



Early indications of changes to the 2015 medicare advantage payment methodology and the potential effect on medicare advantage organizations and beneficiaries

February 6, 2014

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CONSIDERATIONS AND LIMITATIONS

The reimbursement reductions and needed adjustments to MAO pricing will vary considerably by market (e.g., CMS calculates FFS costs on a county level basis). Our purpose here was to estimate reductions and impacts for all MAOs combined. The opinions and conclusions expressed herein reflect technical assessments and analyses, and do not reflect statements or views with respect to public policy.

The Actuarial Practice of Oliver Wyman was commissioned by America's Health Insurance Plans to prepare this report in response to early indications of CMS' Advance Notice of Methodological Changes for Calendar Year 2015 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies. Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of anything set forth herein. The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof. Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of such information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

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INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) will release the Advance Notice of Methodological Changes for Calendar Year 2015 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the 2015 Advance Notice) on February 21, 2014. This notice is expected to outline the planned changes to Medicare Advantage (MA) capitation rates applied under Part C for CY 2015 and other regulatory changes that will affect plan reimbursement. Based on information released by CMS in its December 3, 2013 Actuarial User Group Call and reductions already being implemented by the Affordable Care Act (ACA), Medicare Advantage Organizations (MAOs) could experience substantial payment reductions for 2015. Such reductions would have a significant impact on the sustainability of MAO program participation and the ability of MAOs to provide stable benefits and beneficiary premiums to their members.

Based on the information provided by CMS and the implications of the ACA payment reductions, America's Health Insurance Plans (AHIP) engaged the Actuarial Practice of Oliver Wyman to evaluate the impact of these potential changes in 2015. In this document, we first describe and estimate the value of the changes that could be reflected in the 2015 Advance Notice along with those being implemented due to the ACA, and then estimate the effect these changes will have on beneficiary premiums and benefit levels, MAO enrollment, and the sustainability of MAO program participation.

EXECUTIVE SUMMARY

We find that the potential reductions that could be included in the 2015 Advance Notice, in combination with the continued phase-in of the ACA cuts and other legislative and regulatory cuts which come on top of significant cuts that occurred in 2014 (see chart below), could result in a significant amount of upheaval in the MA market. This includes the potential for plan exits, reductions in service areas, reduced benefits, provider network changes, and reduced MA enrollment as beneficiaries see a significant decline in plan value from 2014 to 2015. These findings include:

- The report estimates that MA plans may see a **6.0% reduction** in payment in 2015 that would produce major disruption for virtually all of the 15 million Medicare beneficiaries who are enrolled. These cuts are on top of significant funding reductions in 2014 (4 – 6%, \$30 - \$70).
- The combined impact of the 2015 changes may result in benefit reductions and premium increases of \$35 to \$75 per member per month and/or plan exits from local markets. Many beneficiaries could lose access to MA plans and their approach to care, which has reduced the incidence of preventable hospitalizations and improved access to primary care, according to recent studies.¹
- The cuts would disproportionately affect beneficiaries with low incomes, including the 41% of MA enrollees with annual incomes below \$20,000 for whom the potential increase in out-of-pocket costs would constitute a significant burden.
- In addition, individuals who utilize services the most would be adversely affected if they are forced to move to Medicare Fee-for-Service (FFS) with its lack of coordinated care.

	Percentage Impact	Dollar Impact PMPM
2014 ²	4 - 6%	\$30 - \$70
2015	6%	\$35 - \$75
Cumulative Impact of 2014 & 2015 Cuts:	10 - 12%	\$65 - \$145

¹ See for example Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P., et al. *Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-09*. Health Affairs 31. No. 12: 1-9. December 2012 and Cohen, Robb, Lemieux, Jeff, Mulligan, Teresa, Schoenborn, Jeff. *Medicare Advantage Chronic Special Needs Plan Boosted Primary Care Reduced Hospital Use Among Diabetes Patients*. Health Affairs 31, No.1: 110-119. January 2012.

² Range reflects varying plan assumptions about sequestration in their bids.

CHANGES TO PAYMENT METHODOLOGY FOR 2015

MA Benchmark Reductions Continue in 2015

The Affordable Care Act (ACA or the law), formally The Patient Protection and Affordable Care Act (Pub L. 111-148) (PPACA) and the Health Care and Education Reconciliation Act (Pub L. 111-152) (HCERA), make several changes to how MAOs are reimbursed by CMS. First, the ACA changed the MA plan payment structure, starting with a freeze in payments to MAOs for 2011. In 2012, the ACA began to phase-in benchmarks calculated as a percentage of per capita fee-for-service (FFS) Medicare spending. County benchmarks will ultimately be set at 95%, 100%, 107.5%, or 115% of projected (by CMS) FFS spending, with higher percentages applied to counties with the lowest FFS spending. The phase-in is taking place over two to six years depending on the county; 2015 will be the fourth year of the phase-in. Based on our models, we are estimating that the impact of moving benchmarks to percentages of FFS costs will be a total reduction in MA plan payment benchmarks of **-2.4%** for 2015.

The ACA payment methodology also *varies* benchmarks based on plan quality, with higher increases for MAOs achieving higher quality ratings. Starting in 2012, plans with at least a 4.0-star rating on a 5.0-star quality rating scale were to receive an increase in their benchmark. New plans or plans with low enrollment also qualify for a benchmark increase. The ACA payment methodology also varies plan rebates based on quality, with new rebates set at 50% to 70% of the difference between the plan bid and the benchmark, where prior to 2012, rebates were 75% for all plans.

However, under authority in Section 402(a)(1)(A) of the Social Security Amendments of 1967, as amended, CMS, through a demonstration program, has been testing an alternative method for computing quality bonus payments. Through the end of 2014, quality bonus payments are computed along a scale; the higher a plan's star rating, the greater the bonus payment percentage. Quality bonus payments are available to plans with ratings of 3.0 and 3.5 stars, but in lower amounts. The demonstration project is testing whether providing scaled bonuses leads to more rapid and larger year-to-year quality improvements in MA program quality scores, compared to the ACA's bonus structure. The demonstration program ends at the end of 2014, thus MAOs will need to achieve a 2015 quality star rating of 4.0 or higher to receive a bonus.

Based on data available from CMS, Oliver Wyman has calculated the effect on Star Rating bonuses of both average plan improvement in quality star rating between 2014 and 2015 and the impact of the removal of the demonstration program (reverting back to ACA rules) at the end of 2014. The improvement in quality star ratings for 2015 partially offsets the ACA reductions; we expect this to be an increase in payments to plans of **+0.4%**. The ending of the demonstration program beginning in 2015 is expected to result in a reduction in plan payments of **-1.9%**.

Beginning in 2015, the end of the demonstration will also adversely impact MA plans operating in counties with a six-year phase-in, and where the blended benchmark including quality bonus would exceed the benchmark calculated under pre-ACA rules. We have isolated the impact of these factors in qualifying counties where plans receive benchmark bonuses that are twice the amount as bonuses provided in other counties. We estimate that this will result in a **-0.1%** reduction to the average benchmark value.

The ACA also establishes an annual fee on the health insurance sector; this became effective for 2014. The new fee applies with some exceptions to any covered entity engaged in the business of providing health insurance (including private plans that participate in public programs), but does not include self-insured, employer-provided health plans. The amount of the fee will be \$8.0 billion in 2014 and \$11.3 billion in 2015, increasing to \$14.3 billion in 2018, and increases based on premium trend thereafter.³ Based on a recently updated study completed by the Actuarial Practice of Oliver Wyman, the median expected fee for 2015 is expected to be 2.9% while the median fee for 2014 was expected to be 2.1%, or an incremental reduction of **-0.8%**. Although not necessarily a reduction in MA payment rates, this tax will have the same effect as a reduction to MAOs.

MAOs are paid on a risk adjustment model that utilizes factors that reflect beneficiaries' health status. Diagnosis coding in traditional FFS Medicare has historically been less focused than MAO diagnosis reporting due to the lack of incentive for providers to correctly and completely code diagnoses (procedure codes rather than diagnoses form the basis for how providers are reimbursed in FFS Medicare). Because the MA risk adjustment model is calibrated based upon FFS costs, beginning in 2010 CMS began offsetting the effect that MAOs' more efficient coding is having on plan reimbursement by reducing MAO payments across all plans. CMS calculated this so called "coding intensity adjustment" and from 2010 through 2013, this calculation has resulted in a 3.41% reduction in MA plan payments. The ACA, as revised by the American Taxpayers Relief Act of 2012, increased the 2014 coding intensity adjustment by setting it at a minimum of 4.91% and mandated that an incremental increase in the adjustment annually starting in 2015 that should further reduce payments by **-0.25%** each year.

For 2014, CMS developed an updated, clinically revised risk adjustment model for Part C. The 2014 Final Rate Notice recalibrated the model and made changes to the diagnostic codes that are included, such as removing codes for early Chronic Kidney Disease and Diabetic neuropathy. The new 2014 CMS-HCC risk adjustment model produced risk scores that were about 2.5% lower than the 2013 CMS-HCC model and particularly impacted MA plans that serve a high proportion of beneficiaries with chronic conditions who benefit from disease and other care management programs. CMS chose to limit the

³ PPACA Section 9010. The statute provides that after 2018 the amount of the tax is the applicable amount for the preceding year increased by the rate of premium growth (as defined in the Internal Revenue Code) the preceding calendar year.

impact of the new model in 2014 by implementing a blended model for 2014 that uses 75% weight on the 2014 CMS-HCC model and 25% weight on the 2013 CMS-HCC model. This means that plans expect to see a change of **-0.625%** ($2.5\% * .25$) in risk scores in 2015 to reflect full implementation of the 2014 CMS-HCC model.

Changes Resulting from Early CMS Expectations

As required by Section 1853(b)(2) of the Social Security Act (the Act), CMS is required to notify MAOs of the changes to MA capitation rate methodology and risk adjustment methodology applied under Part C approximately 45 days prior to releasing the final rate announcement. CMS will release the Advance Notice for 2015 on February 21, 2014. Based upon the initial information released by CMS in December, 2013, the 2015 Advance Notice could include a significant 2015 reduction in the National Per Capita Medicare Advantage Growth Percentage (NPCMAGP) and only a minimal increase in the 2015 Fee-for-Service (FFS) Growth Percentage.

Ratebook Changes for 2015 -- National Per Capita Medicare Advantage Growth Percentage

The NPCMAGP was the mechanism that CMS used in their pre-ACA benchmark changes to increase payment rates and reflects trends in total Medicare costs predicted for the upcoming year and “updates” to historical trends since 2004. This payment methodology is still relevant because CMS is phasing in the new ACA methodology over several years; 2015 being the fourth year of the six-year phase-in. CMS refers to the pre-ACA payment calculation as the “applicable amount.”

In its December 3, 2013 Actuarial User Group call, CMS put forth the initial estimate that the NPCMAGP for 2015 is projected to be -1.98%. This would be the lowest NPCMAGP since the introduction of MA. The 2014 NPCMAGP was an increase of 2.96%. CMS has not yet laid out the detailed reasons behind the large expected decrease to the 2015 NPCMAGP but has cited in general the full implementation of the 2014 CMS-HCC model, Part B costs that are below original projections, and revised economic and changes to market basket assumptions. Our analysis uses the -1.98% NPCMAGP for 2015 based on CMS’ estimate.

Ratebook Changes for 2015 -- FFS USPCC Growth Percentage

Under the ACA, MAO benchmarks are tied to projected FFS costs. The “specified amount,” the new benchmark calculation under the ACA, takes into consideration both a specified percentage (95%, 100%, 107.5% or 115%) of FFS costs and the quality star bonus for each MAO contract. CMS rebased county level FFS cost projections for 2014, which means that it recalculated its projections using a more current dataset. We do not yet know whether or not CMS will rebase the FFS cost projections for 2015. However,

CMS indicated in their December 3, 2013 User Group call that the initial estimate of the FFS trend for 2015 is 0.14%. We suspect that many of the same reasons causing the lower NPCMAGP, as described above, are causing the FFS trend for 2015 to be lower than historical results. For our analysis, we have simply increased county level FFS costs from 2014 levels, reflecting no rebasing of FFS costs in 2015.

Based upon this initial information from CMS, we estimate the combined impact of the NPCMAGP and the FFS USPCC Growth Percentage will reduce MA payments by **-0.3%**. CMS will have the opportunity to revise the initial estimates, possibly based on updated data, when the 2015 Advance Notice is put forth in February. It will also have a chance to revise estimates based on updated information and public comment, when the final rate announcement is made on April 1.

Overall Reduction Calculation

Our overall calculation of the reduction that plans face for 2015 is summarized in the table below. As can be seen from the table, our estimate is for a reduction of **-6.0%**.

Estimated Reduction in 2015 for MAOs

	Reduction (%)
ACA quartile impact for 2015	-2.4%
Change in plans' star rating for 2015	0.4%
Elimination of bonus for 3.0 and 3.5 stars for 2015	-1.9%
Elimination of applicable amount bonus	-0.1%
Ratebook change for 2015	-0.3%
Projected insurer fee for 2015	-0.8%
Full implementation of 2014 CMS-HCC model	-0.625%
Coding intensity change for 2015	-0.25%
Total Reduction for 2015	-6.0%

Plans also face the possibility of several other changes to payment policy that we have not included in our analysis due to the greater variability in potential assumptions and wider range of the possible results. These policy changes include:

- Changes to the calculation FFS rates as a result of rebasing.
- New medical loss ratio requirements as mandated by the ACA, that have gone into effect for 2014 and plans are still adjusting to.
- A likely increase in the FFS Normalization factor CMS has used to account for changes in coding practices in the FFS program between the calibration year and the payment year of approximately 1.5%.

In addition, CMS could move forward with their proposal to remove health risk assessments for HCC coding which may cause lower risk scores that could also negatively impact MA funding and has not been quantified in this analysis. The potential inclusion of this proposal or others could exacerbate the impacts estimated above.

The Impact of Changes on MAOs and Beneficiaries

MAO Impact

The impact on individual MAOs will depend on a number of factors, including changes in expected plan performance such as more effective medical management, the geographic areas in which the MAO participates, and the plan-level effects of the 2014 CMS-HCC model.

To calculate the range of the potential outcomes, we ran different types of plans from different markets through proprietary Part C pricing models developed by the Actuarial Practice of Oliver Wyman, but which mirror CMS pricing rules, using the following assumptions:

- 4.5% trend in medical expenses from 2014 projections to 2015. We used 4.5% based on the July 2013 Oliver Wyman Carrier Trend Report for Medicare Advantage plans covering both Part C and Part D which reflects responses to the Carrier Trend Survey we conducted in 2013.
- The -0.25% change in the coding intensity adjustment and the effect of the full implementation of the 2014 CMS-HCC model (-0.625%) was applied by reducing risk scores.
- The change in the insurer fee for 2015 (-0.8%) was applied as increased non-benefit expenses.
- The remainder of the changes outlined in our table above were applied as reductions to benchmarks.
- Because CMS will have two opportunities to change payment rates before the 2015 rates are final, we ran our analysis at a reduction of 5% and a reduction of 7%.
- The model assumes no change in MAO margins.

The results of our pricing scenarios show a low end effect of about a \$35 needed monthly premium increase per member for 2015 (or some combination of premium increase and benefit reductions). On the high end, we estimate needed monthly premiums or benefit changes per member closer to \$75.

Needed premium increases (or a combination of benefit reductions and premium increases) per member per month of \$35 to \$75 will provide for unstable environment where the potential for disruption for beneficiaries is significant. In recent years, CMS

has constrained the combination of premium increases and benefit reductions. For example, in 2014 this Total Beneficiary Cost (TBC) requirement limited these changes to \$34, subject to plan-specific adjustments. The need to account for the remainder of the deficiency will place greater pressure on plan efforts to achieve increased operational efficiencies.

This situation is compounded because MAOs also experienced substantial cuts in 2014 as described in the table below.

Estimated Reduction in 2014 for MAOs

	Reduction (%)
ACA quartile impact for 2014	-2.5%
Change in plans' star rating for 2014	0.2%
Increased bonus for 4.0+ stars for 2014	0.3%
Partial implementation of 2014 CMS-HCC model	-1.9%
Ratebook change for 2014	3.4%
Projected insurer fees for 2014	-2.0%
Coding intensity change for 2014	-1.5%
Total Reduction for 2014	-4.0%

Sequestration is also a factor for 2014 but is not included in the table because of variability in potential assumptions about the incremental impact of up to 2%. CMS permitted MAOs to take sequestration into account beginning with 2013 bids, but there was significant uncertainty about whether sequestration would be implemented until shortly before submission of 2014 bids. As a result, it is likely that the incremental impact on 2014 for many MAOs reflected the full 2%. The addition of sequestration to the estimated 2014 reduction would bring it to 6%, and when combined with the estimated 2015 cuts, would produce a total estimated reduction of 12.0% over two years, a level that would severely strain program sustainability. We also find the 2014 cut reduced MA funding by \$30 - \$70, which when combined with the 2015 cuts, results in a two-year impact of \$65 - \$145.

Impact on MA Beneficiaries

The potential for higher premiums and reduced benefits could result in a significant amount of upheaval in the MA market that will likely affect virtually all of the approximately 15 million Medicare beneficiaries enrolled in MAOs. This includes the potential for plan exits, reductions in service areas, reduced benefits, provider network changes, and reduced MA enrollment as beneficiaries see a significant decline in plan value from 2014 to 2015, similar to the circumstances in 1999 – 2003 when MA enrollment (then known as Medicare+Choice) declined from 6.2 million to 4.7 million and numerous plans exited markets. Many beneficiaries could lose access to MA plans and may be required to move back to FFS. In so doing, these beneficiaries would lose

access to MA plans' approach to care that has resulted in fewer preventable hospitalizations, better access to primary and preventive care, and more appropriate utilization of services as documented in recent studies.⁴

Impact on Vulnerable Populations

The increased impact on beneficiaries of \$35 - \$75 per member per month, coming after the estimated 2014 cuts of \$30 - \$70, would disproportionately affect beneficiaries with low incomes, including the 41% of MA enrollees with annual incomes below \$20,000⁵ for whom the potential increase in out-of-pocket costs would constitute a significant burden. In addition, we estimate that individuals who are more likely to need medical services will be particularly adversely affected. MAOs that focus on these populations, such as Special Needs Plans for individuals who are dually eligible for Medicare and Medicaid, have limited flexibility to increase beneficiary premiums and members generally have no cost sharing liability. This means that MAOs will have to respond to reductions by reducing additional benefits like dental services and over-the-counter (OTC) medication coverage, etc., to help offset the reductions.

Those who utilize services the most, including beneficiaries enrolled in Special Needs Plans for individuals who have chronic conditions, or reside in institutions, will be required to pay even higher cost sharing or be forced by higher MA premiums or loss of access to MA plans to move back into FFS Medicare with its lack of coordinated care. For example, chronic care SNPs, which enroll only individuals with specific conditions like COPD or diabetes have tailored programs for their members to address these conditions, and loss of access to the coordinated care and lower cost sharing offered by MAOs may interrupt continuity of care, as well as access to disease and care management programs on which beneficiaries rely.

⁴ See for example Ayanian, John Z., Landon, Bruce E., Newhouse, Joseph P., et al. *Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-09*. Health Affairs 31, No. 12: 1-9. December 2012 and Cohen, Robb, Lemieux, Jeff, Mulligan, Teresa, Schoenborn, Jeff. *Medicare Advantage Chronic Special Needs Plan Boosted Primary Care Reduced Hospital Use Among Diabetes Patients*. Health Affairs 31, No.1: 110-119. January 2012.

⁵ AHIP Center for Policy and Research, *Low Income & Minority Beneficiaries in Medicare Advantage Plans, 2011*. February 2013.

