2016 ADVANCE NOTICE: CHANGES TO MEDICARE ADVANTAGE PAYMENT METHODOLOGY AND THE POTENTIAL EFFECT ON MEDICARE ADVANTAGE ORGANIZATIONS AND BENEFICIARIES

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Introduction

The Centers for Medicare & Medicaid Services (CMS) released the Advance Notice of Methodological Changes for Calendar Year 2016 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the 2016 Advance Notice) on February 20, 2015. This notice outlines the planned changes to Medicare Advantage (MA) capitation rates applied under Part C for CY 2016 and other regulatory changes that will affect plan reimbursement. Based on information released in the 2016 Advance Notice and reductions already being implemented by the Affordable Care Act (ACA), Medicare Advantage Organizations (MAOs) are likely to experience additional payment reductions for 2016. Such reductions, coupled with the reductions experienced in 2014 and 2015, 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 2016 Advance Notice 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 2016. In this document, we first describe and estimate the value of the changes reflected in the 2016 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 payment policies proposed in the 2016 Advance Notice, in combination with the continued phase-in of the ACA cuts and the other legislative and regulatory cuts which when combined with the significant cuts that occurred in 2014 and 2015, could result in a high degree of disruption in the MA market. This includes the potential for plan exits, reductions in service areas, reduced benefits, provider network changes, and MA plan disenrollment due to declines in plan value from 2014 to 2016. These findings include:

- This report estimates that MA plans will see a 1.2**% reduction** in payment in 2016. As noted in recent Wall Street analysts' reports, the impact is likely to vary among MAOs and some MAOs are likely to experience payment changes in excess of this amount. These reductions can be expected to negatively impact the benefits for beneficiaries who are enrolled in Medicare Advantage. This reduction comes on top of significant funding cuts that occurred in 2014 and 2015 (9 - 11%, $60 - $140 PMPM).
- The combined impact of the 2016 changes may result in benefit reductions and premium increases of up to $20 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 greatly affect beneficiaries with low incomes, including the 37% 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.

[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 and 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.

Changes to Payment Methodology for 2016

MA Benchmark Reductions Continue in 2016

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), makes 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; 2016 will be the fifth year of the phase-in. Based on Oliver Wyman's 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 **-0.67%** for 2016. This estimate also reflects the cap limiting MA rates to no higher than the amount calculated under the pre-ACA methodology and the impact of the new health insurance tax put in place by the law.

The ACA payment methodology also *varies* benchmarks based on plan quality, with higher benchmarks paid to 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% (the lowest Star rated MAOs) to 70% (the highest Star rated MAOs) 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, tested an alternative method for computing quality bonus payments. Through the end of 2014, quality bonus payments were computed along a scale; the higher a plan's Star rating, the greater the bonus payment percentage. Quality bonus payments were also available to plans with ratings of 3.0 and 3.5 Stars, but in lower amounts. The demonstration project was intended to test 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 ended at the end of 2014, thus MAOs now need to achieve a 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 average plan improvement in quality Star rating between 2015 and 2016. We expect the improvement in quality Star ratings for 2016 to increase payments to plans by **+0.2%** on average.

Changes Related to Risk Adjustment

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 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 an incremental increase in the adjustment annually starting in 2015, and continuing into 2016, that will further reduce payments by **-0.25%** each year.

The risk adjustment model described above is adjusted each year to reflect the level of risk score coding change inherent in FFS Medicare through a normalization factor that is applied to the result of CMS' risk score model. The goal is to adjust the results of the risk score model through this normalization factor such that the overall average risk score across all beneficiaries is 1.000. In 2016, CMS is proposing to fully implement the 2014 clinically adjusted CMS-HCC risk adjustment model. CMS has calculated a 2016 normalization factor of 0.992 for this model, thus the expected change is an increase in the normalization factor from 0.987 to 0.992, or a decrease in plan payment of **-0.47%**.[2]

Based on its own analysis, CMS expects that the 2014 clinically adjusted CMS-HCC risk adjustment model will result in risk scores (and thus payments to MAOs) that are 2.5% below the 2013 CMS-HCC risk adjustment model.[3] Since CMS implemented 1/3 of the 2014 model for 2015 and will fully implement the new model for 2016, we expect reduction in MAO risk scores of -0.8% for 2015 and **-1.7%** for 2016.

Ratebook Changes for 2016

The 2016 Advance Notice included increases to both the 2016 National Per Capita Medicare Advantage Growth Percentage (NPCMAGP) and the 2016 Fee-for-Service (FFS) Growth Percentage. Both of these trend factors are below MAO reported claims cost trends. 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; 2016 being the fifth year of the six-year phase-in. CMS refers to the pre-ACA payment calculation as the "applicable amount." In the 2016 Advance Notice, CMS stated the NPCMAGP for 2016 is projected to be 2.68%. CMS indicated that the 2.68% reduction for 2016 is comprised of 1.14% trend for 2016 and adjustments to the estimates for prior years of 1.52%.

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 2015, which means that it recalculated its projections using a more current dataset. CMS stated that it expects to rebase county level FFS cost projections for 2016. In the 2016 Advance Notice, CMS stated that the 2016 FFS USPCC growth percentage is projected to be 1.47%. For our analysis, we have simply increased county level FFS costs from 2015 levels because CMS has not yet provided the county level rebased FFS costs.

Based upon this initial information from CMS, we estimate the combined impact of the preliminary NPCMAGP and the FFS USPCC Growth Percentage will change MA payments by **+1.7%**. According to the July 2014 Carrier Trend Report, produced by Oliver Wyman, the average trend reported by MAOs was 3.2%. This indicates that the NPCMAGP is approximately 1.5% below the claims cost trend reported by MAOs. CMS will have the opportunity to revise the

[2] In prior years, CMS has calculated the normalization factor by analyzing the risk score coding trend over a five year period. For 2015, CMS changed the methodology used to develop this trend by only using a two year period, from 2012 to 2013, to better capture more recent demographic changes such as the increased portion of younger beneficiaries. We are estimating the change in methodology to have a significant impact on the normalization factors used for 2015 payment, decreasing the weighted average factor from 1.03 to 0.987. The result is an increase of +4.3% to 2015 risk scores.

[3] See page 21 of the 2014 Advance Notice found at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Advance2014.pdf.

initial estimates based on updated information and public comment, when the final rate announcement is made on April 6.

Overall Reduction Calculation

Our overall calculation of the reduction that plans face for 2016 is summarized in the table below. As can be seen from the table, our estimate is for a reduction of **-1.2%**.

Estimated Reduction in 2016 for MAOs

	Reduction (%)
ACA impact for 2016	-0.67%
Change in plans' Star rating for 2016	0.2%
Ratebook change for 2016	1.7%
Coding intensity change for 2016	-0.25%
Change in risk score normalization factor for 2016	-0.47%
CMS-HCC Risk Model Revision for 2016	-1.7%
Total Reduction for 2016	**-1.2%**

Plans also face the possibility of 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 of FFS rates as a result of rebasing.
- The medical loss ratio requirements as mandated by the ACA, that went into effect for 2014 and plans are still adjusting to.
- The impact of additional regulatory changes to the program such as the impact of blending risk scores based partially on encounter data and the implications of implementing ICD-10 for the last quarter of the payment year.

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:

- A 3.2% trend in medical expenses from 2015 projections to 2016. We used 3.2% based on the July 2014 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 2014.
- The -0.25% change in the coding intensity adjustment and the -0.47% change in normalization factor were applied by reducing risk scores by a net amount of 0.72%.
- Changes in the insurer fee were 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 an opportunity to change payment rates before the 2016 rates are final, we ran our analysis under low end and high end scenarios.
- The model assumes no change in MAO margins.

The results of our pricing scenarios show monthly premiums or benefit changes per member of up to $20. Needed premium increases (or a combination of benefit reductions and premium increases) per member per month of $20 will make for a difficult environment where the potential for disruption for beneficiaries is significant. In recent years, CMS has constrained the combination of premium increases and benefit reductions. As proposed in the 2016 Advance Notice, this Total Beneficiary Cost (TBC) requirement limits these changes to $32 for 2016, 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 and 2015 as described in the tables below.

Estimated Reduction in 2014 for MAOs

	Reduction (%)
ACA impact for 2014	-4.5%
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%
Coding intensity change for 2014	-1.5%
Total Reduction for 2014	**-4.0%**

Estimated Reduction in 2015 for MAOs

	Reduction (%)
ACA impact for 2015	-3.2%
Change in plans' Star rating for 2015	0.4%
Elimination of bonus for 3.0 and 3.5 Stars for 2015	-1.7%
Elimination of applicable amount bonus	-0.3%
Ratebook change for 2015	-3.6%
Coding intensity change for 2015	-0.25%
Risk score normalization factor for 2015	4.3%
CMS-HCC Risk Model revision for 2015	-0.8%
Total Reduction for 2015	**-5.2%**

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 and 2016 cuts, would produce a total estimated reduction of nearly 12.4% over three years, a level that is and will continue to severely strain program sustainability. We also find the 2014 cut reduced MA funding by $30 - $70 PMPM, which when combined with the 2015 and 2016 cuts, results in a three-year impact of $60 - $160 PMPM.

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 16 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 2016. 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]

The increased impact in 2016 on beneficiaries of up to $20 per member per month, coming after the estimated 2014 and 2015 cuts of $60 - $140, is also likely to greatly affect beneficiaries with low incomes, including the 37% of MA enrollees with annual incomes below $20,000.[5] 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

[4] See for example Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et. all. 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.

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.

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.

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