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2020 Healthcare Industry Outlook

See the Turns Ahead

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1201 New York Ave., NW Suite 1000
Washington, DC 20005

202.207.1300
Avalere.com

Charting the Future of Healthcare

Matt Brow
President

The presidential election will dominate much of the public discourse in 2020, but there is much more happening in the healthcare environment that may not make headlines.

To adapt to the policy shifts that are taking place, major healthcare players are exploring new ways to use data, enhance partnerships, and leverage technology.

An emphasis on a broader view of patient care and the social factors that influence health and wellbeing will become increasingly important to stakeholders, and providers and plans will be looking for new ways to incorporate these elements into how care is delivered. Doing so will require integration of new and different types of healthcare data with a specific focus on patient-reported outcomes, laboratory values, and socio-economic information. Continued growth of Medicare Advantage (MA) and the expanded supplemental benefits that MA plans offer will further underscore this transition. New technology, innovations in care delivery, and reformed systems of payment for post-acute care will also lead to changes across the continuum of care.

As the drug pipeline advances curative and durable therapies (including many high-value cell and gene therapies), it will be imperative for both plans and manufacturers to identify new payment models that are sustainable in the current system and ensure access to innovative new medicines. Policy changes, such as the ongoing debate over prescription drug spending, will continue to require industry to prepare for change, while the growth of collaborations, such as outcomes-based agreements, will spur new models driven by industry rather than policymakers.

The 2020 presidential election—and debate over expansion of public programs—will heighten discussions about the role of government in health insurance and the remaining uninsured population. But outside of the political debate, the coverage landscape continues to evolve, including state-driven reforms to Medicaid and commerical markets and consumer-oriented trends like transparency reforms and non-traditional insurance options.

The environment is ripe for significant change both in terms of how we pay for and receive healthcare—creating new business imperatives for stakeholders across the industry. Avalere looks forward to working with you, using our industry-leading insights and data, to anticipate the twists and turns and navigate the complexities of the road ahead.

2020 Trends to Watch

Mapping System Transformation: Healthcare Beyond Medicine

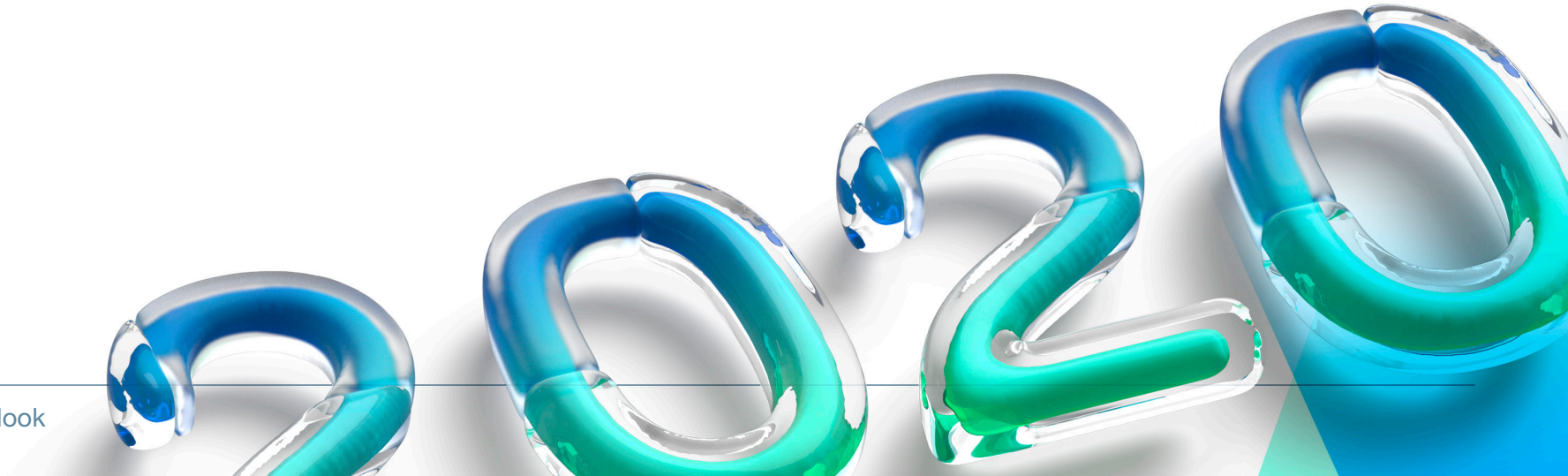
1. Addressing Unmet Social Needs to Drive Better Health
2. Expanding Medicare Advantage (MA) Scope and Coverage
3. Advancing Substance Use Disorder Policies
4. Enhancing Access to Care with Technology
5. Evolving Payment for Post-Acute Care (PAC)

Plotting the Path: Financing the Next Level of Healthcare Innovation

1. Reforming Medicare Drug Programs
2. Funding the Pipeline with Novel Solutions
3. Growing Partnerships with Outcomes-Based Contracts (OBCs)
4. Refining Risk Adjustment in Medicare Part D
5. Driving Value with Alternative Payment Models (APMs)

Paving the Road Ahead: The Future of Coverage

1. Moving Beyond the Medicare-for-All Debate
2. Influencing Medicaid's Future
3. Engaging Consumers with Cost Transparency
4. Stabilizing Individual Markets
5. Targeting the "Young Invincibles"



Mapping System Transformation: Healthcare Beyond Medicine

Stakeholders are increasingly searching beyond the traditional healthcare system rooted in medical services and symptom management to identify new strategies to address the underlying causes of poor health, including unmet social needs, health behaviors, and environmental factors. Providers, plans, and manufacturers will continue to explore new and innovative ways to tailor their services, offerings, and products to focus on the whole patient and all factors that can influence a person's health.

5 Issues to Watch in 2020 /

1	Addressing Unmet Social Needs to Drive Better Health	As providers include social needs in their approach to care, incorporating social risk in payment could provide resources to better address disparities in outcomes.
2	Expanding Medicare Advantage (MA) Scope and Coverage	MA plans have new abilities to address social factors by offering supplemental benefits to some enrollees, and will prepare to enroll beneficiaries with End-Stage Renal Disease (ESRD) in 2021.
3	Advancing Substance Use Disorder Policies	Despite a reduction in the abuse of prescription opioids, overdose deaths due to illicit opioids quadrupled, requiring new policies focused on illegal drug users as well as responsible prescribing.
4	Enhancing Access to Care with Technology	As payers embrace digital health, Medicare beneficiaries will have increased access to telehealth and new rules will set standards for digital information sharing.
5	Evolving Payment for Post-Acute Care (PAC)	Breaking down barriers between settings of care will require providers to rethink PAC clinical and business models.

Meet Our Expert /

"Given the evolution of healthcare and its impact on the delivery of care across settings, payers and providers increasingly recognize the limitations of traditional medical treatment in influencing people's overall health."

Kristi Mitchell
Practice Director
kmitchell@avalere.com

1 **Mapping System Transformation:** Healthcare Beyond Medicine

Addressing Unmet Social Needs to Drive Better Health

Research shows that a patient's interactions with the healthcare system only impact about 10-20% of his or her overall health status. Social needs, such as insecurity related to food, housing, finances, etc., have been shown to have a much more significant impact and are often the root causes of poor health. Providers and plans have historically focused on patients' clinical outcomes without the resources or incentives to address these social needs. Tapping into different data sources is opening new doors to understanding social risk and creating more holistic interventions.

Health systems and plans increasingly seek novel methods of exchanging social-services data sources, patient-reported information, and various real-world data; integrating these data may support the development of more comprehensive care-management approaches that target the right interventions for the right patients at the right time. They are deploying new assessment methods to better screen for unmet social needs and establishing new care models that emphasize multidisciplinary care teams, community health workers, and partnerships with community-based organizations. Plans are also increasingly using primary-care engagement to better manage enrollees' health throughout the continuum of care, to close gaps in care, and to make their social interventions more effective.

Payment models focused on improving patient outcomes are encouraging investment in these approaches, and organizations that invest will gradually realize performance improvement and better cost control for the populations for which they are accountable.

Along with these changes, approaches to plan and provider payment are starting to evolve to reflect the relationship between social needs and health status. Since 2017, each MA plan's performance has been adjusted based on its enrollees' dual eligibility and disability status to better account for beneficiaries' social determinants. However, these adjustments have had little effect on plan rankings because they are relatively imprecise, making them insufficient measures of social risk.

Our research found that adding supplementary factors, such as income, education, marital status, home ownership, and ethnicity, greatly improves how precise prediction can be. Improved understanding of how unmet social needs impact health creates an opportunity to reflect these factors in plan and provider payment to reduce disparities in outcomes and ensure accurate comparisons of quality care across different populations.

Meet Our Expert /

"What happens outside a doctor's office is equally as important as what happens in the medical setting. The ability to gain a more holistic view of a patient's social history and living situation allows for better patient care and outcomes."

Christie Teigland
Principal
cteigland@avalere.com

Expanding Medicare Advantage (MA) Scope and Coverage

The MA program continues to shape how seniors and individuals with disabilities access care, and the program is poised for more expansion—both in enrollment and in the scope of benefits plans will offer.

Across the entire Medicare population, 36% are enrolled in MA now, and in many markets between 40 and 50% of beneficiaries are MA enrollees.

Part of its appeal is the growing array of supplemental benefits MA plans offer, including vision, fitness, hearing, and dental benefits, and an increasing number of plans include meals, transportation, acupuncture, and over-the-counter benefits.

In 2020, MA plans can target supplemental benefits that are not primarily health related to enrollees with specific chronic conditions. Benefits could include access to home-delivered meals, pest control, and non-medical transportation—introducing to the healthcare arena new stakeholders to provide these benefits.

The flexibility allows MA plans to offer more attractive benefits to those with chronic illnesses, while addressing social factors that impact cost and quality of care for complex patients.

MA plans also are preparing to cover a new population of Medicare beneficiaries: people with ESRD. Today, most Medicare beneficiaries with ESRD must enroll in fee-for-service Medicare. Beginning in 2021, all beneficiaries diagnosed with ESRD will also be eligible to enroll in MA.

Because of the high cost of ESRD care, adequate payment will be important for MA plans if a large number of ESRD patients enroll. Yet, in an Avalere Study we found that more than one-third of beneficiaries with ESRD live in areas where MA payment is lower than the actual costs of their care.

The MA program is evolving to better care for more Medicare beneficiaries, but the implications of program change—such as the ESRD transition—must be fully understood. As MA enrollment increases, so will the imperative that the program avoid disruption.

Expanding Medicare Advantage (MA) Scope and Coverage

Meet Our Experts /

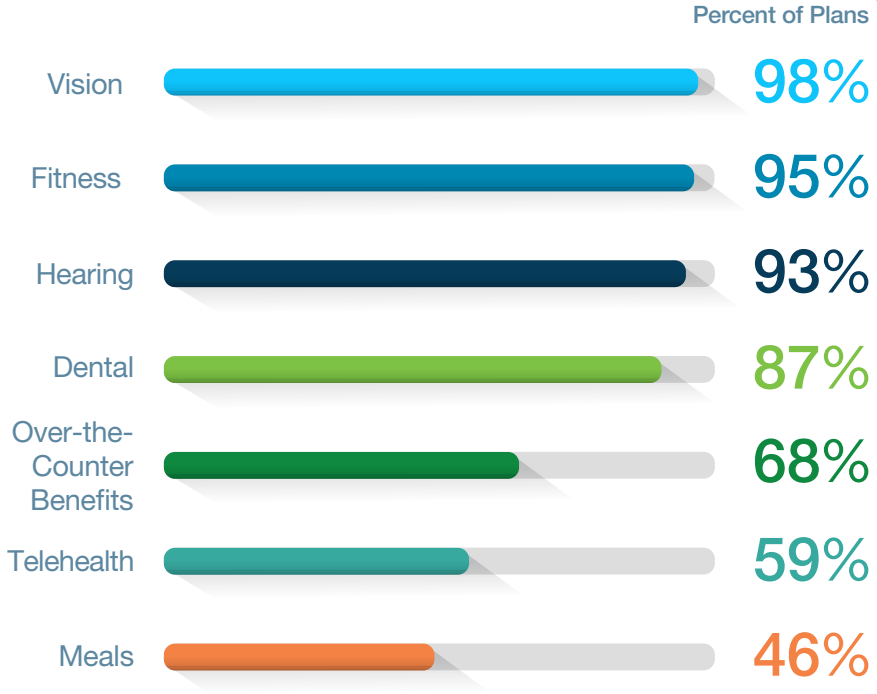
"ESRD costs exceeded MA payment rates in many of the areas with the most ESRD patients enrolled in Medicare, including New York City, Los Angeles, and Chicago. Payment benchmarks in NYC were 12% below costs."

Sean Creighton
Managing Director
screighton@avalere.com

"The breadth of MA benefits continues to expand and evolve to meet patient needs. Plans have more flexibility to offer benefits targeting specific populations, creating opportunities for new partnerships."

Fred Bentley
Managing Director
fbentley@avalere.com

MA Plans Continue to Increase Their Supplemental Benefit Offerings in 2020 /



Source: Avalere Health, "Medicare Advantage Beneficiaries Will Again See a Jump in Supplemental Benefit Offerings in 2020." November 19, 2019.

3 | Advancing Substance Use Disorder Policies /

With over 10.3M Americans misusing prescription opioids in 2018, and an estimated 2M people with opioid use disorders, policymakers will continue seeking new ways to address opioid misuse and substance use disorder (SUD) in general.

Most federal and state policies have centered around treating addiction and overuse, such as increasing the availability of medication-assisted treatment for opioid abuse and allowing states to request Medicaid waivers for SUD treatment. As of December 2019, 29 states and DC have requested or received approval for waivers to improve access to SUD services.

While efforts promoting responsible prescribing have led to a 28% reduction in retail fentanyl sales, overdose deaths due to synthetic opioids quadrupled in the same time period. The shift to illicit opioids will require a new policy direction focused on illicit drug users in addition to provider prescribing patterns.

+414% Increase in synthetic opioid deaths, 2014-2017

4 | Enhancing Access to Care with Technology /

As technology transforms care delivery, many payers view telehealth as a solution to expand access, improve quality, and reduce costs. In 2019, 96% of large employers covered telehealth, but patient access varied: nearly 25% of non-Medicare enrollees have used digital health services, but less than 1% of Medicare beneficiaries have.

In 2020, all enrollees in original Medicare can have virtual check-ins with providers, and MA plans have more incentive and flexibility to offer telemedicine. Over 40 states and DC have enacted telehealth laws increasing patient access and provider payment in the commercial market.

As use of telehealth and other digital solutions grows, privacy, interoperability, and payment will be increasingly important. Rules and regulations expected in 2020 will shape the digital health landscape with new standards to improve information flow among plans, providers, and patients.

40+ States and DC have passed laws to increase access to telehealth since 2017

5 | Evolving Payment for Post-Acute Care (PAC) /

Post-acute care is undergoing a dramatic transformation, forcing providers to redefine their roles and value as the market evolves beyond traditional, setting-specific business and payment models toward a more integrated approach focused on value and outcomes.

Medicare is reorienting payment around patient needs rather than resource utilization, while MA plans and accountable care organizations are encouraging patient care in the lowest-cost, clinically appropriate care settings.

Post-acute care providers will increasingly need to demonstrate their unique value relative to other care settings and evaluate opportunities to diversify into home health. Some providers may choose to become payers themselves, launching Special Needs Plans to secure their foothold in the changing market.

95% of PAC providers will be subject to new payment models in 2020 & 2021

Plotting the Path: Financing the Next Level of Healthcare Innovation

As new and innovative therapies come to market, stakeholders are exploring a spectrum of ways to finance access to treatment, driven by data, collaboration, and policy change. Some of these approaches may include rethinking the structure of public and private insurance and changing how providers and plans are paid.

5 Issues to Watch in 2020 /

1	Reforming Medicare Drug Programs	Congress may find agreement on Part D benefit design, while the administration continues looking abroad, pursuing policies on importation and international prices in Part B.
2	Funding the Pipeline with Novel Solutions	Accommodating the pipeline of new therapies promising long-term clinical benefits, including potential cures, will require systemic solutions, information sharing, and policy changes.
3	Growing Partnerships with Outcomes-Based Contracts (OBCs)	Payers and manufacturers will continue executing OBCs for drugs to realize value for new therapies, reduce costs, improve outcomes, and generate data to inform future financing models.
4	Refining Risk Adjustment in Medicare Part D	Appropriate plan payment for drug costs, especially for high-need beneficiaries, would reduce adverse-selection risks and enhance patient access to needed medications.
5	Driving Value with Alternative Payment Models (APMs)	APMs offer an option to reduce drug spending while recognizing the value of innovation and aligning incentives to lower costs and improve patient care.

Meet Our Expert /

"Our payment and regulatory systems are trying to catch up with the unprecedented clinical and scientific developments coming to market. Potential policy change has real-world implications for market access strategy, creating opportunities for bold moves to position products."

Michael Schneider
Principal

mschneider@avalere.com

Reforming Medicare Drug Programs

Congress ended the year without taking significant steps on policies related to drug prices, but lawmakers will have another opportunity to renegotiate a healthcare package in the spring, before the short-term extension of several health provisions expires on May 22.

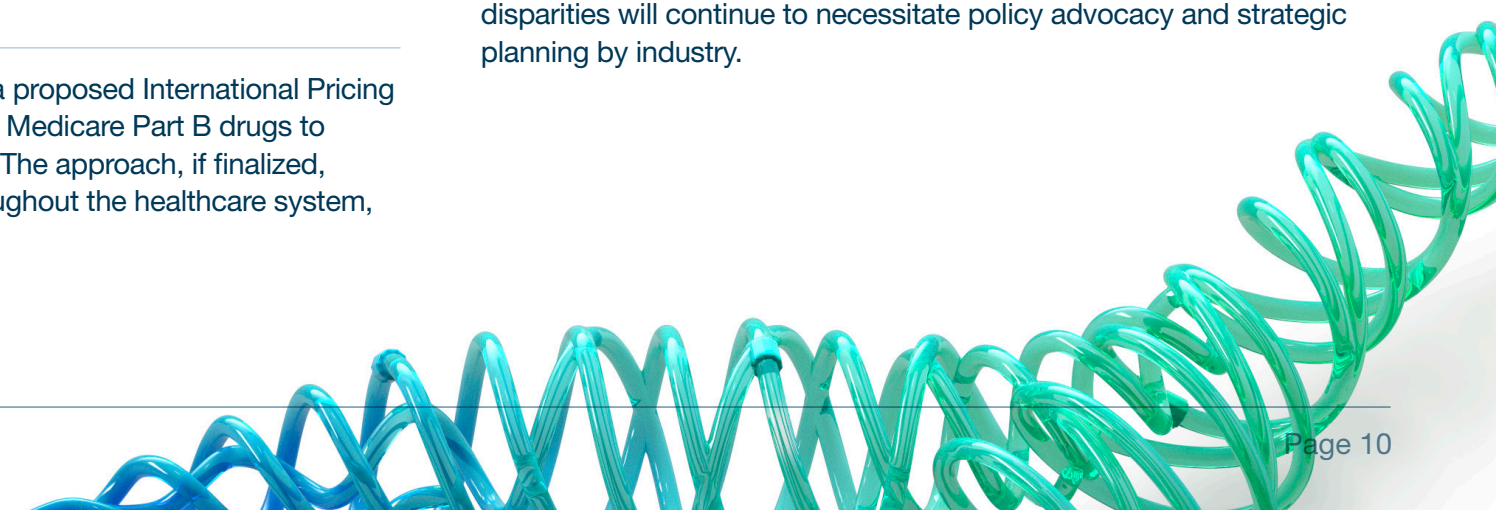
In the meantime, the Trump administration will continue to work with states to improve their plans to establish prescription drug importation programs. Four states (VT, FL, CO, and ME) have passed laws directing the design and implementation of drug importation programs. VT and FL have released concept papers for their programs, but only FL has submitted a concept to HHS. While importation has significant, serious implications for manufacturers, pharmacies, wholesalers, states, and patients, the proposals being discussed are limited and could face operational challenges.

Four states (VT, FL, CO, and ME) have passed laws directing the design and implementation of drug importation programs.

Stakeholders will continue to watch for a proposed International Pricing Index (IPI) rule, tying US prices for some Medicare Part B drugs to the same products' international prices. The approach, if finalized, would have significant implications throughout the healthcare system, changing the way Medicare reimburses physicians for administering drugs (eliminating the "buy-and-bill" model for participants), requiring manufacturers to reconsider their US and international business strategies, and potentially affecting other federal programs (e.g., 340B program, Medicaid) as well as care delivered to Medicare beneficiaries. The activities of Congress and the administration throughout 2019 have demonstrated that there is bipartisan, bicameral agreement on certain aspects of reform—in particular, redesigning the Part D benefit.

Policymakers are focused on addressing increasing out-of-pocket (OOP) costs by adding a maximum OOP limit to Part D. With nearly 800,000 beneficiaries who are not eligible for the low-income subsidy reaching the catastrophic phase of the benefit with average OOP spending of $4,000, manufacturers should continue to plan for Part D redesign, whether in 2020 or beyond.

In addition, regardless of the administration's potential IPI activity, stakeholders should prepare for the conversation about international price benchmarking to continue. Driven by the 2020 election, the importation debate, and proposals in Congress, international pricing disparities will continue to necessitate policy advocacy and strategic planning by industry.



Reforming Medicare Drug Programs

Meet Our Experts /

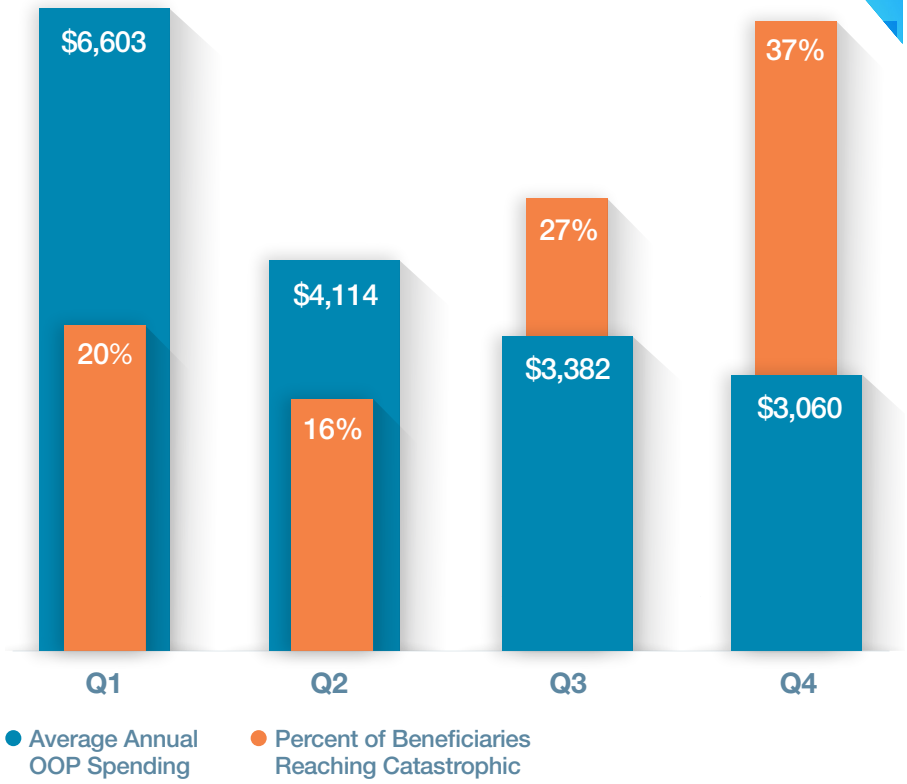
"Congress gets another bite at the healthcare apple in May. Expect a narrower policy focus based on areas of agreement from 2019."

Matt Kazan
Principal
mkazan@avalere.com

"With 40% of Americans foregoing some type of treatment due to costs, Congress' focus on reducing out-of-pocket spend is consistent with voter sentiment."

Josh Seidman
Managing Director
jseidman@avalere.com

Medicare Part D Beneficiaries Reaching Catastrophic Threshold /



Source: Avalere Health, Issue Brief: OOP Costs Among Medicare Part D Enrollees Reaching the Catastrophic Threshold. October 10, 2019. Analysis includes nearly 800,000 beneficiaries who reached catastrophic in 2017 and were not eligible for the low-income subsidy or enrolled in an employer-group waiver plan.

Funding the Pipeline with Novel Solutions

The pipeline of potentially transformative therapies is growing, with more than 800 investigational new drug (IND) applications for cell-based or gene therapy currently on file with the FDA, and over $600M in venture capital investment for gene therapies in the last 5 years. New medicines signal unprecedented scientific innovation and promise long-term clinical benefits for rare conditions, but also challenge current regulatory, financial, clinical, and distribution systems, potentially inhibiting treatment adoption and patient access.

Stakeholders will experiment with new financing or distribution models to begin to address these issues. However, the robust pipeline will demand systemic solutions that include a new level of information sharing and coordination, and in some circumstances, a series of policy changes that support patient access to inline therapies. As more of these therapies enter the market, providers, plans, manufacturers, and policymakers must consider these market challenges to optimize patient access:

Short-Term Budget Impact /

These high-value treatments often require significant upfront costs to plans. The traditional 12-month insurance contracting cycle and enrollee churn between sources of coverage complicate plans' management of the resulting budget impact.

Performance Risk /

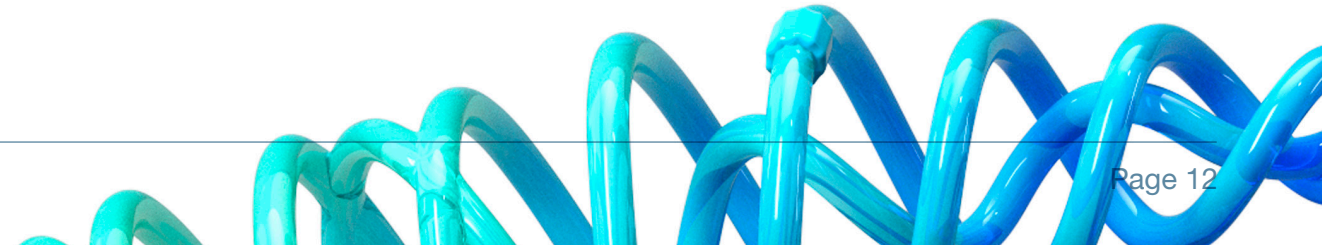
Limited longitudinal data on clinical efficacy and adverse events raises uncertainty about long-term performance. Also, many of these therapies are for ultra-orphan populations, offering small study populations and limited opportunity to aggregate data and extrapolate findings.

Provider Reimbursement /

The current payment model puts providers at financial risk to acquire, handle, and store drugs. While reimbursement varies across settings and markets, inadequate payment will limit providers' ability to care for patients unless reimbursement models adapt as clinical therapies evolve.

Patient Access /

From screening and diagnosis, to coverage and cost sharing, to identifying and traveling to a specialized treatment center, there are a spectrum of inherent hurdles faced by patients seeking access to new therapies.



Funding the Pipeline with Novel Solutions

Meet Our Experts /

"Science is outpacing the way we think about care settings, payment, and the definition of value. The concentration of transformative medicines now in the pipeline may either force change or risk leaving patients behind."

Jay Jackson
Associate Principal
jjackson@avalere.com

"As payers experiment with new payment models, scalability should be top of mind. Designing a new strategy for each unique product is not sustainable."

Lance Grady
Managing Director
lgrady@avalere.com

Stakeholders Are Exploring Various Models to Respond to New Therapies /

Benefit Design and Coverage Models	Multiple-Year Insurance Outcomes-Based Contracts Health Currency Portability Value-Based Insurance Design
Plan Risk-Economics Models	Reinsurance "Stop-Loss" Drug Mortgage/Annuity Plan-Level Amortization
"New Age" Models	Drug Subscription "Netflix Model" Manufacturer as Provider Value-Based Administrator

3 Growing Partnerships with Outcomes-Based Contracts (OBCs) /

Payers and manufacturers continue to collaborate on OBCs for drugs, aiming to reduce costs and improve outcomes by tying reimbursement to clinical, quality, utilization, patient-reported, or financial goals. Avalere's research found that 59% of plans have at least 1 OBC, and 31% have more than 5, a dramatic increase from just 12% in 2017. More than a quarter of payers without an OBC in place are negotiating to enter into one.

Results from OBCs are proving positive. Nearly 60% of plans report cost savings for both the plan and patients as well as improved patient outcomes. Heading into 2020, these contracts have strengthened plan/manufacturer relationships, while creating opportunities for innovative third parties to incorporate clinical, laboratory, and claims data to drive the next generation of arrangements.

58% of payers report that OBCs have improved patient outcomes

4 Refining Risk Adjustment in Medicare Part D /

To prepare for the biopharmaceutical pipeline, changes to the Part D risk adjustment model could ensure appropriate plan compensation for drugs and reduce adverse-selection risks. For example, reliance on diagnosis codes, rather than drugs, to determine risk adjustment payments may inaccurately predict Part D costs, especially for high-need enrollees. We found that the diagnosis-based model used for MA payments—which is similar to the Part D model in that it uses diagnosis codes—underpredicts costs for certain conditions, including chronic kidney disease, osteoarthritis, and rheumatoid arthritis.

Incorporating drug utilization, accounting for new drugs, and recognizing high outlier costs in the Part D model would improve the accuracy of plan payment. Over time, these changes could ensure patient access to needed medications—particularly if plans are asked to assume more risk as a result of policy change.

15% Amount that MA diagnosis-based risk adjustment model underpredicts rheumatoid arthritis costs

5 Driving Prescription Value with Alternative Payment Models (APMs) /

While policymakers aim to reduce drug spending by focusing on unit drug prices, APMs offer an alternative that aligns broader incentives to decrease drug spending and improve patient care.

In the Oncology Care Model (OCM), provider performance is based on Medicare Parts A, B, and some Part D spending, creating incentives to control costs. In the model's next iteration, CMS is considering changes that better account for the increasing cost of treatment, while maintaining incentives to curb spending. Proposed changes to apply the Novel Therapy Adjustment (NTA) and trending factor at the cancer level could increase payments for about 85% of practices currently receiving performance-based payments (PBP). However, stakeholders should also ensure that episodic incentives do not limit access to new treatment approaches, like combination regimens, adjuvant therapy, or cell and gene treatments.

85% of OCM participants receiving a PBP would get a bigger bonus if the NTA was cancer specific

Paving the Road Ahead: The Future of Coverage

With 30M uninsured, 76% of uninsured adults delaying care due to cost, and continued political interest in broadening the government's role to ensure access to care, presidential candidates have proposed a spectrum of approaches to expand healthcare coverage. Additionally, a growing number of people have access to insurance but are opting to go without coverage. Reducing the number of uninsured will require a variety of approaches that not only improve affordability, but also make coverage more attractive to those who voluntarily go without coverage.

5 Issues to Watch in 2020 /

1	Moving Beyond the Medicare-for-All Debate	The 2020 election refocuses the healthcare debate on coverage, but future policy discussions will need to move beyond Medicare-for-All to identify solutions capable of success in Washington.
2	Influencing Medicaid's Future	States' approaches to Medicaid today will influence the budget impact of a potential recession, which would increase Medicaid enrollment and the number of uninsured people.
3	Engaging Consumers with Cost Transparency	As policymakers aim to engage consumers in making better-informed healthcare decisions, plans and providers will be adjusting to market changes from new transparency requirements.
4	Stabilizing Individual Markets	While Affordable Care Act (ACA) litigation continues, states continue to adopt coverage protections and enhance market stability to encourage plan competition and reduce premiums.
5	Targeting the "Young Invincibles"	Non-traditional, less-expensive options to pay for prescription drugs and primary care are becoming more popular among individuals who typically use few healthcare services.

Meet Our Expert /

"Reducing the number of uninsured does not require total system disruption. Targeted policy change can move the needle on coverage."

Elizabeth Carpenter
Head of Advisory Services
ecarpenter@avalere.com

Moving Beyond the Medicare-for-All Debate

Access to healthcare coverage will be a hallmark of the 2020 election. From Medicare-for-All to a public option, candidates' proposals to expand coverage vary significantly and could impact millions of Americans. Based on how the program is designed, a Medicare-for-All proposal could shift the entire US population to public coverage over time, while a "Buy-In" or public option approach may impact far fewer people.

The details matter. Policy decisions such as subsidies for premiums and OOP costs, benefit standards, provider payment rates, and financing, will all shape the potential effects on existing insurance programs, their enrollees, and the uninsured.

While industry stakeholders should closely follow the 2020 healthcare policy debate and understand the effects of candidates' proposals, they would be wise to focus on the subset of policies that have a realistic path toward enactment. A combination of growing access to MA, optimizing the subsidies under the ACA, and creating incentives to expand Medicaid in states that have not yet done so, could satisfy political goals of expanding public programs, reducing the number of uninsured Americans, and minimizing system disruption.

2020 will be a year of preparation. Stakeholders can prepare for election impacts by understanding the candidates' proposals, evaluating the potential impacts, and crafting alternative solutions.

Population Potentially Impacted by Current Source of Insurance /

The impact of coverage proposals varies significantly.

Medicare-for-All

326M

Medicare Buy-In/For More

165M

Public Option

50M

Source: 2019 Avalere analysis of 2017 American Community Survey (ACS) data.

Meet Our Expert /

"Candidates will need to prioritize their policy aims, focusing on the uninsured and affordability issues, in order to enact meaningful reforms post-election."

Chris Sloan
Associate Principal

csloan@avalere.com

Influencing Medicaid's Future

Post-ACA and the flexibility granted by the Trump Administration, the Medicaid program continues to evolve. While some states are expanding Medicaid, seeking new funding, and pursuing innovative care and payment models, others are struggling to find reforms that work. The forecasted economic downturn will also heavily influence the future of the Medicaid program.

Historically, total healthcare spending growth continues in a recession, while patient OOP spending falls as fewer people have coverage, some switch between sources of insurance coverage, and others cut back on services. Economic downturns also increase Medicaid enrollment and the number of uninsured people. During the 2008 recession, the share of uninsured increased by more than 13%; rebounding to pre-recession levels took 5 years, during which the ACA significantly expanded coverage.

Since 2014, 33 states and DC have adopted Medicaid expansion, leaving 17 states yet to expand. Instead of expanding, states like TN are exploring block grant and capped spending proposals that, if approved, would limit federal Medicaid funding and increase state flexibility in Medicaid program design and administration. However, in a recession, a Medicaid block grant could create financial hardships for states that must fill in funding gaps caused by growing Medicaid enrollment.

Adopting work requirements can also cut Medicaid spending, as programs in several states have reduced Medicaid enrollment. However, if work is harder to come by in a recession, enforcing work requirements and validating beneficiaries' work status may increase the administrative burden on states.

While recent sustained economic growth may slow Medicaid enrollment growth, states' approaches today will influence how an economic downturn could affect their budgets in the future.

Meet Our Expert /

"As states adopt varied approaches to Medicaid eligibility and funding today, stakeholders should consider how these changes could play out in a down economy, when state budgets are tighter but demand for Medicaid grows."

Megan Olsen
Associate Principal
molsen@avalere.com

Influencing Medicaid's Future

Meet Our Experts /

"CMS' upcoming decision on Tennessee's waiver request will shape other states' approaches related to capped funding and drug coverage in Medicaid."

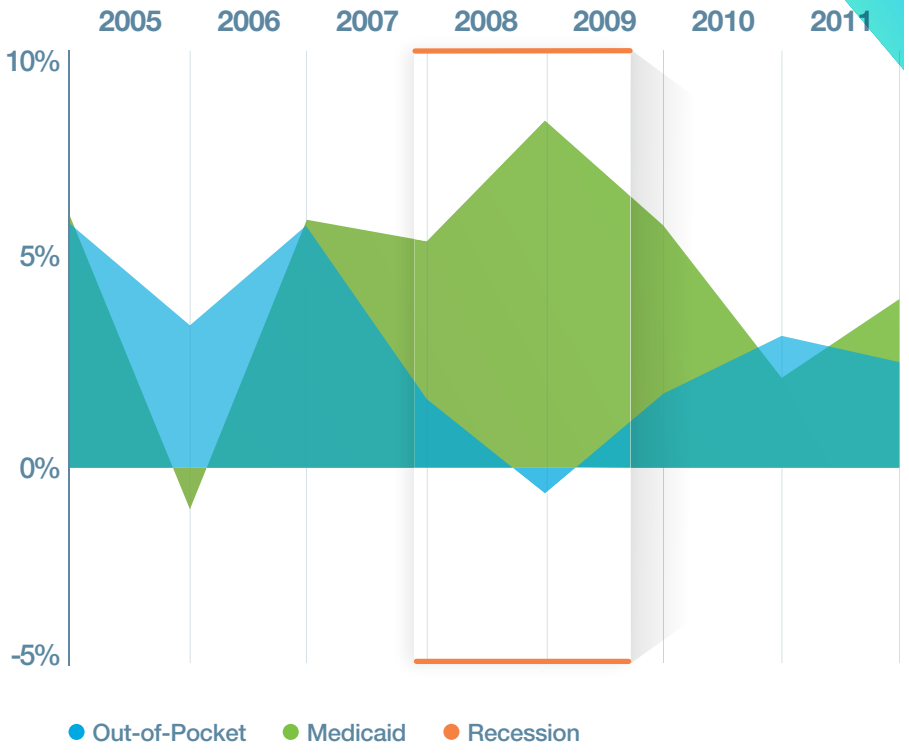
Tiernan Meyer
Associate Principal
tmeyer@avalere.com

"States are testing a variety of creative options to reshape their Medicaid programs, including value-based payment models, centralized control of drug benefits, and extending Medicaid coverage and benefits to non-traditional populations."

Margaret Scott
Associate Principal
mscott@avalere.com

National Health Expenditures, Percentage Growth /

In a recession, Medicaid grows while OOP spending falls.



Source: Avalere Health, "Healthcare and the 2008 Recession." October 2019.

3 | Engaging Consumers with Cost Transparency /

Across the industry, stakeholders are trying to encourage consumers to consider cost in decisions about their care by sharing pricing data for healthcare services. Policymakers have proposed various transparency initiatives, including recent CMS efforts aimed at hospitals and plans.

This year, hospitals will be preparing to post plan-specific negotiated rates, a federal requirement beginning in 2021. CMS may also finalize its proposed requirement that group and individual market plans increase transparency into OOP liability and disclose negotiated prices for covered services. However, implementation of the requirements may be complicated by lawsuits filed by stakeholder groups challenging the rules.

In addition to making new cost information available to patients, these changes will give plans and providers new insights into negotiated prices and contracting disparities, potentially impacting competition and premiums.

300 "Shoppable Services" for which hospitals will post negotiated rates

4 | Stabilizing Individual Markets /

Despite the focus on expanding access to public programs in the presidential campaign and pending Texas vs. Azar litigation, states continue to take their own steps to shore up insurance markets and shape the coverage landscape.

In the last 2 years, CA, MA, NJ, RI, VT, and DC have established state-level coverage mandates, and at least 13 states have enacted laws related to coverage of pre-existing conditions and essential health benefits provided for in the ACA. To mitigate risk for plans participating in the exchanges, 12 states have created reinsurance programs, reducing premiums in their first year by an average of 17%.

As premiums stabilize and plan participation improves, the impetus behind these market reforms may slow, but activity in the courts could again compel states to act in 2020 and beyond.

17% Average premium reduction in first year of reinsurance programs

5 | Targeting the "Young Invincibles" /

As policymakers and stakeholders consider approaches to reduce the number of uninsured, a look at the data shows why traditional health insurance may not be attractive to many Americans.

In the commercial market, 87% of enrollees either take no prescription drugs at all in a given year or only utilize generics. Many others receive only primary care and visit no other providers. As a result, non-traditional, less-expensive options to pay for prescription drugs and primary care are becoming more popular. Some providers also are offering alternatives, such as direct primary-care programs, in which patients bypass insurance and pay their physicians a monthly fee for office visits and other services.

Plans, providers, and non-traditional healthcare players will enter this market in 2020. Policymakers and other stakeholders assessing consumer demand should take note.

87% of commercial market enrollees who fill no prescriptions or only use generics

About Us

Avalere is a vibrant community of innovative thinkers dedicated to solving the challenges of the healthcare system. We deliver a comprehensive perspective, compelling substance, and creative solutions to help you make better business decisions. As an Inovalon company, we prize insights and strategies driven by robust data to achieve meaningful results. **For more information, please contact** info@avalere.com.

Avalere Health
An Inovalon Company
1201 New York Ave., NW
Suite 1000
Washington, DC 20005
202.207.1300
avalere.com

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