NAVIGANT

PULSE ARTICLE SERIES

REAL-TIME PERSPECTIVES FOR THE HEALTHCARE INDUSTRY

AUTHORS

BRUCE HENDERSON
Managing Director
312.583.4156
bruce.henderson@navigant.com

ERIC P. MEINKOW
Director
312.583.2171
eric.meinkow@navigant.com

navigant.com

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The President's 2017 Budget: Key proposals affecting payers

Aggressively moving the industry from fee-for-service to pay-for-value, the Obama administration presented bold healthcare proposals in its final budget wish list. In his last attempt to strengthen the Affordable Care Act (ACA), Obama's budget for FY 2017 claims $378 billion in mandatory health savings over 10 years that are designed to progressively align payments with costs and link them to quality and value.

MEDICARE

One of the largest proposed reductions is a $77 billion 10-year plan to reform Medicare Advantage (MA), the program in which private insurance plans offer Medicare benefits. Currently, plans bid against a government benchmark to win the opportunity to compete for Medicare beneficiaries. Now, the president wants plans to bid against each other.

This proposal incentivizes Medicare Advantage plans to submit cost-effective bids while preserving beneficiary rebates and standardizing quality bonus payments across counties. The president says the bidding program would reward plans for lowering their bids by allowing them to keep 100 percent of the difference between their bid and the benchmark.

The Centers for Medicare and Medicaid Services (CMS) calculates each plan's actual rebate by a county-level case-mix adjustment for the plan's enrollee profile across all markets. Under the ACA, further rebates are tied to the plan's star quality ratings. Consistent with CMS' Triple Aim, plans look to achieve a four-star rating, or higher, that results in receiving a bonus of five percent a year, per member. By law, the bonus payment must be used to pay for extra benefits; which has resulted in plans attracting and enrolling more members ultimately making the plans more profitable.

Maintaining a competitive balance is important in health insurance markets as it is in other market segments. However, the potential impact of MA competition and payment reductions could result in a disruption in the MA marketplace including network changes, benefit reductions, plan departures, and even member disenrollments.

MA plans will have to find ways to deliver the standard benefits at lower costs by using data to support provider improvements in care delivery to obtain better patient outcomes and greater value. The costs of implementing plan performance monitoring could result in decreased supplemental benefits, many of which are important to plan members and prospective members.

As the large baby boom legion ages, Medicare will face growing cost pressures. And with nearly a third of all Medicare beneficiaries now enrolled in private plans rather than the traditional fee-for-service Medicare program, it's imperative that our health plans remain healthy. In fact, more than 17 million people are now enrolled in a Medicare Advantage plan, an increase of more than 50 percent in five years.

On the plus side, the budget expands the ability of Medicare Advantage plans to deliver services via telehealth and enable rural health clinics and federally qualified health centers to qualify as originating telehealth sites under Medicare ($160 million in budget savings). HHS has the discretion to expand the telehealth service.

Another proposal of importance to payers allows Medicare to revise the Part D plan payment methodology to reimburse plans based on their quality star ratings. Plans with quality ratings of four stars or higher would have a larger portion of their bid subsidized by Medicare while plans with lower ratings would receive a smaller subsidy. According to the department of Health and Human Services (HHS), this proposal is modeled after the Medicare Advantage Quality Bonus Program, but would be implemented in a budget neutral fashion. It would not impact risk corridor payments, reinsurance, low-income subsidies, or other components of Part D payments.

MEDICAID

The president's budget continues to provide further incentive for states to expand Medicaid coverage. For states that didn't expand coverage under the Affordable Care Act program through 2015, the budget will cover the full cost of expansion for the first three years, no matter when the state expands. The budget also extends funding for the Children's Health Insurance Program (CHIP) through the fiscal year 2019 and ensures full Medicaid coverage for pregnant and post-partum women.

The budget also includes new proposals to make Medicaid more cost-effective, including requiring remittances from Medicaid and CHIP managed care organizations (MCOs) for costs in excess of a minimum medical loss ratio (MLR) or the percent of premiums spent on health care benefits and creating a federal-state negotiating pool for high-cost drugs.

Under Medicaid managed care, the states pay a fixed capitation rate to insurers to provide coverage for the care of its enrollees. The MLR provision that requires Medicaid MCOs to remit money back to the federal government if their MLR is below 85 percent met with discontent by health insurers. The proposed terms mean at least 85 cents of every premium dollar must be used for medical care. The remainder can go toward administration, marketing, and profit. Plans will not be penalized if they don't meet the ratio, but states could lower future payments if plans are routinely in excess of the minimum MLR. Some states already require MLRs of 85 percent, or more, and several insurers already live within the 85 percent limit; this would generally align Medicaid program requirements with those in Medicare Advantage and private insurance.

The primary goal of the MLR is to prevent insurers from restricting patient care. However, plans could be discouraged from participating if MLR rates are too high or not sustainable.

EMPLOYER PLANS

The president's budget also proposes amending the controversial "Cadillac tax" on expensive private health insurance plans to reflect regional differences. The Cadillac tax, a 40 percent excise tax on high-cost health insurance plans, passed as part of the president's 2010 ACA and set to take effect in 2018, was delayed to 2020 in last year's tax deal. To address one of the common criticisms of the tax, the president's proposal changes the tax, to modify the threshold above which the tax applies to be equal to the greater of the current law threshold or the average premium for a marketplace gold plan in each state..

Additionally, the proposal requires the Government Accountability Office (GAO) to study the potential effects of the tax on firms with "unusually sick employees," in consultation with the Department of the Treasury and other experts.

OTHER

Other key budget recommendations in 2017 affecting payers budget include:

- Corrects ACA Medicaid rebate formula for new drug formulations
- Eliminates beneficiary co-insurance for screening colonoscopies and polyp removal
- Ensures retroactive Part D coverage of newly eligible low-income beneficiates
- Aligns Medicare drug payment polices with Medicaid policies for low-income enrollees
- Modifies reimbursement of Part B drugs
- Provides a rule to address the surprise medical billing
- Requires mandatory reporting of other prescription drug coverage
- Expands basis for beneficiary assignment for ACOs to include mid-level providers

While the president's budget will probably not become law, the proposals he outlined in the 2017 budget demonstrates the administration's commitment to transforming our healthcare payment and delivery system and could emerge in future legislative initiatives. Moving forward as a payer, population health and utilization management are paramount to financial and clinical success.