Special Needs Plan Alliance

Medicare Advantage for All

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The Special Needs Plan Alliance (SNP Alliance) is a mission-driven, thought leadership organization committed to delivering high quality care solutions for complex care populations. As the President and CEO of the SNP Alliance, I believe it is important to present some initial, impartial observations on a re-emerging health policy concept that has significant implications for Special Needs Plans (SNPs) providing complex care.

Over the past several years, Americans had heard a great deal about Medicare for All but less about an alternative proposal, Medicare Advantage for All. The concept was most visibly discussed by Mr. George Halvorson, former CEO of Kaiser Permanente, and Dr. Mehmet Oz in 2020 during Dr. Oz's Senate run. Dr. Oz is President-Elect Trump's CMS Administrator nominee.

In a **2020 OpEd**, Mr. Halvorson and Dr. Oz note, "*We could achieve these goals by buying health-care coverage for every American who is not on Medicaid through the Medicare Advantage program, which a third of Medicare beneficiaries already use very successfully. We could fund this universal coverage entirely with full financial security by using an affordable 20% payroll tax, which is close to the amount most employers currently spend to buy insured care. Half would be paid by employers, so individual Americans would pay no more than 10% of their income to pay for much better coverage than is currently available to most*."

By "every American who is not on Medicaid," the authors mean employer-sponsored insurance, individual coverage options, and the Health Insurance Exchange options. Since then, additional policy thought includes Medicaid in this framework. Specifically, federal Medicaid dollars would flow through an array of Medicare Advantage Organizations (MAOs) along with the aforementioned funds with the intent of providing coverage to using these integrated funds. Any array of policy, operational and financial discussions will be needed about the feasibility of the concept particularly how Medicaid would be included in such MAO arrangements.

For example, one view might be that national Medicaid coverage would offer more consistency for Medicaid populations. Such an arrangement would offer national eligibility criteria and services rather than state by state policies. Conversely, some plans may not be positioned to deliver Medicaid services to individuals eligible for Medicaid through an

Aged, Blind, or Disabled eligibility pathway, importantly those dually eligible for Medicare and Medicaid. Medicaid is key to SNP populations as discussed, below.

The SNP Alliance is contemplating how the existing Medicare Advantage Special Needs Plan framework, under the Medicare Modernization Act (MMA), would be addressed in the proposed Medicare Advantage for All concept in an array of approaches. Here, I highlight two areas. First, to-date, 1,384 SNPs exist with total enrollment of over 7 million beneficiaries. Decades of SNP experience would greatly inform Medicare Advantage for All discussions. Of note with Medicaid, while Dual SNPs (D-SNPs) are the designated SNP type for beneficiaries eligible for Medicare and Medicaid, the vast majority of all SNP enrollees, D-SNPs, Chronic Condition SNP (C-SNPs), and Institutional SNPs (I-SNPs) are dually eligible making Medicaid important to all SNP types.

Additionally, SNP enrollees need highly specialized care which historically has been delivered by local physicians with whom these beneficiaries have longstanding relationships. This could be the case with any SNP but in particular C-SNPs who serve persons with very severe, life-threatening chronic conditions. For D-SNPs , in addition to specialty physicians, they may also rely upon local community-based organizations (CBOs) for home and community-based services or complex care coordination. I-SNP enrollees have long-standing relationships with the nursing facilities in which they reside. Specifically, some plans may not have relationships with these CBOs.

As we approach the 2025 Medicare Advantage for All policy dialogue, some policy thinkers have noted, "... *Medicare for All has several key limitations and risks. Eliminating private health insurance would effectively eliminate a large sector of the US economy. Additionally, this model would leave an unclear role for managed care organizations (MCOs), which are how most individuals in the US currently receive health insurance coverage*." (Dr. G. Zahner, MD, MSc, et al., *Medicare Advantage for All A Potential Path to Universal Coverage,December16,2021. **doi:10.1001/jama.2021.23329**)*.

As I read the available literature, I find myself wondering how such a sweeping concept might be advanced. A couple of points come to mind:

- First, in the short term, the Center for Medicare and Medicaid Integration (CMMI) current waiver authority, under Section 1115A of the ACA might offer some flexibilities;

- Second, the Supreme Court's *Chevron* and *Loper-Bright* rulings may impact administrative flexibility; and

- Third, MA Reform legislation, which seems probable in 2025, could contain demonstration authority or a demonstration requirement for parts or all of the proposal to be tested.

I offer these initial observations to prioritize the needs of SNP-enrolled complex care populations in the unfolding discussions. As ideas develop into detailed proposals, the SNP Alliance, a bipartisan thought leadership group, is prepared to actively participate in this critical dialogue and provide constructive input.