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Investment Area of Interest:

Startups Improving Medicare Advantage Plans' Star Ratings

September 2019

Executive Summary:

Medicare is currently undergoing a remarkable reorganization. In recent years, Americans over the age of 65 have shifted from traditional Medicare plans to Medicare plans operated by private insurers—also known as Medicare Advantage (MA) plans—at staggering rates. In light of this growth, MA insurers are fighting to accommodate such volume, while remaining competitive.[5]

To capture the high demand for MA, insurers are making their plans more appealing and improving their Star Ratings. Star Ratings are measurements, conducted by the Centers for Medicare & Medicaid Services (CMS), of the quality of each MA plan. High ratings are associated with significant benefits, such as monetary rewards and boosted enrollment, incentivizing insurance companies to raise each plan's Star Ratings as quickly as possible.[7] A multitude of different measurements factor into a plan's overall rating, but rather than addressing each individually, insurers are investing in three larger areas with broad potential impact—enhancing health outcomes, introducing new data collection and analysis, and improving patient engagement to boost patient satisfaction.[5] However, large insurers often lack the technology or capabilities to enact these changes in-house, so they enlist the help of innovative startups.

Given the dynamic nature of the MA environment and of healthcare policy, it is crucial that insurers, startups, and other stakeholders remain attuned to several industry trends. First, the cost of MA plans is decreasing, increasing their desirability to customers. Second, overall Star Ratings are increasing, amplifying competition between plans. Third, new plans and insurers are entering the market, also increasing competition. Fourth, the amount Medicare pays MA plans is increasing, meaning MA plans will stand to make greater profits each year. Finally, policy changes are encouraging the introduction of more supplemental benefits like in-home support services, opening new avenues on which companies can capitalize. Healthcare startups that leverage each trend and provide meaningful solutions to insurers have the potential to reinvent quality of care and to experience rapid financial gains.

Medicare Advantage

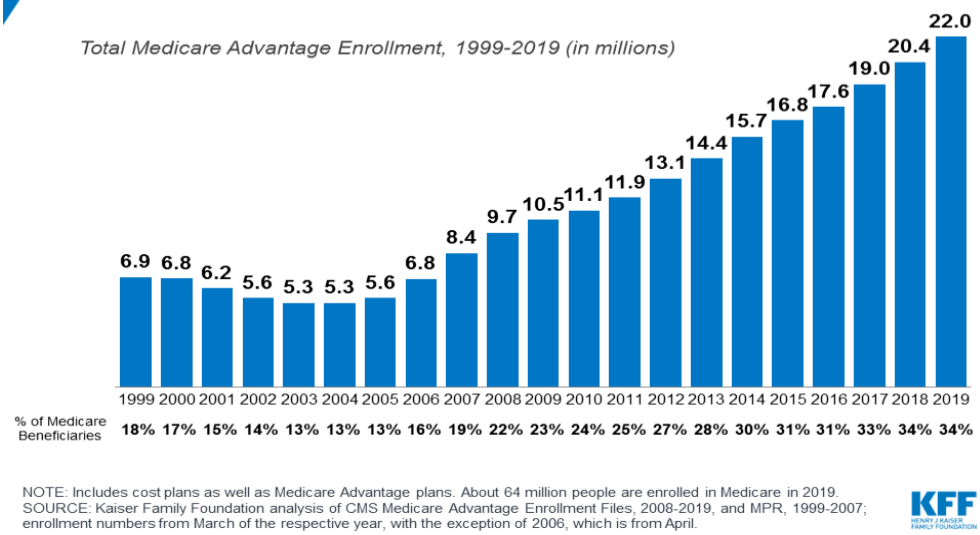
Medicare Advantage (MA) plans are a form of Medicare offered by private companies—often called Medicare "Part C". They include the same benefits as traditional Medicare Part A (Hospital Insurance), Part B (Medical Insurance), and often Medicare Part D (Prescription drug coverage), but are all rolled up into one plan. Unlike traditional Medicare, the majority offer supplemental benefits as well. In fact, 67% of MA enrollees have access dental care, 78% have access to eye exams or glasses, and 72% have access to some fitness benefit. However, also unlike traditional Medicare, most MA beneficiaries' care is covered only if they visit providers in the plan's network.[1]

The State of Medicare Advantage

Currently, 64 million Americans are enrolled in Medicare and spend over $730 billion annually. 22 million of these individuals—over one-third—are enrolled in MA plans, accounting for $233 billion of total Medicare spending. Yet, MA's footprint in the industry was not nearly as large just a decade ago. In fact, in 2010, there were only 11.1 million MA beneficiaries, meaning enrollment nearly doubled in under ten years. This trend toward growth is expected to continue as more players enter the MA space and established insurance companies continue to introduce new plans each year.[5] According to

Figure 1

Enrollment in Medicare Advantage has nearly doubled over the past decade



NOTE: Includes cost plans as well as Medicare Advantage plans. About 64 million people are enrolled in Medicare in 2019.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2008-2019, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

KFF HENRY J KAISER FAMILY FOUNDATION

L.E.K., MA enrollment is projected to reach 45-55% of total Medicare beneficiaries by 2025.[40]

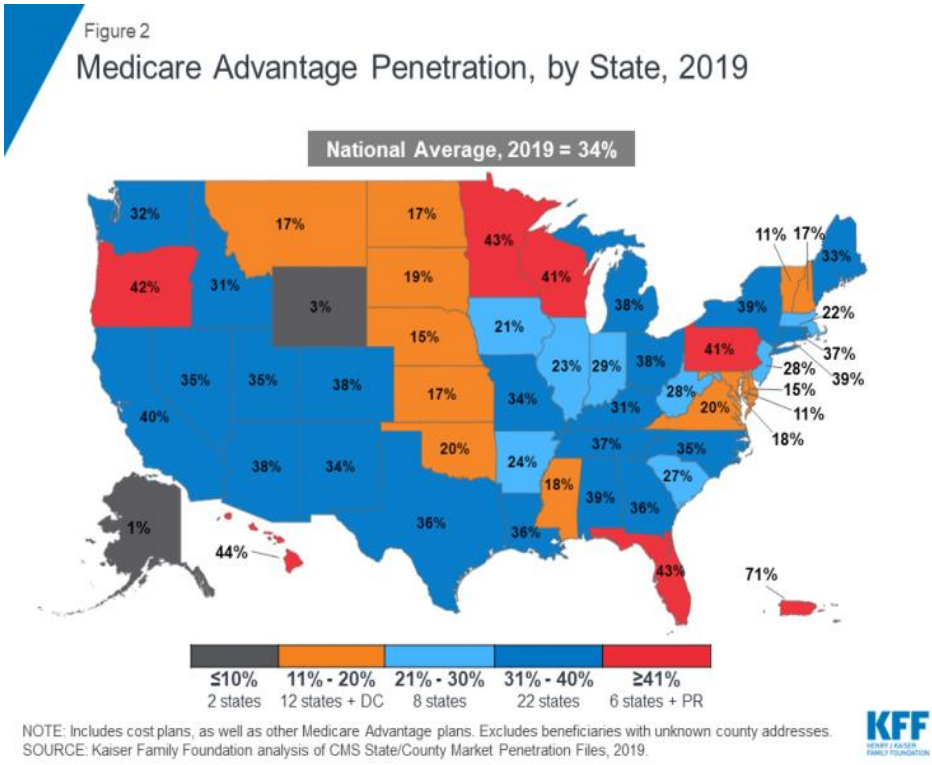
The importance of capturing and retaining this growing MA market is becoming increasingly imperative. To help insurers achieve this goal, Cavulus, a startup based in South Carolina, optimizes the success and efficiency of the customer acquisition process specifically for MA plans. The company's MedicareCRM technology offers marketing, sales, and enrollment capabilities to grow a plan's membership. They currently partner with over 35 MA plans, which all report market growth that is 20% greater than the industry average.[35]

Interestingly, the majority of new MA beneficiaries do not enroll in MA immediately upon turning age 65, but instead switch over from traditional Medicare within their first year of enrollment. Certainly, this trend demonstrates that MA must offer unique and appealing benefits. There are three notable traits thought to be driving this shift.

First, MA plans may be less costly. Under traditional Medicare, beneficiaries are responsible for a greater number of out-of-pocket costs, which generally present a higher price tag than the costs associated with MA plans. In fact, most Americans have access to at least one MA plan with a $0 monthly premium.[12] Each MA plan also includes a maximum annual limit that beneficiaries can pay out-of-pocket, after which insurance covers all costs, effectively preventing an enrollee's costs from skyrocketing for any reason. The second appealing trait of MA is that 90% of plans offer drug coverage as an included benefit. Traditional Medicare enrollees, in contrast, must purchase a separate Part D prescription drug plan and pay an additional premium, costing an average of $29 per month, or $350 per year. Thus, MA circumvents some prescription drug coverage costs and houses all plans in one, easily accessible location. Finally, MA plans are unique in that they cover additional benefits not included in Part A or Part B. These supplemental benefits include eye care, dental, vision, fitness, and much more.

Despite the variety of plan options, the MA industry is extremely concentrated in regards to major players. The two most popular insurers—UnitedHealthcare and Humana—enroll 44% of all MA beneficiaries. The next five companies—BlueCross BlueShield, CVS/Aetna, Kaiser Permanente, Wellcare, and Cigna—enroll another 36% of total MA beneficiaries. UnitedHealth and CVS/Aetna are the two insurers experiencing the fastest growth rates, with each gaining a staggering 500,000 enrollees between 2018 and 2019. For these insurers, the MA business comprises a notable portion of total revenue. For example, in the first quarter of 2019, UnitedHealth reported $21 billion in revenue from its MA plans, which was equal to 35% of its total $60 billion in first quarter revenue.[36] With this in mind, it is evident that startups that develop relationships with the top insurers can effectively increase their likelihood of winning a large volume of MA-related contracts and of significantly growing revenue.[5]

In contrast, MA enrollment is diverse from a geographic standpoint. The national average MA penetration rate is 34%, yet some states fall significantly above and some fall significantly below this figure. Six states—Hawaii, Florida, Minnesota, Oregon, Pennsylvania, and Wisconsin—report that over 40% of total Medicare beneficiaries are enrolled under MA plans. Regionally, the greatest MA penetration rates can be observed in the Southeast and the Southwest. In fact, between 2009 and 2017, the South Atlantic region accounted for 23.3% of total MA enrollment growth and 12.3% of MA



penetration growth. Similar nuances in MA enrollment also exist at the county level. Seniors in metropolitan counties have the option to choose from twice as many, on average, MA plans than those in rural counties.[7] This suggests that the urban counties in the South Atlantic region may be ideal locations for startups looking to enter an established MA market.

Medicare Advantage Payment Structure

Despite operating through private insurers, MA plans receive a bulk of their funding from Medicare itself. Each month, Medicare pays each MA plan a particular amount, determined by a bid-to-benchmark process. To initiate the process, Medicare determines a benchmark equal to the average monthly cost of covering a traditional Medicare beneficiary. The benchmark is specific to location, meaning each county receives a unique value representative of the traits of the local population. The county with the highest rate of chronic diseases in the country, for example, would have a much higher benchmark than the county with the lowest rate of chronic diseases in the country. After this, each MA plan submits a bid to Medicare stating the cost it expects to incur to cover the Part A and Part B benefits for an average enrollee in each county. If the bid is below the benchmark, Medicare pays the plan the benchmark rate plus a rebate equal to 50-70% of the difference between the benchmark and the bid. If the bid is above the benchmark, Medicare pays the plan only the benchmark rate and enrollees must pay the additional difference between the benchmark and the bid.[19]

Example of the Medicare Advantage Process

In Davidson county Tennessee, for instance, a senior who has recently turned 65 years old and is shopping for an MA plan can choose from 21 different plans offered by eight different insurance providers. Nine of the plans include a $0 monthly premium, with the remaining plan premiums ranging from $14 to $221 per month. Of the 21 plans, the lowest maximum out-of-pocket spending limit is $3,400 and the highest is $6,700.

Hypothetically, if the individual selects the Humana Gold Plus HMO plan, he or she is responsible for a $0 monthly premium, a $100 deductible, and a $6,700 maximum out-of-pocket limit. On the other side of the transaction, Humana receives, at the least, approximately $840 from Medicare each month—equal to the county-specific benchmark determined by Medicare—to support that individual's care. If Humana submits a bid of $800 this year—a value lower than the benchmark—the insurer receives a few benefits. First, Medicare pays the company the full benchmark of $840 per person per month, meaning the enrollee's monthly premium is completely covered, resulting in the $0 premium. Second, Medicare pays the company a rebate of 50-70% of the difference between the benchmark and the bid. In this case, the difference is $40, so the plan could earn an additional $20 to $28 each month for this single enrollee. On an annualized basis, this means the MA plan can earn up to $10,400 for one enrollee for one year. In contrast, Medicare Supplement Insurance plans only earn between about $2,200 and $2,600 per enrollee per year. Given such vast financial benefits, it is imperative for MA plans to acquire and retain as many beneficiaries as possible.

Star Ratings

As the MA space becomes increasingly crowded, CMS is using Star Ratings to encourage both new and existing insurers to offer the highest quality options to consumers. Star Ratings are scores ranging from one to five, with five stars being the highest, that are released each year by CMS. A plan's Star Rating denotes its overall quality and the monthly payment it receives from Medicare. Specifically, higher scores equate to plans with better customer reviews, delivery of care, and health outcomes.[8] They also result in higher monthly payments.[11]

Structure

Each Star Rating is determined by calculating the weighted average of a multitude of quality measurements. The specific measurements themselves are different for two types of plans—MA plans, also known as “Medicare Part C”, and Part D (Prescription drug coverage) plans. MA plans that provide both types of coverage receive an overall Star Rating equal to the average of its Part C and Part D scores. In total, there are 34 measurements for Part C plans and 14 measurements for Part D plans.

There are five overarching categories of measurements under Part C. The first category is titled “Staying Healthy: Screenings, Tests and Vaccines.” Quality in this area is determined by metrics like the percent of enrollees who received the annual flu vaccine and the percent of enrollees age 50-75 who received colon cancer testing in the last year. The second category is “Managing Chronic (Long Term) Conditions.” Quality in this dimension is evaluated on measures like rates of annual pain screenings, blood sugar management for diabetic enrollees, lower percentages of hospital readmissions, and more. The third category is “Member Experience with Health Plan”. This surrounds patient satisfaction, such as member ratings of the plan and ease of receiving care. The fourth category is “Member Complaints and Changes in the Health Plan’s Performance.”

Measures included in all Star Ratings years, 2009–18		Weighted-average Star Rating, 2009	Weighted-average Star Rating, 2018	Change, 2009–18
Outcome	Improving or maintaining physical health	3.4	2.8	–0.59
	Improving or maintaining mental health	3.0	3.8	0.87
	Diabetes care, blood sugar controlled	3.6	4.7	1.07
Process	Colorectal cancer screening	3.5	4.0	0.50
	Annual flu vaccine	3.2	3.6	0.33
	Osteoporosis management in women with fracture	1.5	3.1	1.58
	Diabetes care, eye exam	3.2	4.0	0.78
	Diabetes care, kidney disease monitoring	3.8	4.0	0.17
	Rheumatoid arthritis management	2.9	3.7	0.78
	Monitoring physical activity	3.0	3.2	0.26
	Reducing the risk of falling	3.1	2.2	–0.89
	Improving bladder control	2.2	3.2	0.93

Measurements in this area include frequency of enrollee complaints and plan attrition rates. The final category under Part C is “Health Plan Customer Service.” Some of the focus areas within this category are availability of Foreign Language Services at the call center and the percent of individuals who left the plan due to issues with price, accessibility of care, availability of information, or insufficient in-network coverage.[9]

There are four fairly similar categories of measurements under Part D. The first area is “Drug Plan Customer Service.” Again, this includes measurements of Foreign Language Service availability in call centers and timeliness of enrollee appeals. The second category is “Member Complaints and Changes in the Drug Plan’s Performance.” This section considers metrics like frequency of enrollee complaints and improvements, or lack thereof, in Star Ratings over time. The third category is “Member Experience with the Drug Plan”. Measurements under this category include enrollee ratings of the drug plan and the ease with which members receive essential prescription drugs. The final category is “Drug Safety and Accuracy of Drug Pricing.” Although fairly clear from the title, this area evaluates the accuracy of a plan’s advertised drug prices and the appropriate prescriptions are recommended for conditions like diabetes, high blood pressure, and high cholesterol.[9]

When calculating Star Ratings, each of the 48 individual measurements is initially taken as a percentage. For example, one of the Part C measurements is the percent of enrollees in the plan who received a flu shot prior to flu season. The resulting percentage, reported by the plan, corresponds with a Star Rating between one and five. In the case of flu shots, any value below 66% is one star, any value between 66% and 70% is two stars, and so on. After the percentages for all measurements are converted to ratings, a weighted average is taken of all the Part C scores, then all of the Part D scores. For MA plans that include both components, these two scores are finally averaged into an overall Star Rating.[18]

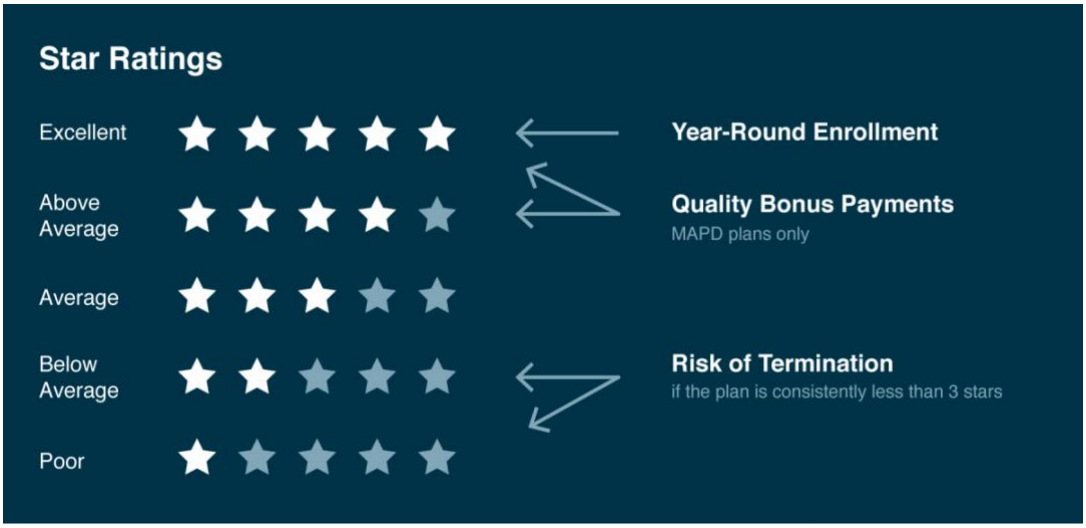
When evaluating the 48 metrics, it appears that the greatest potential for MA-related startups lies within the category of “Staying Healthy: Screenings, Tests and Vaccines”

category. These measurements are relatively easy for startups to influence and have a clear, significant impact on Star Ratings. Examples of metrics with notable startup opportunity include flu shot rates among enrollees, breast cancer screening rates, colorectal screening rates, improvements in physical health, improvements in mental health, the percent of enrollees who discussed exercise with a provider, and the percent of enrollees who had their BMI calculated and noted in their medical record. In the case of flu shots, for example, a startup could potentially become an expert in marketing flu shots and provide a mobile flu shot delivery system to sell to insurers. The startup benefits by earning contracts from MA plans and the MA plan benefits by raising its Star Ratings quickly and with low internal lift.

Star Rating Benefits

The Star Rating system does not simply act as a reporting tool, but as a way for CMS to leverage the bid-to-benchmark process and incentivize insurers to improve product quality. In fact, highly-rated plans receive three notable benefits—Quality Bonus Payments (QBPs), greater rebates, and increased enrollment. Both QBPs and rebates are estimated to add $6 billion to annual Medicare spending annually, meaning insurers stand to earn a significant financial benefit from raising Star Ratings.[13]

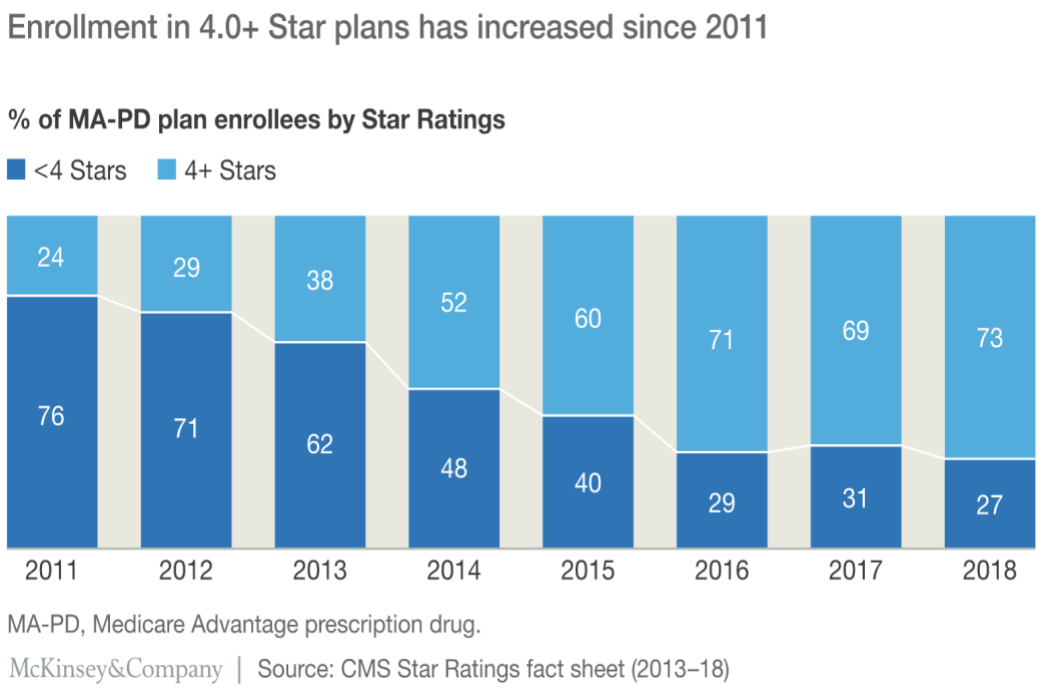
Quality Bonus Payments (QBPs) are increases in the Medicare benchmark given only to high-quality or new plans. For plans with greater than four stars, Medicare raises the benchmark by 5%. For new plans with data insufficient to determine a Star Rating, Medicare raises the benchmark by 3.5%. This increase effectively pays insurers 5% or 3.5% more every month for every enrollee. In urban counties with high MA enrollment but low spending per beneficiary on traditional Medicare, the QBP percentage is doubled. These areas are called “Double-bonus counties”. On a national scale, QBPs for all counties have increased total Medicare spending by 3%.[11] Put into perspective, this means each plan with four or more stars stands to earn an additional $800 million to $1.2 billion annually solely from QBPs.[20]



Not only do high-ranking MA plans benefit from higher benchmarks, they also collect larger rebates. The rebate for plans above four and a half stars is equal to 70% of the difference between the benchmark and its bid, while a plan with three and a half to four stars earns 65%, and a plan with fewer than three stars only earns 50%. Thus, if a plan's bid remains constant from one year to the next, but the plan reaches 4 stars, the difference between the benchmark and bid increases and the amount of this difference the plan keeps increases as well, compounding the benefit. With the additional rebate money, insurers can invest in new supplemental benefits and bolster existing offerings to further differentiate the plan from its competitors. [11]

Beyond financial benefits, high Star Ratings can increase demand for a particular plan. Upon their release each year, ratings are posted on the government's official Medicare Plan Finder website alongside the names and descriptions of the associated plan. Thus, consumers shopping for an MA plan will immediately see the Star Rating for each plan and will likely be inclined to select four- or five-star options.[22] It is not entirely clear why some seniors still opt to enroll in plans with fewer than four stars, but their choice may result from a lack of information, a dearth of high-quality plans in their county, or recognition of the insurer's brand. Meanwhile, seniors who do demonstrate a preference for five-star plans can benefit from the Five-Star Special Election Period (SEP). The Five-Star SEP is a timeframe outside of normal Medicare enrollment

periods during which seniors can sign up for five-star MA plans, while lower quality plans are unable to enroll new beneficiaries.[21]



Long-term trends support the association between Star Ratings and higher demand. In fact, the number of beneficiaries in plans with four or more stars almost quadrupled from 17% to 73% of total MA enrollees between 2009 and 2018.[12] The reason for this trend may be that MA enrollees in plans with lower ratings are more likely to switch plans during the annual enrollment period than those in plans with higher ratings. Between 2013 and 2014, 14% of enrollees in 2 or 2.5 star plans switched to a different plan, while only 9% of those in 4 or 4.5 star plans switched to another plan.[41] In addition, according to the Urban Institute, “Counties gaining a five-star plan had MA penetration growth 7.31 percentage points larger than those counties that never had a five-star plan”.[15] Clearly, high Star Ratings or the benefits associated with high quality plans are desirable for beneficiaries, prompting insurers to aim for Star Rating improvement.

Innovations in Medicare Advantage

Startups in the MA industry are innovating in three dimensions—health outcomes, data collection and analysis, and patient engagement—to help insurers raise Star Ratings and improve overall plan quality.

Health Outcomes

In general, healthy patients visit the hospital infrequently and spend less on medical care than patients with poor health. To insurance companies, healthy enrollees produce low costs and high Star Ratings. Given the need to actively improve and maintain seniors' health, companies such as SilverSneakers are leveraging MA's supplemental benefits to facilitate better health outcomes for enrollees. SilverSneakers, owned by Tivity Health, partners with MA plans to provide free local gym memberships to beneficiaries as a supplemental benefit. The company currently offers over 16,000 fitness locations to seven of the ten largest health insurers nationwide, serving 56% of the MA market. In 2018, SilverSneakers earned about $500 million in revenue and $114 million in EBITDA, clearly demonstrating that the service delivers notable value to insurers.[27] Through regular exercise, seniors improve physical, social, and mental health outcomes, reducing medical costs per enrollee and boosting Star Ratings on measurements like, "Improving or maintaining physical health", "Monitoring physical activity", and, "Checking to see if members are at a healthy weight."[9]

Similarly, Insight Optics utilizes MA supplemental benefits to enhance health outcomes, but focuses on a more specific realm—eye care. The company offers primary care providers (PCPs) a platform through which they can record and refer videos of patient eyes to retinal specialists. In this way, patients, especially older individuals, can receive free diagnoses and access skilled care early, before irreversible damage occurs. MA plans that offer this service promote better health outcomes, lowering costs by avoiding intensive eye surgeries or treatments and

boosting Star Ratings for metrics like, “Eye exam to check for damage from diabetes”.[34]

Spiras Health, a Tennessee-based startup founded in 2015, also works to identify and improve health outcomes proactively. The company utilizes patient data to identify high-risk asthma and COPD patients and then delivers individualized treatment plans that include in-home visits from a Clinical Care Team and checkups via a telehealth platform. Joel Hasenwinkel, the Chief Operating Officer (COO) of Spiras, believes that there exists a considerable opportunity to provide complex, clinically challenged patients with a form of care delivery that is more accessible and less intimidating than current approaches. He also believes that for seniors, “Some of the simplest technologies are where the greatest opportunities are.” Thus, Spiras targets seniors who may lack control over their condition and provides them with simple ways, such as text message, to interact with their health. Certainly, this tactic has proven successful to Spiras, resulting in over 50% lower costs from asthma, COPD, and other conditions. The company also reports that its platform drives impressive improvements in clients’ Star Ratings related to asthmatic drug therapy.

Data Collection and Analytics

Second, improved data collection and analytical methods promote better reporting, thus, more accurate Star Ratings. Through technology like Electronic Health Records (EHRs), integration of data across health systems, and Artificial Intelligence (AI), startups can enable providers and MA plans to collect extremely precise data more efficiently than ever before. Innovaccer, a California-based startup, offers a data activation platform for insurers and health systems that collects comprehensive, real-time patient data, integrates information from disparate sources, and analyzes this data to identify gaps in care. Since its inception in 2014, the company has reached over 10,000 providers in 500 locations nationwide.[26] Providers and insurers that harness Innovaccer’s technology ensure the delivery of accurate, up-to-date reporting for Star

Ratings and the establishment of a robust blueprint for any future improvements in plan quality.

Yet, older patients often access care outside of the hospital or PCP office. The data from these visits is a crucial component of the quality of a patient's care, but many MA plans are unable to acquire this information. CarePort Health, founded in 2012, addresses this issue head-on. The company provides a web-based product that collects data from a patient's post-acute provider, such as a skilled nursing facility or home nurse, and allows this information to be accessed by the patient's PCP, in-network hospitals, and insurance company.[32] Thus, CarePort enables insurers to report an enrollee's full journey of care, thoroughly demonstrating a plan's quality and improving Star Ratings

Patient Engagement

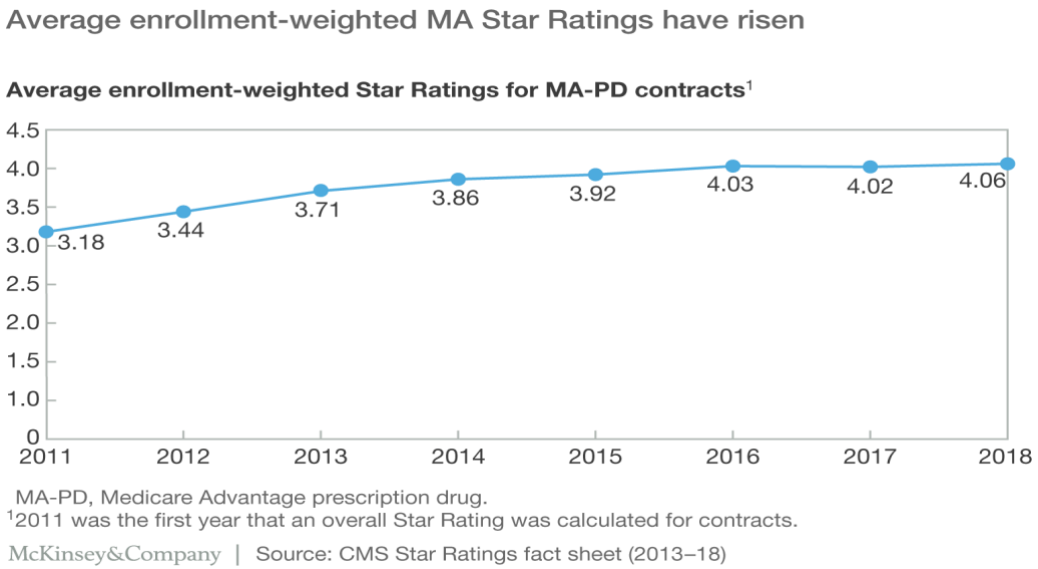
As the base of MA patients grows, but ratings for patient experience remain constant, many insurers are turning to technology-based solutions to improve patient engagement. Joel Hasenwinkel, COO of Spiras Health, aligns with this strategic trajectory for healthcare startups, believing that one of the greatest opportunities in the MA space is to establish a low-cost way to engage those who are not currently engaged in their health. California-based mPulse Mobile capitalizes on this opportunity by harnessing Artificial Intelligence (AI) capabilities to facilitate personalized text conversations with patients. The startup's platform sends regular messages to patients concerning disease management, health plan navigation, health engagement, and medication adherence. Users can also receive texts specifically related to Star Rating measures, such as reminders to receive an annual flu shot.[24] The company already partners with several leading MA providers, including Humana and Kaiser Permanente, generating over 200 million conversations annually.[25] Ultimately, highly-engaged enrollees are more likely to demonstrate favorable health outcomes, more likely to deliver positive feedback of the plan, and less likely to leave the plan.

Future Trends

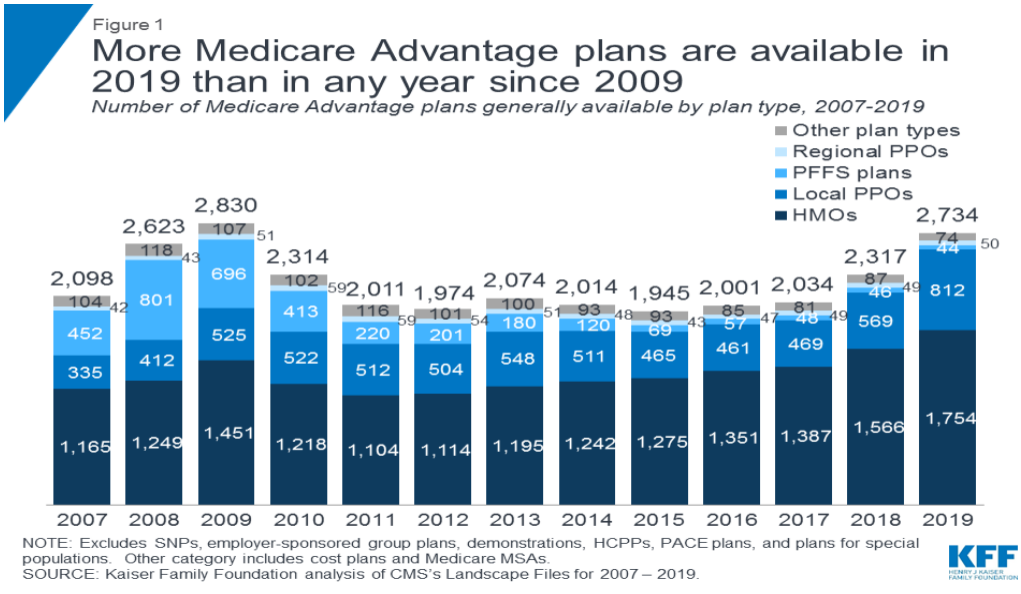
MA Star Ratings have now existed for over a decade and clear trends are beginning to emerge. Six trends in particular have significantly influenced MA's past and are likely to shape its future—MA plan prices are decreasing, more plans are entering the market, startups are beginning to offer MA plans, Star Ratings are rising, Medicare spending is increasing, and MA policy is becoming more lenient. Insurers and startups must remain cognizant of each trend to optimize their performance in the industry.

First, MA premium prices are decreasing. Between 2010 and 2019, the average premium for MA plans with prescription drug coverage decreased from $44 per month to $29 per month. In 2019 alone, the average premium for all MA plans decreased from $34 per month to $29 per month.[5] This trend is expected to continue into the near future, making MA options increasingly attractive to eligible seniors. Additionally, considering most Americans already have access to an MA plan with a $0 premium, it is likely that more of these fee-less plans will emerge as prices decrease and the market becomes increasingly saturated.[12]

Second, Star Ratings are rising. This year, 72% of MA beneficiaries were enrolled in plans with four or more stars.[5] On average, MA plans scored 4.06 stars, compared to a mere 3.18 stars in 2011. Counterintuitively, the standards for Star Rating scores became stricter during this time period, suggesting plan quality increased significantly. At a more granular level, Star Ratings for most categories are increasing as well. Metrics related to process efficiencies are experiencing the greatest improvement, having increased an average of 2.8 stars between 2009 and 2018. Behind process measurements fall metrics related to access to care and patient outcomes. During the same time period, access to care improved by 2.4 stars and patient outcomes improved by 1 star. Measurements of patient experience, however, have improved the least, reporting an increase of only 0.3, indicating an opportunity for investment.[12]



As existing plans are modified to become more attractive, new plans are entering the MA environment. In fact, the number of total MA plans increased from 3,100 in 2018 to 3,700 in 2019, with 14 new insurers entering the mix.[10] The average eligible Medicare beneficiary has over 20 different plans available to him or her. When viewed geographically, however, the changing MA landscape appears to benefit some groups, but not others. A large portion of this year's growth occurred in Florida, while the District of Columbia and Maine decreased in plan number[16]. The noticeable, sustained growth of MA plans suggests that the market continues and will continue to be appealing to insurance companies, but expansion may be geographically disproportionate.



The market is so appealing to insurance companies, in fact, that several startup insurers have begun to offer their own MA plans. Three startups—Clover Health, Devoted Health, Bright Health—all introduced MA offerings in 2018 and have seen consistent enrollment growth. Clover Health, a San Francisco-based insurance startup, was founded in 2013 and exclusively offers MA plans. The company provides unique value to enrollees by collecting and analyzing patient data to improve health outcomes and lower enrollee spending. Clover has experienced notable success in a short period of time, raising over $925 million in funding and becoming one of the fastest growing MA companies in the United States.[39] Similarly, Devoted Health, founded in 2017, also focuses solely on the MA market. The insurer offers plans designed to make beneficiaries' healthcare, "Easier, more affordable, and a whole lot more caring."[38] To date, Devoted Health has raised $363 million in funding. Lastly, the startup Bright Health was founded in 2015 in Minneapolis with the goal of leveraging technology to offer accessible and understandable individual health plans. Since then, the company has raised $440 million in funding, expanded into family and MA plans, and begun operations in Alabama, Arizona, Colorado, New York, Ohio, and Tennessee. As soon as 2020, Bright Health plans to enter five more states.[37] As these new insurers emerge armed with technology and existing insurers scramble to keep up by expanding the number of plans they offer, competition is likely to increase.

Fourth, as the MA market grows over time, government funding will grow as well. In 2018, Medicare spending equaled a shocking 15% of total federal spending —a figure that is expected to reach 18% in 2029.[5.] Not only will cost increase due to market growth, but also due to increased payments from CMS to MA plans. In fact, Kaiser Family Foundation estimates that, between 2018 and 2028, the amount CMS pays MA plans for each enrollee will increase by 5.1% annually.[23] Since the government will be paying insurers more and more for each enrollee in the future, it becomes increasingly essential for MA insurers to acquire as many enrollees as possible. By enhancing Star Ratings through optimization of health outcomes, data collection and analytics, and patient engagement, insurers can begin to reinvent enrollee acquisition.

Finally, in addition to increasing MA spending, the government is expanding the breadth of supplemental benefits included under MA policy. As a result, startups will have access to more avenues through which to contract with MA insurers than ever before. In 2019, for example, CMS added new MA supplemental benefits like in-home support services, massage therapy, and non-medical transportation.[10] In 2020, new benefits will include telehealth access, food delivery for those with chronic conditions and accessibility improvements to enrollees' homes, including ramps and shower grips.[17] Certainly, coverage of these benefits will differentiate certain MA plans from others. Companies that can facilitate their delivery stand to provide a completely new source of value for insurers.

Select Startups Impacting the Industry

The following pages outline some of the companies operating in the Medicare Advantage (MA) industry and drive improvements in health outcomes, data collection and analytics, and patient engagement.

Companies are organized in the following three categories:

1. Health outcomes
2. Data collection and analytics
3. Patient engagement

Startups Improving Health Outcomes

spiras HEALTH
Helping You Breathe Better

Founded: 2015

Size: 1-10 employees

Spiras harnesses and analyzes patient data to identify at-risk patients and deliver specialized care through a Clinical Care Team and telehealth platform.

Spiras' technology can prevent hospital re-admissions and manage chronic conditions, reducing costs and improving patient satisfaction.

Total Funding: $3.5 million

Brentwood, TN
https://www.spirashealth.com

Founded: 2014

Size:11-50 employees

Illuma Care identified at-risk patients and leverages a nationwide provider network to connect patients to specialty care.

Illumicare improves Star Ratings through proactive appointment scheduling, reduces costs, and acquires comprehensive patient data.

Total Funding: $2.6 million

Alpharetta, GA
https://www.illumacc.com

Founded: 2011

Size:501-1000 employees

NaviHealth tracks and manages individualized post-acute care plans for Skilled Nursing, Inpatient Rehab, Long-Term Acute Care, and Home Health.

NaviHealth works with millions of MA patients to improve quality of care, reduce readmissions, and increase patient satisfaction.

Total Funding: $100 million

Brentwood, TN
https://www.navihealth.com/

ELEMENT3 HEALTH

Founded:

Size: 1-10 employees

Element3 Health provides a platform for seniors with MA plans to connect to nearby social and recreational clubs.

Element3 Health aims to stand out as a selling point for MA plans and to promote better health outcomes through physical, social, and mental activity.

Total Funding: $8 million

Denver, CO
https://element3health.com/

INSIGHT OPTICS

Founded: 2014

Size: 1-10 employees

Insight Optics' platform allows PCPs to record and send retinal videos of patients to eye specialists.

Insight Optics' goal is to identify and prevent significant eye damage and blindness.

Total Funding: $190,000

Atlanta, GA
http://io.care/index.html

RubiconMD

Founded: 2013

Size:1-10 employees

RubiconMD's eConsult platform allows Primary Care Physicians (PCPs) to quickly and virtually consult specialists about their patients' conditions.

RubiconMD aims to improve access to care, quality of care, and to reduce avoidable specialist appointments, producing cost savings for patients and payers.

Total Funding: $19.9 million

New York, NY
https://www.rubiconmd.com/

CareLinx

Founded: 2011

Size: 30 employees

CareLinx partners with MA plans to provide non-medical home care to enrollees as a free, supplemental benefit.

CareLinx facilitates communication between in-home care providers and patients, enhancing patient experience and reducing hospital readmission.

Total Funding: $5 million

San Bruno, CA
https://www.carelinx.com/

Landmark

Founded: 2013

Size:251-500 employees

Landmark partners with health plans and providers to facilitate free house calls to patients with chronic conditions.

Landmark can improve long-term health outcomes, reduce ER visits by an average of 39%, and frequently achieves over 5-star ratings.

Total Funding: $60.8 million

Latham, NY
https://www.landmarkhealth.org

SilverSneakers by Tivity Health

Founded: 1992

Size: 60 employees

SilverSneakers equips MA beneficiaries with the ability to join local fitness locations free of charge.

SilverSneakers helps make MA plans more unique and improves the overall health of enrollees, fostering lower health costs and better outcomes.

Owned by Tivity Health
Publically traded
Market Cap: $823 million

Franklin, TN
https://www.silversneakers.com/

Startups Improving Data Collection & Analytics

CarePort
An Allscripts Company

Founded: 2012

Size: 40 employees

CarePort's platform allows patients to select the best post-acute facilities and insurers to collect detailed data on the patient's care in the facility.

CarePort fortifies MA plans' quality of care data through in-depth care information beyond the hospital or PCP.

Acquired by Allscripts

Boston, MA
https://careporthealth.com/

Founded: 2009

Size: 110 employees

Apixio's Compliance Auditory platform leverages AI to help insurers assess the accuracy of risk assessment coding.

The Compliance Auditory platform enables providers to avoid legal risk and accurately code risk in-house.

Total funding: $36.1 million

San Mateo, CA
https://www.apixio.com/

Founded: 2012

Size: 250-500

Innovaccer's system collects performance data, integrates data across networks, and delivers point-of-care alerts.

Innovaccer empowers MA plans by analyzing real-time data, engaging members, and analyzing gaps in plan quality.

Total funding: $54.1 million

San Francisco, CA
https://innovaccer.com/

HEALTHEDGE

Founded: 2004

Size: 260

HealthEdge's HealthRules suite is used by MA plans to optimize enrollment, claims processing, regulatory compliance, tracking of Star Rating measures, and administrative

HealthRules has empowered health systems to reach over 90% auto-adjudication rates and 95% of claims processed in a week.

Total Funding: $97.8 million

Burlington, MA
https://www.healthedge.com/

Startups Improving Patient Engagement

SAFERIDE

Founded: 2015

Size: 11-50 employees

SafeRide Health's platform enables providers to schedule reliable non-emergency transport for patients.

SafeRide coordinates over one million rides annually, completing 95% of rides on-time an reducing cost to health plans by 50%.

Total Funding: $8 million

Culver City, CA
https://www.saferidehealth.com

Founded: 2014

Size: 70 employees

mPulse Mobile harnesses AI to text and engage in personalized conversation with MA enrollees regarding their health.

mPulse mobile can improve disease management, health plan navigation, Star Ratings, medication adherence, and patient experience.

Total Funding: $24.4 million (From 1 acquisition)

Encino, CA
https://mpulsemobile.com/

Founded: 2008

Size: 21-30 employees

Cavulus provides marketing, sales, and enrollment technology to MA companies.

MedicareCRM, a Cavulus product, helps insurers improve MA enrollment and retention.

No funding information available.

Hilton Head Island, SC
https://www.cavulus.com/

Call9

Founded: 2015

Size: 60 employees

Call9 provides a telehealth platform to connect nursing home residents with providers during periods of worsening condition.

Call9 acts swiftly to provide care, effectively optimizing health outcomes and patient experience.

Total Funding: $34 million

Brooklyn, NY
https://www.call9.com/care-delivery

lark

Founded: 2010

Size: 120 employees

Lark's AI-driven platform facilitates chronic disease management through health coaching, monitoring, and connection to clinical resources.

Lark is the fastest-growing Diabetes and Hypertension management company, with successful results published in 13 journals.

Total Funding: $45.7 million

Mountain View, CA
https://www.lark.com/

Conclusion

The Medicare Advantage (MA) industry is immense and stands to grow rapidly and significantly in the near future. As the market becomes increasingly saturated, it is imperative for insurers to differentiate their plans from those of competitors. Startups that partner with these MA payers and associated providers can improve health outcomes, optimize data collection and analysis, and raise patient engagement to unlock untapped value for clients and beneficiaries. By earning contracts with a few major insurers, companies can quickly scale to a significant market share and expand with the industry. The Medicare Advantage market is changing at the pace of a sprint. Those equipped with the appropriate technology-based solutions have the power to keep up and even pull ahead to facilitate the delivery of efficient, high quality care.

Founded in 1996, FCA Venture Partners has a long history of investing in successful healthcare entrepreneurs. We are passionate about building sustainable businesses and providing strategic value to our portfolio companies.

FCA invests $3-6M in fast growing healthcare companies making processes in the industry faster, better, and cheaper while improving the quality of care and the patient experience.

With its location in Nashville, roots with Clayton Associates and the McWhorter Family, and deep involvement in the growth of the U.S. healthcare community, FCA Venture Partners is poised to take advantage of disruptive opportunities that help move healthcare forward.

Investing in Entrepreneurs that Improve Healthcare

110 Winners Circle North | Suite 100
Brentwood, TN | 37027
Phone: 615-326-4848 | www.fcavp.com

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