Medicare Advantage trends quarterly review, Q2 2022:

Navigating the Medicare Advantage customer landscape

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The waves of change

Over the past decade, a wave of Medicare Advantage plans—the private plan alternatives to the traditional government program—rolled in as the high tide in the Medicare space. Today, there are more than 26 million beneficiaries enrolled in a Medicare Advantage plan, offered through one of the 3,500 plans available throughout the United States. Each year the enrollment in Medicare Advantage rises, with no decline in sight, triggering billions in investments into this booming market.

By 2030, the entire baby-boomer generation will be 65 or older. As the healthcare industry prepares for the incoming wave of baby boomers, born between 1946 and 1964, there are noticeable differences within the age bands. Knowing their characteristics, attitudinal differences, and what they expect from their healthcare providers will impact how you target and communicate with them as individuals.

// Ages 65-69

This segment's main priority is health maintenance. Look to highlight the importance of preserving their health as they age by focusing on prevention topics, wellness incentives, healthy eating recipes, and stress management as many may still be working.

// Ages 70-75

Many in this segment are diagnosed with a chronic disease—prediabetes is especially common in this age bracket. Communications should emphasize disease management programs or new disease findings that provide helpful knowledge to this population. Inform them of where they can stay involved in their community through social activities—some even led by health insurance brokers—and expand their awareness around caregiving and home health options.

// Ages 76 and older

At this stage, it is helpful to underscore the importance of benefits, coverage, and potential savings. Members at this age visit a doctor an average of nine times per year. Additionally, highlight the care management and virtual or in-home options available, behavioral health and pharmacy medication therapy management (MTM) programs, and end-of-life or hospice coverage.

According to a 2020 J.D. Power study, despite the significant positive effect on member satisfaction, just 15% of Medicare Advantage plans deliver relative to all three key information and communication performance indicators they identified—making sure members fully understand their out-of-pocket costs; providing health education; and delivering useful reminders for preventive services. This gap amplified during the COVID-19 pandemic as consumers have been 3.3 times more likely to receive helpful communication from their bank than from their health plan.[1]

Plans that invest in improving member information and communications increased their Net Promoter Scores by an average of 10 points.[2]

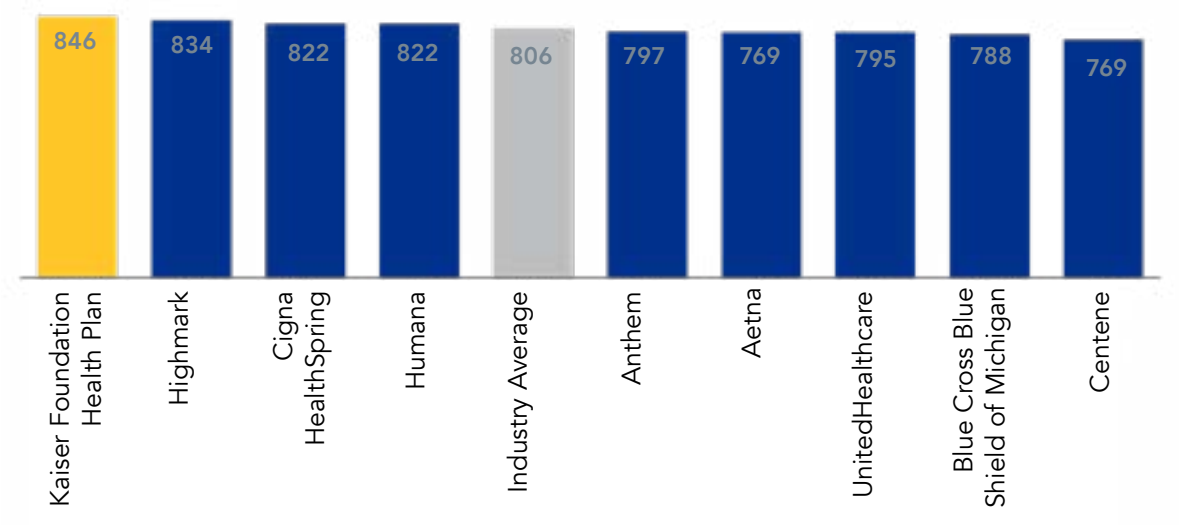
[1] https://www.jdpower.com/sites/default/files/file/2020-06/2020068%20U.S.%20Medicare%20Advantage%20Study.pdf
[2] https://www.jdpower.com/sites/default/files/file/2020-06/2020068%20U.S.%20Medicare%20Advantage%20Study.pdf

The same study finds that while the majority of Medicare members still prefer communication via phone, nearly a third of members surveyed indicated that they prefer email, text, website, or apps as a vehicle for communication. With these increasing numbers of seniors activating digital channels—this study noted that 94% of seniors use the internet every day—providers should allow this significant factor to inform how they engage and interact with their members. A 2020 Media Logic survey of senior media habits might provide more insight into that online activity, finding that 88% of seniors use social media daily with 93% of seniors active on Facebook, 25% using Twitter, and 33% on Instagram.[2]

For any Medicare Advantage plan provider, executing a successful communication engagement formula significantly improves overall customer satisfaction, advocacy, and retention. In the J.D. Power study, which measures customer service, provider choice, information and communication, coverage and benefits, and billing and payment, Kaiser Foundation Health Plan ranked the highest on MA plan overall satisfaction followed by Highmark and Cigna HealthSpring.[3]

Overall customer satisfaction index ranking[2]

(Based on a 1,000 point scale)



[2] https://www.medialogic.com/wp-content/uploads/2020/06/2020-senior-media-habits-survey-medialogic.pdf
[3] https://www.jdpower.com/business/press-releases/2021-us-medicare-advantage-study

Stormy headwinds pressure reimbursements

The process for Medicare reimbursements is routine, carried out in a certain way according to a set method, and with formulaic rates. The Centers for Medicare and Medicaid Services (CMS) use the reimbursement process to repay doctors and other providers for medical services to beneficiaries. The reimbursement rate, also called the Medicare Physician Fee Schedule (MPFS), varies based on the services rendered along with other factors that are key to delivering patient care.

But that may need to change. As the baby boomer healthcare market grows, that method could result in decreased affordability for both employers offering coverage and for the privately insured.

Understanding the current reimbursement process

When providers opt to participate with Medicare, they first accept to take assignment, meaning that they agree to accept Medicare-established fees as reimbursement. Providers then bill Medicare directly based on those accepted rates. As a policy, CMS sets reimbursement rates according to the Current Procedural Terminology (CPT) codes, which are numeric values assigned by CMS for services and equipment used to treat Medicare patients.[4]

CMS uses a standard formula to determine reimbursement rates for allowable medical charges, known as the Customary, Prevailing, and Reasonable Charge (CPR) method. Under Medicare, a "reasonable" or "allowed" charge is the lowest of any of the following:

1. **The actual charge made by the physician for a given service**
2. **The physician's customary charge (the physician's 50th percentile) for that service**
3. **The prevailing charge (the physician's 75th percentile) in a given locality for that service**

Increases to prevailing charges—the maximum Medicare allows—are typically limited to an economic index that adjusts for budgetary changes to the cost of providing patient care. In many cases, patients will pay their provider any associated deductibles or coinsurance, in addition to receiving reimbursement for administered services or equipment. Other participants or facilities involved with patient care that receive Medicare reimbursement may include hospitals, outpatient rehabilitation facilities, skilled nursing facilities, etc., as noted in the 2020 Physician Fee Schedule Guide.[5]

The amount of money reimbursed to providers also depends on the provider designation. Participating providers sign Medicare form CMS-460 and agree to charge no more than Medicare-approved amounts as listed in the MPFS. In many cases, the patient seeing a participating provider will have some form of cost-share, such as coinsurance.

For nonparticipating providers who do not sign form CMS-460, Medicare reduces the reimbursement amounts by 5%.

[4] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo
[5] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched

There are notable variations in average reimbursements for provider services, including the demographics and geography of the Medicare beneficiary. Although Medicare premiums and deductibles are consistent, reimbursement rates vary based on the specific location and the prices charged by local physicians or other accepted care providers.[6]

As an alternative to traditional Medicare, qualifying patients have the option to receive coverage through Medicare Advantage plans. These private health plans agree to receive capitated payments for Medicare-covered services. In this case, approved Medicare Advantage providers are paid set amounts for each enrolled person, regardless of whether that person seeks care during a given period of time. CMS calculates the payments based on the average expected healthcare utilization of a typical patient. More remuneration is paid for patients with extensive or complicated medical histories, and other factors considered include age, race, sex, type of employment, and geographic location.

What's next for Medicare reimbursement?

The cost of healthcare is increasingly harder to afford for both privately insured individuals and employers who offer health insurance coverage. Over the past 50 years, private insurers paid higher prices for patient care versus Medicare, and this gap continues to grow. Reducing the prices that private insurers pay for healthcare services could help alleviate the financial burden for employers and individuals with private insurance, but it would also reduce revenue for hospitals and other providers with uncertain effects on patient care.

One option before Congress is reimbursement for private insurers, hospitals, and other providers at Medicare rates. According to a March 2021 study by the Kaiser Family Foundation:[7]

"Total health care spending for the privately insured population would be an estimated $352 billion lower in 2021 if employers and other insurers reimbursed health care providers at Medicare rates. This represents a 41% decrease from the $859 billion that was projected to be spent in 2021."

Other possible ways to make healthcare more affordable include reducing the private insurer price gap by lowering private-sector healthcare prices to some multiple of current Medicare rates or phasing in lower rates gradually; enacting legislation that limits the prices that providers charge private insurers; and bundling a payment model that rewards providers with integrated service models that emphasize greater efficiency and care coordination.

Another government healthcare issue affecting provider reimbursement concerns Medicare sequestration—a mandated spending restriction that would reduce federal spending for Medicare services by a set percentage (2% prior to 2022). Following the passage of the American Rescue Act, Congress agreed to reduce the sequester to 1% for both participating and non-participating providers through the end of March 2022.

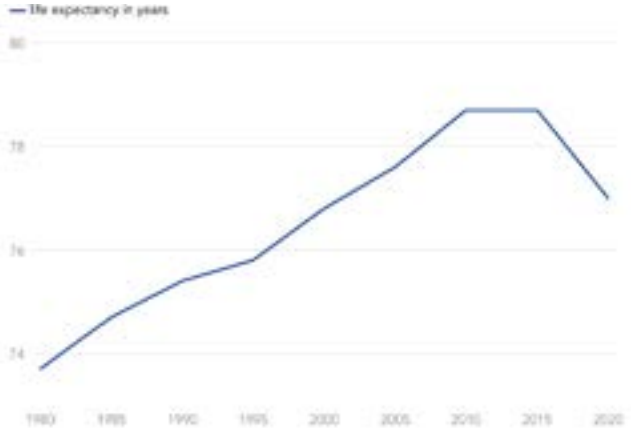
All of these options point to the same underlying need: In the future, payers have to focus on cutting-edge trends to follow technology's trajectory and better serve the demands of their burgeoning baby boomer market.

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191131/
[7] https://www.kff.org/medicare/issue-brief/limiting-private-insurance-reimbursement-to-medicare-rates-would-reduce-health-spending-by-about-350-billion-in-2021/

The "Silver Tsunami"

There is a perfect storm coming out of advanced aging—leading to higher medical costs and increasing demands on caregivers.

The term "Silver Tsunami" describes a "tidal wave of older Americans who are living longer and therefore more likely to develop age-related conditions like Alzheimer's disease and other forms of dementia, heart disease, cancer, and Parkinson's disease."



With the average life expectancy now at 77.3 years—an almost 5% increase from the past 40 years—Americans are living longer than prior generations. [8] The Administration for Community Living (ACL), estimates that "a senior turning 65 today has a 70% chance of requiring long-term care in their remaining years." [9]

As Americans live longer, the **expectation of more age-related conditions requiring medical care rises**. Combined with the 40 million Americans providing care for older family members, we are on the verge of "a financial crisis in the making" according to the founder and CEO of AgingCare.com. [10]

With 83% of care recipients either living in their own home or in their caregiver's household, the demands placed upon the caregiver are ever-increasing. Since 54% of family caregivers are aged 50 or older, there is a perfect storm brewing on the shores of Medicare.[11] Compounding waves of surging medical needs for elderly Medicare recipients are rolling into the tide of the final baby boomer caregivers joining the ranks of the Medicare-eligible population over the next eight years, creating the real possibility of caregiver burnout. It will be critical for Medicare Advantage plans to not only support the Medicare recipient but also caregiver demands to mitigate negative outcomes and the rising cost of home care for the aging. ROP is a business case built by incorporating qualitative and quantitative measures. Qualitatively, a consultative approach can demonstrate the necessity of treating employee and customer experience equally, while, quantitatively, a financial model is associated with measuring the value return in investing in building experiences.

[8] https://usafacts.org/data/topics/people-society/health/longevity/life-expectancy/
[9] https://acl.gov/ltc/basic-needs/how-much-care-will-you-need
[10] https://www.agingcare.com/articles/who-are-family-caregivers-459287.htm
[11] https://www.agingcare.com/articles/who-are-family-caregivers-459287.htm

Modern answers for the modern caregiver

Caregivers take on a number of roles—96% of caregivers help with activities of daily living, such as eating, bathing, and dressing; 66% monitor care; 63% communicate directly with medical providers; and 50% take on the role as an advocate for the recipient with government agencies and services.[12] There is a significant opportunity for Medicare Advantage plans to provide resources for both the caregiver and their recipients.

Person-to-person supports such as meal prep and delivery options, caregiving coaches, caregiver support networks, and the assignment of an advocate Senior Care Specialist would offer a direct system for caregivers to use for their personal wellbeing and education. Modern solutions to traditional concerns may also be found in technology—from medical equipment to condition monitoring.

Now is the time for payors to lay the necessary groundwork to encourage more positive outcomes by incorporating more advanced technologies and support for both Medicare Advantage members and their caregivers.

[12] https://medicare.highmark.com/learn/medicare-basics/caregiver-support.html

The rising tide of technology in 2022

Medicare Advantage continues its impressive rise in popularity among both baby boomer members and their caregivers in post-pandemic 2022.

Leading Medicare Advantage payers will research, invest in, and embrace this year's latest cutting-edge technologies, such as wearable and portable connected devices, interactive apps, artificial intelligence (AI), and machine learning. This is critical to remain competitive and fully satisfy—or even exceed—member needs. U.S. healthcare consumers are increasingly adopting new portable tech and health and fitness apps to measure their health metrics. In fact, a recent Deloitte study found that 28% of survey respondents used technology (websites, smart phone/tablet apps, personal medical devices, etc.) to monitor health issues in 2020—an increase from 15% in 2013—and 75% of those with chronic conditions would rather share their health data with their primary care provider (PCP) via a monitoring device.[13] Such technology already bridges the information gap between Medicare Advantage payers and members, improving remote patient monitoring (RPM), preventative care, and emergency safety response.

Competitive payers understand that digitally savvy consumers opt for medical providers with robust digital capabilities. Some companies, such as Cigna, Humana, and UnitedHealthcare, have recognized this demand and are embracing the technology, launching their own RPM programs tailored to a post-COVID market. For instance, Cigna recently launched its first RPM program in January 2022.[14]

Today's senior healthcare consumer navigates an ever-increasing wealth of RPM device choices, including:

// ECG[15] and digital stethoscopes as portable electrocardiogram monitors (e.g., Eku DUO, Omron, Biocare devices)

// Bluetooth blood pressure cuffs (e.g., Greater Goods Smart Blood Pressure Monitor)

// Glucometers for continuous glucose monitoring (CGM) (e.g., DexCom G6 CGM system and Walgreens TrueMetrix Bluetooth Blood Glucose Meter)

// Pulse oximeters (e.g., Zacurate Pro Series 500DL Fingertip Pulse Oximeter)

// Wearable activity trackers and continuous monitoring devices (e.g., Fitbit and Apple Watch)

// Bluetooth thermometers (e.g., Motorola Care Thermometer)

// Bluetooth scales (e.g., Withings, Fitbit, and Garmin)

// Advanced medication management tools and tech (e.g., Hero medication dispenser)

// Advanced fall protection tech (e.g., Medical Guardian)

// Video monitoring technology (e.g., Ring and Nest systems)

[14] https://mhealthintelligence.com/news/cignas-mdlive-deploys-remote-patient-monitoring-program
[15] https://www.healthline.com/health/ecg-monitor

These same consumers also connect to a wide spectrum of mobile, real-time, and interactive apps to complement their personal healthcare maintenance.[16] This includes programs such as three-minute mindfulness for breathing exercises, exercise tracking via Fitbit, calorie counting with MyFitnessPal, healthy sleep cycle regulation with myNoise, brain training with Elevate, heart rate tracking with Cardiogram, and a number of activities with smartwatches like Apple Watch—including heart rate and rhythm notifications, ECG, and even fall detection.

Artificial intelligence (AI) and machine learning take pole position as payers race to amass this lucrative baby boomer market and harness the benefits of such technologies. Current statistics clearly support this trend: 60% of health plans increased investment in AI in the last year to leverage data and analytics to solve cost challenges.[17] Advanced pricing can help determine fair and reasonable rates benefitting providers, patients, and payers—50% of payers "have innovation labs in the belief that digital innovation will be the key to the future"[18] and 64% of health insurance executives report an accelerated adoption of digital health initiatives such as virtual health and automated plan management systems due to the pandemic.[19] These technological advances mitigate waste fraud, abuse, and billing inaccuracies, potentially decreasing healthcare costs by 20 to 30 percent.[20]

From remote healthcare to mobile devices, the latest technological advances help seamlessly connect payers, providers, and patients while affording Medicare Advantage members a better chance to access the highest quality healthcare available today.

[16] https://www.imore.com/best-health-fitness-apps
[17] https://www.multiplan.us/five-healthcare-trends-rein-in-skyrocketing-costs/
[18] https://www.healthcarefinancenews.com/news/medicare-advantage-consolidation-drove-healthcare-insurer-trends-2021
[19] https://www.clarishealth.com/blog/healthcare-payer-technology-trends/
[20] https://www.clarishealth.com/blog/healthcare-payer-technology-trends/

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