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ISSUE BRIEF

Dual Eligible Special Needs Plan (D-SNP) Look-Alikes: A Primer

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Introduction

Approximately twelve million individuals are eligible for both Medicare and Medicaid across the country.[1] This population, referred to as dual eligibles or sometimes as Medi-Medis, is comprised of adults 65 and over and younger individuals with disabilities, all with low income and assets. Dual eligibles are one of the populations with the highest number of chronic conditions and correspondingly higher costs. They also face unique barriers in navigating and coordinating two separate healthcare programs.

Developing better ways to deliver Medicare and Medicaid services to dual eligibles has been a high priority for the Centers for Medicare & Medicaid Services (CMS). Working with states and stakeholders, the agency has launched several delivery models that integrate Medicare and Medicaid benefits. For example, demonstrations are currently underway testing both managed fee-for-service models and Medicare-Medicaid plans (MMPs) that integrate services from both programs. Further, CMS recently issued new regulations to strengthen the integration requirements for Dual Eligible Special Needs Plans (D-SNPs), Medicare Advantage plans designed specifically to serve dual eligibles. All of these efforts recognize that dual eligibles face serious challenges in navigating two benefit programs. All models place specific additional requirements on plans and providers seeking to serve the complex needs of duals to better coordinate and integrate care.

Over the last few years, however, Medicare Advantage plans have emerged that are undermining the move toward integration. These plans, which have come to be called D-SNP look-alikes, are aggressively marketed almost exclusively to dual eligibles, but are not D-SNPs or integrated products. They are not subject to the regulations governing D-SNPs and have no responsibility to coordinate Medicare and Medicaid benefits. Unlike D-SNPs, they have no contracts with state Medicaid agencies that define their responsibilities to better integrate care for duals and no accountability. They draw dual eligibles away from coordinated options and place responsibility on the consumer to navigate two separate delivery systems. The Medicare Payment Advisory Commission (MedPAC) reports that in 2017, 44 look-alike plans operated in 16 states and enrolled over 200,000 beneficiaries.[2] MedPAC conservatively estimates that as of 2019 the number of look-alike plans has nearly doubled since 2017, and they are now available in 35 states. Enrollment is estimated to have increased to at least 220,000.[3] Given the proliferation of look-alike plans, advocates working with dual eligibles need to be prepared to identify the impact of these plans on dual eligibles and report their experiences to Justice in Aging and CMS.

This issue brief:

- Outlines some key requirements of D-SNPs;
- identifies the basic characteristics of D-SNP look-alikes and how they differ from D-SNPs;
- discusses problems look-alikes are causing for dual eligibles; and
- proposes ways to restrict them in the Medicare market.

WHO ARE DUAL ELIGIBLES?

Dual eligibles are individuals who qualify for both Medicare and Medicaid benefits. Of the over 12 million dual eligibles, they are more likely to be women (61 percent to 53 percent) and people of color (42 percent to 15 percent) than Medicare-only individuals. Over half (57 percent) have one or more ADL limitations compared to only 28 percent of the Medicare-only population; fewer tend to report themselves in excellent or very good health (23 percent compared to 51 percent). Although dual eligibles are only 20 percent of the Medicare population, they account for 34 percent of aggregate Medicare spending.[4] Similarly, though they represent only 18 percent of the Medicaid population, they account for 46 percent of Medicaid spending.[5]

An Introduction to D-SNPs and Their Key Requirements

Because D-SNPs are Medicare Advantage plans exclusively for dual eligibles, D-SNPs are subject to several unique requirements, perhaps most importantly those imposed as a result of the Medicare Improvements for Patients and Providers Act (MIPPA). MIPPA requires that D-SNPs contract with state Medicaid agencies, and those contracts must address eight minimum areas, including the D-SNP's responsibility to provide or arrange for Medicaid benefits; the types of dual eligibles who can enroll into the plan; the Medicaid benefits covered under the plan; and the plan's cost-sharing protections, among others.[6]

States have the option to require more of D-SNPs in their contracts, including additional reporting or notification requirements. Some states that offer or require enrollment in Medicaid managed care also require D-SNPs to offer a matching Medicaid managed care plan for alignment purposes.[7] The extent to which states require additional Medicare and Medicaid alignment or coordination beyond the minimum MIPPA requirements varies from state to state. For example, Arizona mandates that D-SNPs in the state coordinate all aspects of enrollee's health, and have an established contact at the plan to share information with the member's Medicaid plan to coordinate care.[8] In Hawaii, D-SNP enrollees must have a service coordinator who is responsible for coordinating Medicaid long-term services and supports with Medicare services.[9]

Furthermore, all D-SNPs must have a Model of Care (MOC) approved by CMS. The MOC provides a basic framework that the SNP will use to meet the unique needs of the enrollee population it serves through the plan's care management practices.

Effective in 2021, as a result of the Bipartisan Budget Act of 2018, D-SNPs will have to meet additional requirements around coordinating Medicaid benefits, integrating appeals, and notifying the state regarding hospital admissions. For more information on these new requirements, refer to Justice in Aging's factsheet.[10]

Look-Alikes: The Basics

What are D-SNP look-alikes?

D-SNP "look-alike" plans (sometimes called "mirror" plans) are Medicare Advantage plans that plan sponsors have designed specifically to attract dual eligible beneficiaries. Though plan sponsors sought and received approval from CMS for these plans as ordinary Medicare Advantage plans, the numbers show that enrollment is almost exclusively comprised of dual eligibles. For example, an analysis by MedPAC of look-alikes in California found that 95 percent of those enrolled in a look-alike plan in the state are dually eligible for Medicare and Medicaid.[11] Despite serving nearly exclusively dual eligibles, these plans have no obligation to comply with any of the rules created by Congress and CMS for serving duals in integrated products like D-SNPs, Medicare-Medicaid plans, or the Program for all Inclusive Care (PACE). These look-alike plans are serving dual eligible populations with none of the safeguards and none of the stakeholder input involved in regulation and oversight of D-SNPs and other integrated delivery models.

What do look-alikes look like?

Look-alike plans typically have a beneficiary premium for Part D, a high Part D deductible and the highest out-of-pocket limit on Part A and B services allowed by CMS. They generally offer supplemental services such as dental or vision or transportation, that are not fully covered by Medicare or Medicaid. The premiums and deductibles make the plans unattractive generally to most Medicare beneficiaries when they compare plan options through the Medicare.gov Plan Finder. Dual eligibles, however, are shielded from the high out-of-pocket costs associated with these plans because they receive cost-sharing assistance through the Medicare Savings Programs and Low-Income Subsidy (LIS) and are protected from improper billing. Plans and brokers, therefore, have been aggressively marketing look-alike plans almost exclusively to dual eligibles.

COMPARING D-SNPS AND D-SNP LOOK-ALIKES

	D-SNPS	D-SNP LOOK-ALIKES
Available to dual eligibles as an enrollment option	☑	☑
Must have a contract with state Medicaid agency outlining key coordination and alignment responsibilities	☑	✗
Must have a Model of Care that is subject to approval and oversight from CMS	☑	✗
Generally have $0 premium and cost-sharing structure	☑	✗

Impact on Dual Eligibles

A number of problems have arisen with the introduction and growing penetration of look-alikes in the market. Advocates report that many beneficiaries have been confused by look-alikes and their marketing. Beneficiaries believed that they were enrolling in a plan that would coordinate their Medicare and Medicaid benefits, although look-alikes have no obligation to do so. Advocates also have reported many instances in which brokers violated Medicare marketing rules when enrolling dual eligibles in look-alikes. Advocates report questionable practices around marketing of look-alikes including targeting beneficiaries with limited English proficiency, who may have

lower health literacy, and those in rural communities, where supplemental services such as transportation are particularly attractive to beneficiaries.

In states with dual eligible demonstration projects aimed at testing the effectiveness of integrated Medicare-Medicaid plans to reduce costs and deliver better care, the promotion of look-alikes has impacted the development, evaluation, and sustainability of demonstration models. In California, for example, look-alike plans have enrolled almost as many dual eligibles as are enrolled in the integrated products, threatening the viability of integrated plans.[12] Look-alikes have also impacted efforts to evaluate the reasons duals did not choose to enroll in a Medicare-Medicaid plan. Again in California and other demonstration states, the narrative in the early years of the demonstration attributed lower than expected enrollment in the integrated plan option to beneficiaries who refused managed care and to their providers who steered their patients away from the Medicare-Medicaid plans.[13] Yet, the high enrollment numbers in the look- alike plans indicate that in fact look-alikes were targeting duals to enroll in this alternative product.

Addressing the Problem

CMS must continue its work to curb look-alikes in the Medicare market. When look-alikes target dual eligibles without submitting to a regulatory framework that addresses their unique needs, it confuses consumers and their advocates and interferes with the development of genuinely integrated approaches.

Initial Steps Taken by CMS

In draft revisions to the Medicare Communications and Marketing Guidelines, CMS took steps to ensure more accurate and transparent marketing of look-alikes. Specifically, look-alikes would be prohibited from claiming that their plan is designed for dual eligibles and from primarily targeting dual eligibles in their marketing efforts.[14] These plans also cannot use a plan name that includes the state's Medicaid program or use any language that implies that the plan has a relationship to Medicaid.

In the 2020 Call Letter, CMS, after soliciting comments on the impact of look-alikes, indicated the agency's belief that look-alike plans impede progress toward developing products that meaningfully integrate Medicare and Medicaid benefits for dual eligibles. The agency stated that it is considering future policy development on the issue.[15]

While these initial steps to limit the harmful effect of look-alikes are noteworthy and important, more action is needed to ensure dual eligibles are making educated decisions about their enrollment options and to oversee plans enrolling primarily dual eligibles.

Additional Advocacy Opportunities

Additional action is needed to address how look-alikes impact dual eligibles. CMS needs to hear from advocates who serve dual eligibles on what issues dual eligibles are experiencing with look-alikes and how to address these issues.

Share the experiences of dual eligibles enrolled in look-alikes. It is essential that the policy solutions designed to curb the promulgation of look-alikes and mitigate their impact in the marketplace are grounded in the real lived experiences of dual eligibles. For example, stories of consumers enrolled in look-alikes and their experiences with a potential lack of care coordination can inform CMS action. Similarly, stories of agents and brokers marketing look-alikes to consumers help CMS issue guidance via Medicare marketing rules that adequately address broker and agent conduct.

Advocate for more information on look-alikes. The lack of transparency around look-alikes has made it difficult for advocates and counselors to help their dual eligible clients choose plans appropriate to their needs. We ask that

CMS share publicly more information on the identity and service areas of non-integrated Medicare Advantage plans with high dual eligible enrollment. Plan Finder improvements on the Medicare.gov website as well as State Health Insurance Program (SHIP) training also should more clearly highlight the difference between integrated and non-integrated products for dual eligibles.

Advocate for additional CMS measures to regulate look-alikes. Advocates can tell CMS, both when formal comment opportunities arise and in other forums, that the agency should take additional measures to better ensure that plans serving duals are actually designed to do so. For example, CMS could treat any plan with membership of at least 50 percent dual eligibles as a D-SNP subject to the regulatory requirements for D-SNPs, including the requirement for a contract with the state Medicaid agency.[16] A recent MedPAC analysis demonstrated that a 50 percent cut-off could be highly effective in capturing most look-alikes.[17] CMS could also require that any plan sponsor seeking to offer an integrated product must agree, as a condition of its contract, that the sponsor will not offer a non-integrated product in the same service area that enrolls more than 25 percent dual eligibles and/or has a plan design that appears to be particularly attractive to dual eligibles.

Advocate for solutions that target plans and not beneficiaries. Beneficiaries did not create the problem of look-alikes. Yet some proposals, including those put forward by MedPAC, call for increasing passive enrollment and locking dual eligibles into integrated plans.[18] These measures are not consumer-friendly and are not appropriate solutions. Passive enrollment can result in unmet continuity of care needs when a consumer is auto-enrolled in a plan. Further, dual eligibles need to be able to change Medicare plans because of their complex health needs and their poverty. Those needs continue. Rather than restricting beneficiary choice, what should be stopped instead is aggressive marketing of inappropriate products.

Conclusion

D-SNP look-alikes cause confusion, have no obligation to deliver coordinated or integrated benefits, and are not subject to the rules and oversight that apply to integrated products. Simply put, in the Medicare marketplace, look-alikes are not appropriate enrollment options for the high-need, high-cost population of dual eligibles and distract them from more genuinely integrated options that could better deliver care, like D-SNPs, MMPs and PACE. If gone unchecked, D-SNP look-alikes will continue to significantly interfere with policy initiatives to better coordinate care for dual eligibles. Therefore, it is important that advocates understand look-alikes and push for more information to facilitate identification of look-alikes operating in their communities. CMS must start treating these look-alike plans with disproportionately high enrollments of dual eligibles as D-SNPs and reject measures that do not serve dual eligible consumers, like passive enrollment and lock-in periods. Advocates should share with their state Medicaid agency and with CMS specific examples of the issues they see with D-SNP look-alikes and work together to develop solutions.

Advocates seeking technical assistance with D-SNP look-alike issues or who have stories of dual eligibles being impacted by look-alikes can contact Justice in Aging at info@justiceinaging.org.

Endnotes

1 Centers for Medicare & Medicaid Services, "People Dually Eligible for Medicare and Medicaid," (Mar. 2019), available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

2 MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System," (June, 2019) ("2019 MedPAC Report"), p. 442, available at medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0.

3 *Id.*, pp. 442-43. MedPAC identified Humana Value Plus and United Healthcare MedicareComplete Assure plans as among the most widely offered plans that appear to be look-alikes. *Id.*, p. 443.

4 MacPAC, "MacPAC Duals Data Book," (Jan. 2017), available at macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf (using data for fee-for-service Medicare beneficiaries); Commonwealth Fund, "Medicare Spending Growth for Dual-Eligible Beneficiaries Has Trended Down Since 2011," (Aug. 2018), available at commonwealthfund.org/publications/journal-article/2018/aug/medicare-fee-for-service-spending-dual-eligibles.

5 SCAN Foundation, "Characteristics of Dual Eligibles," (Sep. 2010), available at thescanfoundation.org/sites/default/files/DataBrief_No1.ppt.

6 42 C.F.R. § 422.107(c).

7 Four states (Idaho, Massachusetts, Minnesota, and New Jersey) have gone further, allowing D-SNPs to only enroll beneficiaries who are enrolled in the same sponsor's Medicaid managed care plan. 2019 MedPAC Report, *supra* note 2, p. 447.

8 Copies of Arizona's D-SNP agreements can be found at azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/medicareagreements.html. The care coordination responsibilities are identified in Section 2.1.

9 State of Hawaii, Department of Human Services, "Request for Proposal Quest Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals" (Aug. 2013), Sec. 40.900, available at clpc.ucsf.edu/sites/clpc.ucsf.edu/files/Quest%20Integration%20RFP%202013.pdf.

10 Justice in Aging, "CMS Regulations Set Ground Rules for D-SNPs" (Apr. 2019), available at justiceinaging.org/wp-content/uploads/2019/04/CMS-Regulations-Set-Ground-Rules-for-D-SNPs-Fact-Sheet.pdf.

11 MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2018) ("2018 MedPAC Report"), p. 274, available at medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0.

12 *Id.*

13 See, e.g., Debra J. Lipson, et al, "The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries" (Dec. 2018), pp. 20-21, available at macpac.gov/wp-content/uploads/2019/01/Enrollment-in-Integrated-Care-Demonstrations-for-Dually-Eligible-Beneficiaries.pdf. See also, RTI International, "Financial Alignment Initiative California Cal MediConnect: First Evaluation Report" (Nov. 2018), pp. 42-43, available at innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf.

14 Centers for Medicare & Medicaid Services, "Medicare Communications and Marketing Guidelines," (2019), § 30.7, available at cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Draft_2020_MCMG.pdf.

15 Centers for Medicare & Medicaid Services, "Announcement of Calendar Year 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" (Apr. 1, 2019), pp. 194-196, available at cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf.

16 Since 50 percent membership demonstrates that a plan is primarily serving duals, we believe this approach is consistent with Congressional intent in the D-SNP definition in 42 U.S.C. § 1395w-28W(b)(6). Further, we note that MedPAC found in the California demonstration counties that it reviewed, regular Medicare Advantage plans had dual eligible enrollment of only 10 percent. 2018 MedPAC Report, *supra* note 11 at p. 274. Thus, there is little chance that a 50 percent cut-off would capture Medicare Advantage plans that were not directly targeting dual eligibles.

17 2019 MedPac Report, *supra* note 2, pp. 448-49.

18 2018 MedPAC Report, *supra* note 11, pp. 276-278.