Healthcare BUSINESS STRATEGY™

Nearly 1.9 Million People in Medicare Advantage Special Needs Plans

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Nearly 1.9 million people or 12% of the 15.7 million people enrolled in Medicare Advantage plans have selected or been auto-assigned to what it is known as a Special Needs Plans (SNPs). In 2003, Congress established SNPs to serve institutionalized beneficiaries, dual-eligibles, and/or individuals with severe or disabling chronic conditions. Of the 566 SNPs authorized in 2014, 152 were Chronic or Disabling Condition SNPs (C-SNPs) serving 286,163 and 353 were Dual-Eligible SNPs (D-SNPs) serving 1,552,681 beneficiaries. Sixty-one (61) Institutional SNPs (I-SNPs) were serving 49,525 beneficiaries. UnitedHealthcare, the largest health insurance carrier in the U.S. based on enrollment, provides coverage for 23% of people enrolled in SNPs and is by far the leading organization in the Medicare Special Needs market. Frail and chronically-ill Medicare and Medicaid beneficiaries represent US health care's highest-cost and fastest-growing service group. Managing care for this population through high quality, effective and efficient, coordinated-care programs benefits everyone.

Background

Frail and chronically-ill Medicare and Medicaid beneficiaries represent US health care's highest-cost and fastest-growing service group according to the National Health Policy Group[1]. Recognizing a program was needed to meet the health insurance and coordination of care needs of this population, Congress established a new type of Medicare Advantage (MA) coordinated care plan (CCP) in the Medicare Modernization Act of 2003 (MMA). MA CCPs that are set up to provide services to these special needs individuals are called "Specialized MA plans for Special Needs Individuals," or SNPs. In the MMA, Congress identified "special needs individuals" as: institutionalized beneficiaries; dual-eligibles; and/or individuals with severe or disabling chronic conditions as specified by the Centers for Medicare & Medicaid Services (CMS). SNPs may be any type of MA CCP, including a health maintenance organization (HMO), or a local or regional preferred provider organization (PPO) plan.

Congressional authorization that allowed SNPs to restrict enrollment to special needs individuals, and basically exist, originally expired in December 2008 but SNPs have been reauthorized and changed several times. The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) extended authorization through December 31, 2009. The MMSEA also placed a hold on the Department of Health and Human Services (HHS) ability to designate other MA plans as SNPs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended authority for SNPs to restrict enrollment to special needs individuals through December 31, 2010. Effective January 1, 2010, MIPPA required all Dual-eligible SNPs (D-SNPs) to have contracts with state Medicaid agencies to provide benefits to eligible individuals under Medicaid. MIPPA did make an exception through December 31, 2010, for existing plans not expanding their service areas. MIPPA also extended the moratorium on HHS to designate other MA plans that disproportionately serve special needs individuals as SNPs through December 31, 2010 (an existing MA plan could not convert to an SNP), but lifted the moratorium on new SNPs and existing SNPs at the end of 2009.

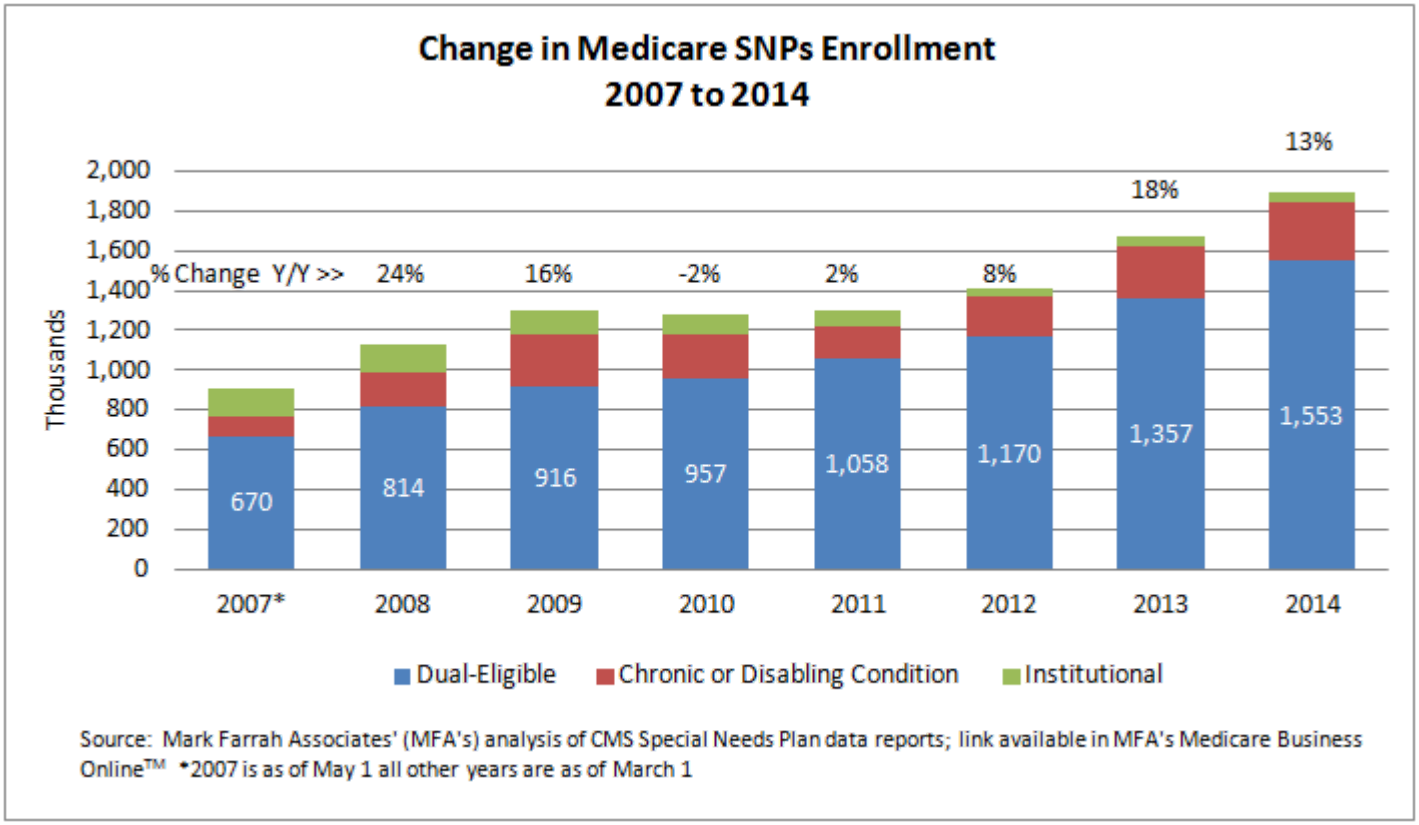
The Patient Protection and Affordable Care Act of 2010 (PPACA) extended authority for SNPs to restrict enrollment to special needs individuals through December 31, 2013. According to the March 2013 Medicare Payment Advisory Commission (MedPAC) report[2], SNPs were extended from 2013 to 2014 by the American

Taxpayer Relief Act of 2012. SNP authority expires at the end of 2014. In the absence of congressional action, on January 1, 2015, SNPs will not be terminated, but they will have to operate as other MA plans in which all beneficiaries are eligible to enroll, not just beneficiaries with special needs.

Congress intended for SNPs to enroll people with serious chronic conditions and more effectively serve high-risk populations through specialization. SNPs must offer Medicare Parts A, B, and D benefits. SNPs function under most of the same Medicare Advantage regulations, with some exceptions, and use the same payment methodology as other MA plans. The most significant exception relates to enrollment. Dual and institutional beneficiaries can enroll in and disenroll from a SNP anytime throughout the year. Chronic Condition beneficiaries have a one-time special election period, based on their being diagnosed with a condition that qualifies them for SNP enrollment. In addition to meeting all the requirements of other MA plans, all SNPs, including D-SNPs, are required by CMS to provide specialized services targeted to the needs of their beneficiaries, including a health risk assessment and an interdisciplinary care team for each beneficiary enrolled.

SNP Enrollment Growth

Since May 2007, when CMS began reporting SNP data, total enrollment has more than doubled from 906,000 to nearly 1.888 million as of March 1, 2014. Roughly 12% of the 15.7 million people enrolled in Medicare Advantage plans are in a SNP. From March 2014 to March 2013, SNP enrollment increased 13%.



All but six states have people enrolled in SNPs as of March 2014. The six exception states are: Alaska, Montana, North Dakota, South Dakota, Vermont and Wyoming. In 2013, Windsor Health Plan, a WellCare company, offered a D-SNP in Central and Western Montana but enrollment in this plan was less than 11 in any specific county and the plan was discontinued in 2014.

UnitedHealthcare, the largest health insurance carrier in the U.S. based on enrollment, provides coverage for 23% of the people enrolled in SNPs and is by far the leading organization in the Special Needs market. Humana, with only a 7% share of the SNP market, moved into second place as of 2014.

Enrollment for Top SNP Organizations

Parent	Mar-13	Dec-13	Mar-14
UnitedHealth	400,675	459,818	437,655
Humana	97,619	119,715	135,529
Innova Health	143,281	143,589	126,962
Cigna	102,288	110,789	106,778
Wellcare	84,774	103,273	103,183
Subtotal Top 5	828,637	937,184	910,107
All Others	814,371	914,062	978,262
Total SNP Enrollment	**1,643,008**	**1,851,246**	**1,888,369**

Source: Mark Farrah Associates (MFA) analysis of CMS enrollment data;
data is available in Medicare Business Online™
Numbers may differ slightly from company records due to CMS' under-11 rule

Innova Health Systems (formerly Aveta Health Care) now ranks third in terms of SNP enrollment. Innova Health continues to insure SNP members primarily in Puerto Rico. Cigna, which acquired HealthSpring/Bravo health plans in 2012, now ranks fourth among leading SNP organizations as of March 2014.

As of March 2014, CMS had approved 318 MA contracts offering 566 SNPs. The number of SNPs in 2014 is down from the 329 MA contracts offering 644 SNPs in March 2013, but enrollment is higher than the 1.357 million people enrolled in 2013. Of the 566 SNPs in 2013, 152 were Chronic or Disabling Condition SNPs (C-SNPs) serving 286,163 and 353 D-SNPs were serving 1,552,681 beneficiaries. Sixty-one (61) Institutional SNPs (I-SNPs) were serving 49,525 beneficiaries.

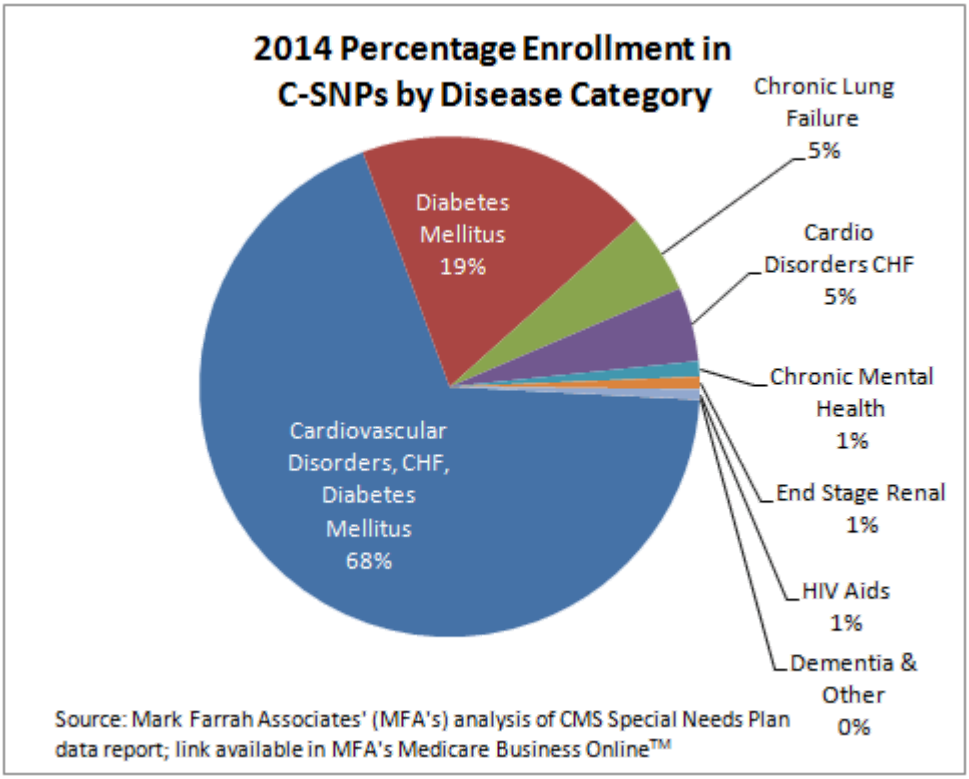
Institutional SNPs (I-SNPs)

I-SNPs serve the needs of those who reside or are expected to reside for 90 days or longer in a long term care facility which is defined as a skilled nursing facility (SNF), nursing facility (NF), intermediate care facility (ICF) or inpatient psychiatric facility. I-SNPs also cover those living in the community but requiring an equivalent level of care to those residing in a long term care facility. Sixty percent (60%) of I-SNP enrollment is in HMO type products, with 55% in HMOs and 5% in HMO Point of Service (HMOPOS) products. The remainder of I-SNP enrollment is in local PPO products.

UnitedHealthcare enrolls more than 73% of all people nationwide in I-SNPs. UnitedHealth's nearest competitor in this market is Scan Health Plan which covers 9%. A dozen additional companies offered coverage for I-SNP enrollees as of March 2014.

Chronic or Disabling Condition SNPs (C-SNPs)

CMS does not provide a detailed definition of C-SNPs in regulations, leaving its options open to the industry's judgment on which diseases to focus on. Among the chronic conditions targeted by C-SNPs are: cardiovascular disease, diabetes, congestive heart failure (CHF), mental disorders, end stage renal disease (ESRD) and HIV/AIDS. Most enrollment is in C-SNPs covering multiple cardiovascular disorders, CHF and Diabetes together.



Nearly 56% of C-SNP enrollment is in HMO type products, with 50% in HMOs and 6% in HMOPOS products. The remaining 44% of C-SNP enrollment is in PPO products with the majority in regional PPOs. UnitedHealth Group's Care Improvement Plus Gold Rx (Regional PPO SNP) plan is the leading C-SNP product sold in the country with 24% of the 286,163 C-SNP enrollees covered by this product.

Dual-eligible SNPs (D-SNP)

Nearly 92% of all D-SNP enrollment is in HMO products, with 5% or less enrolled in regional PPO, local PPO and HMOPOS products. With more than 100 companies participating in the D-SNP market, there are more options for people eligible for both Medicare and Medicaid (dual- eligibles) to choose from. However, UnitedHealthcare holds more than a third of all contracts issued by CMS for D-SNP plans.

Dual-eligible beneficiaries have health plan options beyond D-SNPs as well. They may choose to enroll in other types of SNPs for which they are eligible, including I-SNP or C-SNP. They can also enroll in other MA plans, or remain in Medicare fee-for-service (FFS). A person must be eligible for Medicare and Medicaid to enroll in a D-SNP. However, Medicare Advantage plans that are not designated as a special needs plan can also enroll dual-eligibles. Dual-eligible beneficiaries in D-SNPs do not necessarily get more benefits than those in other MA plans, but care coordination services are usually more comprehensive than other MA plans.

D-SNPs do not all cover the same categories of dual-eligible beneficiaries. Some D-SNPs may enroll all dual-eligible beneficiaries or just Qualified Medicare Beneficiaries [QMB] who do not qualify for any additional Medicaid benefits [QMB - only] or QMB pluses -- those who also meets the financial criteria for full Medicaid coverage. Additionally, some D-SNPs are open only to disabled beneficiaries under age 65, whereas others are open only to those aged 65 and over. Comparing various D-SNPs is difficult because of the variability in enrollment criteria.

The federal government and others have focused increased attention on care coordination for dual-eligible beneficiaries. PPACA required HHS to establish the Federal Coordinated Health Care Office (generally known as the Medicare-Medicaid Coordination Office) within CMS to more effectively integrate Medicare and Medicaid benefits and to improve federal-state coordination for dual-eligible beneficiaries to ensure that they receive full access to the items and services to which they are entitled.

The Medicare-Medicaid Coordination Office, working with the Center for Medicare & Medicaid Innovation (called the Innovation Center), is testing new payment and services models and evaluating best practices in most states across the nation and in Puerto Rico. These models are intended to align Medicare and Medicaid services and funding so as to reduce costs while improving beneficiaries' care. Managing care for this population through high quality, effective and efficient, coordinated-care programs benefit everyone.

The dual-eligible population is an enticing target for health plans that have seen Commercial enrollment stagnate, especially given the growth projections for this segment. SNPs will continue as long as Congress continues to authorize their existence. With nearly 1.9 million vulnerable people enrolled in SNPs, it is likely that the authorization will continue into the future, especially if evidence shows that these plans improve care for the beneficiaries while reducing the financial burden.

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[1] National Health Policy Group (NHPG) is a Washington-based health policy group focused on improving policy and practice for frail elders, adults with disabilities, and other Medicare and Medicaid beneficiaries with complex care needs using specialized managed care methods. NHPG works primarily with and through members of the SNP Alliance. http://www.nhpg.org/about-us.aspx

[2] The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. MedPAC's March 2013 report to the Congress included a full chapter on SNPs. See page 313, http://www.medpac.gov/chapters/Mar13_Ch14.pdf

About This Data

This brief is based on an analysis of enrollment data for Medicare Advantage Special Needs Plans released by The Centers for Medicare and Medicaid Services (CMS). Additional sources used included CMS' Special Needs Plan - Fact Sheet & Data Summary available at http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/downloads/FSNPFACT.pdf and the Government Accounting Office report GAO-12-864 titled "MEDICARE SPECIAL NEEDS PLANS CMS Should Improve Information Available about Dual-Eligible Plans' Performance", dated September 2012.

Additional information on Medicare Advantage plan enrollment, premium, product and even corrective and enforcement action data can be accessed through the CMS website or Mark Farrah Associates' Medicare Business Online™ (/products/medicare-business-online.aspx) and Medicare Benefits Analyzer™ (/products/medicare-benefits-analyzer.aspx). Mark Farrah Associates offers these products to make analysis of local markets, trends and competition easier. Enrollment data is updated monthly as soon as CMS releases new data to save organizations from having to aggregate and organize data themselves. Premiums and benefit attributes are updated each year.

About Mark Farrah Associates (MFA)

Mark Farrah Associates (MFA) is a leading data aggregator and publisher providing health plan market data and analysis tools for the healthcare industry. MFA's Medicare Business Online™ (MBO) product simplifies the tracking of Medicare Advantage and PDP growth and competition on a monthly basis. MBO coupled with Medicare Benefits Analyzer™ provides a full suite of business intelligence for the competitive Medicare Advantage market. Committed to simplifying analysis of health insurance business, our products include Medicare Business Online™, Medicare Benefits Analyzer™, Health Coverage Portal™, County Health Coverage™, Health Insurer Insights™, and Health Plans USA™.

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