

Proposed changes to 2014 Medicare Advantage payment methodology and the effect on Medicare Advantage organizations and beneficiaries

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CONSIDERATIONS AND LIMITATIONS

The reimbursement reductions and needed adjustments to MAO pricing will vary considerably by market (i.e., 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 CMS's Advance Notice of Methodological Changes for Calendar Year 2014 Medicare Advantage ("MA") 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

On Friday, February 15, 2013, CMS released its Advance Notice of Methodological Changes for Calendar Year 2014 Medicare Advantage ("MA") Capitation Rates and Part C and Part D Payment Policies. The report outlines the planned changes to MA capitation rates applied under Part C for CY 2014. The announcement calls for significant reimbursement reductions to Medicare Advantage Organizations ("MAOs"), and coupled with the payment reductions already being implemented by the Affordable Care Act, indications are that this will have an adverse effect on MAOs and Medicare beneficiaries in 2014 and beyond.

America's Health Insurance Plans (AHIP) engaged the Actuarial Practice of Oliver Wyman to review the 2014 Advance Notice and prepare this report. The purpose of this document is to first describe and estimate the value of the changes proposed in the 2014 Advance Notice and the ACA, and then estimate the effect these changes will have on beneficiary premiums and benefit levels, MAO enrollment, and MAO financial viability.

EXECUTIVE SUMMARY

We find that the changes proposed in the 2014 Advance Notice and the ACA 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, smaller provider networks, and reduced MA enrollment as beneficiaries see a significant decline in plan value from 2013 to 2014. These findings include:

- Virtually all of the 14.1 million Medicare beneficiaries are likely to be affected by these
 changes, either through increased premiums, reduced benefits, 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.
- The combined effect of the changes included in the ACA and those proposed in the Advance Notice could necessitate benefit reductions and premium increases of \$50 to \$90 per member per month.
- These benefit reductions and premium increases are the result of an estimated 6.9% 7.8% reduction in payment that MA plans would face in 2014.
- Those who utilize services the most may be most adversely affected by potential loss of access to MA plans and forced to move back into FFS Medicare with its large cost sharing requirements.

CHANGES TO PAYMENT METHODOLOGY – THE ACA AND THE 2014 ADVANCE NOTICE

ACA IMPLEMENTATION CONTINUES IN 2014

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"), which we will refer to collectively as the Affordable Care Act ("ACA" or "the law"), establishes an annual fee on the health insurance sector – effective in 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 billion in 2014, increasing to \$14.3 billion in 2018, and increased based on premium trend thereafter¹. Based on a prior study completed by the Actuarial Practice of Oliver Wyman, we estimated these fees will impact MA economics by 1.9% to 2.3% of revenue for MAOs in 2014. Although not necessarily a reduction in MA payment rates, this tax will have the same effect as a reduction in revenue to MAOs.

The ACA 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 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 will take place over two to six years. 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 2.5% for 2014.

The ACA also increases benchmarks based on plan quality, with higher increases for MAOs achieving higher quality ratings. Starting in 2012, plans with at least a 4-star rating on a 5-star quality rating scale will receive an increase in their benchmark. New plans or plans with low enrollment may also qualify for a benchmark increase. The ACA 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 before 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 project, is testing an alternative method for computing quality bonus payments. Quality bonus payments will be computed along a scale; the higher a plan's star rating, the greater the bonus payment percentage. Quality bonus payments will also be available to plans with ratings of 3 and 3.5 stars, but in lower amounts. The Demonstration Project tests whether providing scaled bonuses will lead to more rapid and larger year-to-year quality improvements in Medicare Advantage program quality scores, compared to the ACA's bonus structure.

¹ PPACA Section 9010. The statute provides that after 2018 the amount of the tax is the applicable amount for the proceeding year increased by the rate of premium growth (as defined in the Internal Revenue Code) the preceding calendar year.

CMS recently released findings that suggested there is upward performance in plan Quality Star ratings for 2014. Since higher quality ratings lead to higher bonus payments to MAOs, plans on average will be receiving higher Star rating bonuses in 2014. We, along with other

industry experts, are estimating the impact of these extra bonuses, along with higher Part C rebates, to be between 0.5% and 1.0%, partially offsetting the ACA mandated reductions.

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 efficient 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 since 2010, this calculation has resulted in a 3.41% reduction in MA plan payments. The ACA mandated that this adjustment should further reduce payments by 1.30%, beginning in 2014. The American Taxpayers Relief Act of 2012 has since revised the 2014 additional reduction to a minimum of 1.50%, bringing the total 2014 coding intensity adjustment to 4.91%.

PAYMENT CHANGES RESULTING FROM 2014 ADVANCE NOTICE

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 released the Advance Notice for 2014 on February 15, 2013. The 2014 Advance Notice included significant 2014 reductions in both the National Per Capita Medicare Advantage Growth Percentage ("NPCMAGP") and the Fee-for-Service ("FFS") Growth Percentage.

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. CMS refers to the pre-ACA payment calculation as the "applicable amount."

The NPCMAGP for 2014 is projected to be -2.3%. This is the lowest NPCMAGP since the introduction of MA. The 2013 NPCMAGP was an increase of 2.8%. Most recent Advance Notices' have shown a low or negative increase in the most recent year (i.e., 2013-2014 trend) because CMS reflects current law in its trend calculations and the law, at the time of rate setting, has called for significant decreases to the Medicare physicians fee schedule under the Sustainable Growth Rate (SGR) formula. The 2014 trend change, which is part of the NPCMAGP, is -3.2%.

Because the change in the physician fee schedule has eventually, in recent years, been re-set by Congress to something in the 0-2% range, the following year CMS must restate the NPCMAGP trend from the previous year to reflect the physician fee schedule change that was actually implemented. The revision to the 2013 trend in the 2014 Advance Notice is 4.4%.

In this year's Advance Notice CMS has made large, negative prior year revisions to 2010 through 2012 growth rates. Although CMS does not release details of the calculation, in a recent call, CMS intimated that the prior years' revisions (2010 – 2012) included in this year's Advance Notice, which were all fairly large negative adjustments, resulted from restated case mix indices, lower than projected market basket prices and lower utilization than initially projected. CMS may have made similar revisions to 2013 estimates but, because the size of physician fee schedule is significant, such revisions are not apparent. Without considering any potential 2013 revisions, the total revision for prior estimates in the 2014 Advance Notice is -3.4%.

The table below shows the prior and current estimates of trends and the calculation of the NPCMAGP.

EXHIBIT 1: CALCULATION OF 2014 NATIONAL PER CAPITA MA GROWTH PERCENTAGE:

YEAR	APR - 12	FEB - 13	REVISION
2004 growth rate =	7.8%	7.8%	0.0%
2005 growth rate =	6.9%	6.9%	0.0%
2006 growth rate =	5.0%	5.0%	0.0%
2007 growth rate =	4.5%	4.3%	-0.2%
2008 growth rate =	5.4%	5.6%	0.2%
2009 growth rate =	4.1%	4.0%	-0.1%
2010 growth rate =	1.4%	0.9%	-0.4%
2011 growth rate =	3.5%	2.1%	-1.4%
2012 growth rate =	1.7%	0.2%	-1.5%
2013 growth rate =	-2.3%	2.0%	4.4%
2014 growth rate =		-3.2%	-3.2%
2014 Adjusted Growth Percentage			-2.3%

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 that each MAO is assigned. CMS is rebasing county level FFS cost projections for 2014 which means that it is recalculating its projections using a more current dataset. The initial estimate of the overall change in FFS costs for 2014 is -2.1%, but actual changes to FFS cost projections will vary by county, sometimes significantly. This is not a surprising result as the pending physician fee schedule changes need to be reflected in the 2014 FFS cost trends and any prior revisions will be reflected in the actual FFS costs (2007 to 2011) and trends (2012 to 2013) that CMS uses to calculate its actual county level projections of FFS costs.

CMS has the opportunity to revise the initial payment estimates, based on updated information and public comment, when the final rate announcement is made on April 1. However, in the past, revisions made between the Advance Notice and the Final Announcement have been minor. CMS has noted that the preliminary estimate of the combined effect of the NPCMAGP and the FFS USPCC Growth Percentage is -2.2%.

OVERALL REVENUE REDUCTION CALCULATION

Our overall calculation of the reduction that plans face for 2014 can be seen in the table below. We show both a high and low estimate for both the new insurer fees and the increased Star Rating bonuses that plans are expected to receive from improved quality Star Ratings. As can be seen from the table, our estimate is for a reduction that ranges from 6.9% to 7.8%.

EXHIBIT 2: ESTIMATED REVENUE REDUCTION IN 2014 FOR MAOS

	нідн	LOW
Projected insurer fees for 2014	-1.9%	-2.3%
ACA quartile impact for 2014	-2.5%	-2.5%
Stars bonus increase for 2014	1.0%	0.5%
Coding intensity change for 2014	-1.5%	-1.5%
Ratebook change for 2014	-2.2%	-2.2%
Total Reduction for 2014	-6.9%	-7.8%

Plans also face 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:

- Large changes to the CMS-HCC risk adjustment model including removal of certain condition categories inclusion of new co-morbidities and the possibility that the new model is not budget neutral to the old model
- Changes to the calculation of rebased FFS rates
- Reduced cost sharing for standard Part D coverage that would affect total plan payments
- New medical loss ratio requirements as mandated by the ACA

THE IMPACT OF CHANGES ON MAOS AND BENEFICIARIES

FINANCIAL IMPACT

MAOs will need to react quickly to the 6.9% to 7.8% reduction, with pricing for 2014 due to CMS in a few months. How individual MAOs react will depend on a number of factors including the financial results of plan offerings in 2012 and early 2013, changes in expected plan performance such as more effective medical management, risk scores that are more reflective of plan morbidity and more efficient operations.

To calculate the range of the potential financial 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:

- 3% trend in medical expenses from 2013 projections to 2014. We used 3% based on the January 2014 Oliver Wyman Carrier Trend Report²
- Scenarios were run for both the high and low estimated revenue reductions shown above
- The pending insurer fees were applied as increased non-benefit expenses
- The -1.5% change in the coding intensity adjustment was applied by reducing risk scores
- The ACA mandated reductions to percentages of FFS costs, the 2014 growth rate reductions and the Star Rating bonus improvement were applied to benchmarks
- The model assumes no change in MAO margins

The results of our pricing scenarios show a low end effect of about a \$50 needed monthly premium increase for 2014 (or some combination of premium increase and benefit reductions). The low end effect assumes a 6.9% reduction and occurs for MAOs operating in counties with lower benchmarks and/or having lower available rebates. On the high end, assuming the 7.8% reduction, we estimate needed monthly premiums or benefit changes closer to \$90. This generally happens for plans in high benchmark areas or plans with high available rebates.

Needed premium increases (or a combination of benefit reductions and premium increases) of \$50 to \$90 will leave MAOs in a precarious position. In its draft 2014 Call Letter, CMS lowered the maximum change from 2013 to 2014 for the combination of premium increases and benefit reductions to \$30 subject to plan-specific adjustments. The remainder of savings will need to come from improved operational efficiencies.

POTENTIAL IMPACT ON ENROLLMENT

With the potential for higher premiums and reduced benefits, we expect a significant amount of upheaval in the MA market that will likely affect virtually all of the 14.1 million Medicare beneficiaries enrolled in MAOs. This includes the potential for plan exits, reductions in service areas, reduced benefits, smaller provider networks, and reduced MA enrollment as beneficiaries see a significant decline in plan value from 2013 to 2014. 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.

IMPACT ON SPECIFIC POPULATION SEGMENTS

With increased beneficiary premiums and increased beneficiary cost sharing, we estimate that individuals with lower incomes and those more likely to need medical services will be particularly adversely affected.

2 The most recent Oliver Wyman Trend Report can be found at http://www.oliverwyman.com/4930.htm#.USZ3W3k8p8E

The lowest income individuals enrolled in MAOs (those dually eligible for both Medicare and Medicaid) are generally enrolled in Special Needs Plans ("SNPs), commonly referred to as D-SNPs. For these products, MAOs have very little or no room 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 OTC medication coverage, etc., to help offset the payment reductions.

Those who utilize services the most 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 large cost sharing requirements and lack of coordinated care. Loss of access to the coordinated care and lower cost sharing offered by MAOs may significantly affect individuals with chronic conditions, including individuals in chronic care SNPs which enroll only individuals with specific conditions like COPD or Diabetes.

