2019 ADVANCE NOTICE: CHANGES TO MEDICARE ADVANTAGE PAYMENT METHODOLOGY AND THE POTENTIAL EFFECT ON MEDICARE ADVANTAGE ORGANIZATIONS

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Introduction

On February 1, 2018, The Centers for Medicare & Medicaid Services (CMS) released the Advance Notice of Methodological Changes for Calendar Year 2019 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Part 2 of the 2019 Advance Notice). Part 1 of the 2019 Advance Notice, released in December 2017, covered proposed changes to CMS' Hierarchical Condition Categories (CMS-HCC) risk adjustment model, while Part 2 outlined proposed changes to MA capitation rates, and other regulatory changes that will affect plan reimbursement. Beginning with the 2018 notice and continuing for 2019, as a result of the Securing Fairness in Regulatory Timing Act of 2015 (SFRTA) (Pub. L. 114-106), the Advance Notice must be released at least 60 days prior to the Final Announcement. In addition, CMS must provide a 30-day public comment period.

Based on information released in the 2019 Advance Notice, Medicare Advantage Organizations (MAOs) are likely to experience changes in payment rates for 2019 slightly below the expected growth in MAOs' health care costs. The July 2017 Oliver Wyman Carrier Trend report reflects MAO reported pricing trends of between 2 to 4 percent, while CMS estimates MA payment rates will increase 1.84 percent.

To understand the implications of Parts 1 and 2 of the 2019 Advance Notice for the future of the MA program, America's Health Insurance Plans (AHIP) engaged the Actuarial Practice of Oliver Wyman to evaluate the impact of these potential changes in 2019. In this document, we describe and estimate the value of these changes.

Executive Summary

Based on our analysis, we estimate that the payment policies proposed in the 2019 Advance Notice are expected to fall just shy of MAO health care cost trend expectations. Health care costs are projected to grow by between 2 to 4 percent, and payments, based on the 2019 Advanced Notice, are expected to increase by less than 2 percent. Our findings are shown the table below:

- This report estimates that MA plans will see an increase in net revenue of 1.86 percent in 2019. MAO net revenue will be strongly influenced by the ratebook change for 2019 (+4.35 percent), offset partially by the normalization of the CMS-HCC risk adjustment model (-2.24 percent). These payment adjustments are likely to vary among MAOs and by county, and some MAOs could experience lower payment increases. These changes will be better understood once CMS rebases FFS costs in April and once plans can see how the changes to the CMS-HCC risk adjustment model will influence their businesses.

Estimated Net Revenue Impact in 2019 for MAOs

	Impact (%)	Impact (%)
	Oliver Wyman	CMS Estimate
Change to CMS HCC Model for 2019	0.28%	0.28%
Change in Plan's Star Rating for 2019	-0.20%	-0.20%
Coding Intensity Change for 2019	0.01%	0.01%
Change in FFS Normalization for 2019	-2.24%	-2.26%
Change from RAPS to EDS data submission (2018 to 2019)	-0.04%	-0.04%
Change to EGWP Payment Policy (2018 to 2019)	-0.30%	-0.30%
Health Care Cost Growth for 2019 (Ratebook Change)	4.35%	4.35%
Total Net Revenue Change for 2019	**1.86%**	**1.84%**

- In addition to the changes described above, MAOs are likely to experience an additional payment change in 2019 due to the use of encounter data in risk adjustment. For 2019, CMS has proposed to increase the weighting of risk scores based on encounter data. We note that many plans are reporting a significant negative payment effect as a result of the transition to EDS.

- CMS is proposing fairly major changes to the CMS-HCC risk adjustment model for 2019. These changes include new HCCs and additional payment weights for members with multiple HCCs. As proposed, the model would be phased in over four years but there are implications of the model change that are concerning. As shown below, certain model segments, and in particular the full dual eligible, are affected negatively by the model change. Also, plans would receive a larger increase for members with **No** HCCs as compared to those with HCCs. These results suggest that the intentions of the new model are not entirely being met by the proposed model.

Changes to Payment Methodology for 2019

Changes Related to Risk Adjustment

MAOs are paid on a risk adjustment model that utilizes factors reflecting beneficiaries' health status. The 21st Century Cures Act provides CMS with a new focus on improving the predictability of the risk adjustment model's claim costs. CMS is proposing changes to several aspects of the CMS-HCC risk adjustment model for 2019.

- It will be calibrated using 2014 diagnosis data to predict 2015 costs, which are then adjusted forward to the payment year.
- It will include coefficients to reflect the comorbidity of members diagnosed with multiple payment HCCs. Additional risk factors will be added to reflect the count of payment HCCs with which a member has been diagnosed.
- New HCC categories will be introduced for Mental Health, Substance Use, and Chronic Kidney Disease. CMS proposed to revise the diagnosis to HCC mappings and renumbered specific HCCs within these categories.

CMS proposes phasing-in changes to the CMS-HCC model over a four-year period. CMS is proposing that the new model be weighted 25 percent in 2019, increasing by 25 percent each year until fully phased-in, starting in 2022. The current model will be weighted 75 percent in 2019 and phased-out by 2022. In addition, CMS is proposing to apply the new model to EDS records and the old model to RAPS.

CMS estimates changes proposed to the CMS-HCC model for 2019 will increase payments to MA plans nationwide by **0.28 percent** (1.10 percent fully implemented), but the final impact will vary considerably by plan. We note that CMS proposed one alternative methodology for updating the CMS-HCC model for 2019, but the alternative model resulted in much greater variation in plan-level impacts.

Using the Medicare 5 percent limited dataset, Oliver Wyman has analyzed the impact of the change to the new CMS-HCC model and found that the estimates published by CMS (1.10 percent fully implemented) are, in total, reasonable. We also analyzed changes produced by the new model depending on the number of HCC's a member has in the measurement period (HCC count). As can be seen in the table below, the model will increase payments significantly (3.6 percent vs. 1.1 percent overall) for members with NO conditions, will decrease payments for members with one to three conditions, and on average will have no effect on members with four or more conditions. These unintended consequences of how the model is specified may undermine the apparent intent of the new model to increase plan reimbursement for members with more clinical conditions.

Change in Average Risk Score by Payment HCC Count

		Count of HCCs				
Population	**Total**	**0**	**1**	**2**	**3**	**4+**
Non-Dual Aged	1.3%	1.9%	-0.1%	-1.6%	-2.6%	0.5%
Non-Dual Disabled	0.6%	4.9%	0.0%	-2.3%	-3.7%	0.5%
Full-Dual Aged	0.7%	2.4%	0.9%	-1.0%	-1.9%	-1.1%
Full-Dual Disabled	0.4%	8.4%	-0.6%	-3.6%	-5.5%	0.7%
Partial-Dual Aged	0.5%	2.3%	-0.7%	-2.4%	-3.5%	-0.5%
Partial-Dual Disabled	0.6%	6.6%	-0.5%	-3.0%	-4.5%	1.0%
Overall Total	**1.1%**	**3.6%**	**-0.2%**	**-2.3%**	**-3.5%**	**0.0%**

Below we show the prevalence of members for 2019. We note that for 67 percent of the population, meaning members with at least one HCC, the impact of the new HCC condition count model would be flat or reduce payments.

Percent of Members in HCC Count Cohort

		Count of HCCs				
Population	Total	0	1	2	3	4+
Non-Dual Aged	1,114,944	35.4%	24.5%	15.6%	9.3%	15.2%
Non-Dual Disabled	100,088	35.0%	24.7%	16.4%	9.5%	14.4%
Full-Dual Aged	119,630	20.6%	21.3%	17.7%	12.9%	27.5%
Full-Dual Disabled	92,118	23.5%	25.9%	19.5%	11.9%	19.3%
Partial-Dual Aged	39,793	27.7%	22.8%	16.9%	11.3%	21.3%
Partial-Dual Disabled	33,445	22.8%	26.0%	19.7%	12.0%	19.5%
Overall Total	**1,500,018**	**33.0%**	**24.3%**	**16.2%**	**9.9%**	**16.6%**

Coding Intensity Adjustment

In 2010, CMS began reflecting an observed difference in how MA plans were coding diagnoses versus FFS Medicare. In 2010, CMS reduced risk scores for MA organizations by 3.41 percent, and the adjustment was increased to 4.91 percent for 2014. Each year since, the American Taxpayers Relief Act of 2012 required the coding intensity adjustment to increase by 0.25 percent and required the MA coding adjustment be at least 5.90 percent by 2020. The 2018 adjustment is 5.91 percent, and CMS is proposing the statutory minimum of 5.90 percent, which means effectively no change (**0.01 percent**) to the coding intensity adjustment for 2019. CMS notes that it is considering alternative methodologies of calculating an adjustment for coding patterns to inform its final decision, but does not provide enough detail to evaluate the potential impact of these methodologies.

FFS Normalization

The risk adjustment model 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 CMS' risk score model. The goal of this normalization factor is to adjust the results of the risk score model such that the overall average risk score across all beneficiaries is 1.000 in the payment year.

For 2019, CMS is proposing to continue to use the linear forecast model to predict risk scores that was implemented for 2018. At the time of the Advance Notice, CMS expects Part C normalization factors to be 1.041 for the current CMS-HCC risk adjustment model (which will be weighted at 75 percent) and 1.038 for the new Payment Condition Count model (weighted at 25 percent). Since the normalization factor was 1.017 in 2018, the proposed factors will result in a Part C revenue decrease to plans of about **2.24 percent** for 2019.

We note that the recent change from ICD-9 to ICD-10 could potentially be causing the recent up uptick in normalization factors that CMS is observing in its modeling.

Encounter Data

Since CMS began using the CMS-HCC model, plans have submitted diagnosis codes through Risk Adjustment Processing System (RAPS) files. Starting in 2016, encounter data submitted through the Encounter Data Submission (EDS) system is being used for plan payments. CMS is implementing the EDS methodology over several years. In 2016, risk scores calculated using the RAPS methodology were weighted at 90 percent while those using the EDS methodology were weighted at 10 percent. For 2018, these weights were 85 percent for RAPS and 15 percent for

EDS. CMS states that the quality of encounter data has improved, though CMS does not provide specific evidence or metrics that show how it has improved.

However, there continue to be a number of operational challenges in order to make a successful change from RAPS to EDS. Citing the improvement in the infrastructure to implement EDS reporting and the need to continue to move forward with the implementation of EDS, CMS has proposed to increase the weighting from 15 percent on EDS in 2018 to 25 percent weight on EDS in 2019. Despite this improvement and the initial intent of this change from RAPS to EDS to be budget neutral, the change is still estimated to reduce plan payments.

Based on industry studies, we along with CMS estimate the incremental change in risk scores as a result of the increase in EDS weighting to be **-0.04 percent** on average. This estimate assumes a continued increase in the quality of the data, and the impact could vary significantly by plan.

Star Ratings for 2019

Starting in 2012, plans with at least a 4.0 Star rating on a 5.0 Star quality rating scale have received 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 rebates set at 50 percent (the lowest Star rated MAOs) to 70 percent (the highest Star rated MAOs) of the difference between the plan bid and the benchmark. CMS is estimating that the average change in plans' quality Star rating between 2018 and 2019 will lower Star rating bonuses by -**0.2 percent**.

Ratebook Changes for 2019

The 2019 Advance Notice included estimates for both the 2019 National Per Capita Medicare Advantage Growth Percentage (NPCMAGP) and the 2019 FFS Growth Percentage. The NPCMAGP was the mechanism that CMS used in their pre-ACA benchmark calculation and reflects trends in total Medicare costs predicted for the upcoming year and "updates" to historical trends since 2004. In the 2019 Advance Notice, CMS stated the NPCMAGP for 2019 is projected to be 5.44 percent. CMS indicated that the 5.44 percent increase for 2019 is comprised of 4.05 percent trend for 2019 and adjustments to the estimates for prior years of 1.01 percent.

CMS rebased county level FFS cost projections for 2018, 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 2019. In the 2019 Advance Notice, CMS stated that the 2019 FFS USPCC growth percentage is projected to be 4.08 percent.

Based upon this initial information from the Advance Notice, CMS is estimating the combined impact of the preliminary NPCMAGP and the FFS USPCC Growth Percentage will change MA payments by **+4.35 percent**.

This payment growth reflects a larger increase in the ratebook than the last several years; however, underlying medical trends are also expected to be higher. The increase reflects CMS' expectations that FFS and potentially MA claims cost trends could be on the rise, influenced heavily by a 2019 larger increase in Prospective Payment System (PPS) market baskets[1].

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html

CMS will have the opportunity to revise the initial estimates of both the FFS Growth Percentage and the NPCMAGP based on updated information and public comment when the final rate announcement is made on April 2.

Employer Group Waiver Plans

CMS is proposing to continue to waive the bidding requirements for EGWPs in 2019.

In 2017, CMS made a change to the Part C payment policy it uses to reimburse EGWPs. The new methodology aligns more closely with EGWP reimbursement for Part D coverage. The 2017 methodology uses a blend of individual market MA Bids (non-EGWPs) and EGWP bids to establish county level bid-to-benchmark ratios in order to calculate EGWP payments. EGWP bid-to-benchmark ratios were calculated for each quartile and were announced at the same time regional MA benchmarks were released. CMS is considering an adjustment to the EGWP bid-to-benchmark ratios to account for higher EGWP enrollment in PPOs, which tend to have higher ratios than in the individual MA market.

For CY2019, CMS is planning to fully implement the new EGWP payment policy. Based on CMS's own estimate, the effect between 2018 and 2019 will reduce payments to MA plans by **-0.30 percent**.

Overall Calculation

Our overall calculation of the reduction that plans face for 2019 is summarized in the table below.

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Repeal of the Health Insurance Tax for 2019

The Affordable Care Act established an annual fee on the health insurance sector – effective in 2014, which has been labeled in the industry as the Health Insurance Tax ("HIT"). This 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 was $8 billion in 2014, increased to $14.3 billion in 2018, and will increase based on premium trend thereafter.[2]

The Continuing Resolution Act passed January 22, 2018 repeals the HIT for 2019. Based on a prior study completed by the Actuarial Practice of Oliver Wyman, we estimated that the fee in 2019 would be 2.6 percent of revenue.[3] Although not an increase in MA payment rates, the removal of this tax for 2019 will provide MA plans flexibility to provide enrollees lower premium options, or an improved benefit package. Plans will need to anticipate the temporary nature of the HIT repeal in their 2019 bids. Should Medicare Advantage plans reflect the impact of the suspension of the fee by offering additional benefits, for example, the resumption of the fee in 2020 could create instability for Medicare beneficiaries if the suspension is not extended and any changes made in 2019 are reversed.

[2] 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.

[3] http://www.stopthehit.com/wp-content/uploads/2017/08/Oliver-Wyman-2018-HIT-Analysis%E2%80%8E-August-8-2017.pdf

Considerations and Limitations

The reimbursement changes will vary considerably by market (e.g., CMS calculates FFS costs on a county level basis) and MAO. Our purpose here was to estimate reductions 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' Advance Notice of Methodological Changes for Calendar Year 2019 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.