enough (typically a minimum of 500 or 1,000

lives). Some plans prefer to review at least 12 months of claims experience while others prefer two years. Some plans indicated they may use an adjusted community-rating model or manual rates for new groups or smaller groups. One plan indicated using a pooling charge, which allows the plan to spread large claims across its book of business.

Other rate setting considerations include geographic and demographic factors, the competitive landscape and retention, trend projections, and whether pharmacy benefits are included. Plans include a profit/risk margin or set premiums to achieve a targeted loss ratio.

The rating methodologies used are similar to how group insurance plans are typically rated but the primary difference is that Medicare Advantage plans reduce the total premium to reflect the projected CMS payment, which is based on where the member resides, risk scores, and other federally mandated payment adjustments.

Annual vs. Multi-Year Contracts (Question 3.5.3)
The Board currently has a multi-year contractual agreement with its Medicare Advantage vendor, and annual contractual agreements with all other health plans. The RFI asked plans to describe the challenges and opportunities for multi-year contracts versus annual contracts.

Some plans indicated support for multi-year contracts and indicated that this approach can support more stable rates over time, facilitates stronger partnerships, helps with provider contracting, and is less of an administrative burden.

Others however indicated that multi-year rates can result in outsized rate increases at contract renewal if the rate cap is unrealistic. Others raised concerns that changes in CMS funding amounts and pharmacy benefit changes make projecting multi-year rates a challenge and could result in overly conservative premiums.

Two plans suggested multi-year contracts with annual rate negotiations.

Risk-Sharing (Question 3.5.4)
The RFI asked vendors to share their experience contracting with employer groups on a risk-sharing basis for fully insured plans. Some plans indicated they do not have these risk-sharing arrangements with groups sponsoring Medicare populations. Several plans indicated that they do contract on a risk-sharing basis with employers, but it is contingent on the size of the group and/or a benefit structure where the plan is the only plan available. When risk-sharing is available, it is usually based on achieving a certain medical loss ratio.

Willis Towers Watson Response
ETF received a response from Willis Towers Watson, a global health insurance broker that administers a private marketplace or exchange for Medicare beneficiaries. This

marketplace offers individual Medicare insurance plans including Medicare Advantage, Medicare supplement and Medicare Part D prescription drug plans. It can also serve pre-Medicare retirees. In Wisconsin it's program currently covers 900 individual retirees. Nationwide it covers 307,191.

Under the Willis Towers Watson proposal, retirees would have access to a nationwide benefits marketplace to shop for individual health, pharmacy, vision and dental insurance. Willis Towers Watson administers the marketplace and is responsible for approving the plans offered. The platform would assess each retiree's needs and provide assistance in finding, comparing and enrolling in an individual health care plan. A variety of plans are available with different premium and out-of-pocket costs. Willis Towers Watson would be responsible for providing customer service to individuals using its platform. The State of Ohio currently uses this service for its retirees.

The Willis Towers Watson marketplace appears to provide Medicare beneficiaries significantly more options than are currently available through the GHIP. However, ETF has concerns about the tax implications of using sick leave credits to pay for health insurance in this model. ETF's view is that such a change would result in all sick leave being converted into a cash benefit that would result in taxation, even if the retiree remained in the GHIP. Willis Towers Watson has not been able to refute these concerns. Therefore, ETF is not recommending the Board consider the exchange approach offered by Willis Towers Watson at this time. If the Board is interested in a private exchange approach to providing health insurance to retirees, ETF can come back to the Board at a future meeting with additional information.

Staff will be at the Board meeting to answer any questions.