2018 ADVANCE NOTICE: CHANGES TO MEDICARE ADVANTAGE PAYMENT METHODOLOGY AND THE POTENTIAL EFFECT ON MEDICARE ADVANTAGE ORGANIZATIONS

February 22, 2017

GLENN GIESE
FSA, MAAA

Josh Sober
FSA, MAAA

Randall Fitzpatrick
FSA, MAAA

OLIVER WYMAN

CONTENTS

Introduction

On February 1, 2017, the Centers for Medicare & Medicaid Services (CMS) released the Advance Notice of Methodological Changes for Calendar Year 2018 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the 2018 Advance Notice). The Advance Notice outlines the planned changes to Medicare Advantage (MA) capitation rates applied under Part C and Part D for calendar year (CY) 2018 and other regulatory changes that will affect plan reimbursement.

Beginning with the 2018 notice, 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.

Given the implications of the 2018 Advance Notice for 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 2018. In this document, we describe and estimate the value of the changes reflected in the 2018 Advance Notice along with those being implemented due to the Affordable Care Act (ACA).

Executive Summary

Based on our analysis, we estimate that the payment policies proposed in the 2018 Advance Notice could disrupt beneficiaries in the MA market. This disruption could occur because of an estimated average 5 percentage point gap between expected growth in projected health care costs (+3 percent) and a reduction in net payments to Medicare Advantage Organizations (MAOs) (-2 percent). As a result, absent changes in CMS policy in the Final Announcement, beneficiaries enrolled in MA plans could, on average, face higher premiums and costs or reduced benefits. Our findings are shown in the table below:

- This report estimates that MA plans will see a reduction in net revenue of -1.8 to -2.0 percent in 2018.
- This negative impact is due in part to the reinstatement of the Health Insurer Tax (HIT) for 2018, which will take effect unless legislative action is taken to extend the one-year moratorium or permanently repeal the tax prior to the bid deadline. Although the HIT is not a reduction in payment rates, it does serve as a reduction in net revenue to the MA program by imposing an additional cost on MAOs.
- Another cause of the negative impact is CMS' change in the normalization factor used to adjust risk scores.
- The impacts are likely to vary among MAOs, and some MAOs could experience larger payment reductions.
- Even without the reinstatement of the HIT, the change in plan revenues would not keep pace with health care cost inflation. That is, while the county benchmarks on average would increase by 2.8 percent, the net change in payment would be negligible at 0 to 0.25 percent.

Estimated Net Revenue Impact in 2018 for MAOs

	Impact (%) Oliver Wyman	Impact (%) CMS Estimate
Change in Plan's Star Rating for 2018	-0.4%	-0.4%
Coding Intensity Change for 2018	-0.25%	-0.25%
Change in FFS Normalization for 2018	-1.9%	-1.9%
Change from RAPS to EDS Data Submission	0.0%	Not Included
Change to EGWP Payment Policy	0.0 to -0.2%	Not Included
Health Care Cost Growth for 2018 (Ratebook Change)	2.8%	2.8%
Subtotal Impact for 2018 (Excluding Health Insurer Tax)	**0.05 to 0.25%**	**0.25%**
Reinstatement of Health Insurer Tax for 2018	-2.10%	Not Included
Total Net Revenue Impact for 2018	**-1.85 to -2.05%**	**0.25%**

- In addition to the changes from 2017 to 2018 described above, MAOs will experience an additional impact on total payments for 2018 due to the use of encounter data in risk adjustment. Although CMS has proposed for 2018 to leave the weighting of risk scores based on encounter data equal to the weighting for 2017, thus having no incremental effect for 2018, we do note that plans will continue to see reductions in payments until the infrastructure is in place to make encounter data reporting complete, accurate, and reliable. We estimate this payment reduction at between -$2B and -$9B for 2018 (or -1 percent to -4 percent of total payments).

Reinstatement of the Health Insurance Tax for 2018

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"), 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, is expected to increase to $14.3 billion in 2018, and will increase based on premium trend thereafter.[1] The Consolidated Appropriations Act of 2016 imposed a one-year moratorium on the collection of the HIT for 2017.

Based on a prior study completed by the Actuarial Practice of Oliver Wyman, we estimated the HIT will reduce MA plan net revenue by **-2.1 percent** in 2018. Although not a reduction in MA payment rates, this tax will decrease net revenue for MA plans by increasing their costs. The HIT will be collected in 2018 based on current law, absent any legislative action. Unless the HIT is repealed for 2018 prior to the June 5, 2017 deadline for bid submission, plans will need to anticipate the HIT in their 2018 bids.

Changes to Payment Methodology for 2018

Changes Related to Risk Adjustment

MAOs are paid on a risk adjustment model that utilizes factors reflecting beneficiaries' health status. Diagnosis coding in traditional fee-for-service (FFS) Medicare has historically been less accurate 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). The MA risk adjustment model is calibrated based upon FFS costs. Starting in 2010, CMS began offsetting the effect that MAOs' efficiency in coding had on plan reimbursement by reducing MAO payments across all plans. CMS applied a 3.41 percent "MA coding intensity adjustment" reduction to MA plan payments in 2013. The American Taxpayers Relief Act of 2012 increased the 2014 coding intensity adjustment by setting it at a minimum of 4.91 percent and mandated an annual incremental increase in the adjustment starting in 2015 that will further reduce payments by at least **-0.25 percent** each year. CMS has set the 2018 adjustment at 5.91 percent, or the minimum level required by law. It is mandated that the MA coding intensity adjustment be no less than 5.91 percent in 2019 and subsequent years.

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.

CMS calculated FFS risk scores from 2012 to 2016 in order to predict the 2018 risk score for the FFS population. CMS calculated an abnormally large increase in the FFS risk score for 2016

[1] 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.

(1.022 vs. 1.001 for 2015). The increase in FFS risk scores from 2015 to 2016 may be an aberration in the trend observed from 2011 to 2015 due to the introduction of ICD-10 diagnosis coding on October 1, 2015. Using publicly available data, Oliver Wyman was able to explain some of the increase in FFS risk scores for 2016. The normalization factor estimate by CMS is highly dependent on the 2016 estimate, which appears to not be representative of FFS risk score trends based on our analysis of FFS claims data. CMS has not yet provided an explanation for this increase.

For 2018, CMS is proposing to use a different methodology to calculate the normalization factor. CMS believes that the quadratic methodology that has been used for the last several years would produce an unreasonable FFS normalization factor for 2018, and thus is proposing to use a linear forecast model. Using the linear forecast model, the Part C normalization factor will increase from 0.998 to 1.017 for 2018, which will have the effect of reducing payments to plans by **-1.9 percent** (1 - 0.998/1.017).

Encounter Data

Since CMS began using the CMS-HCC model, plans 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 incorporated within the final risk score for plan payments. CMS is implementing the EDS methodology over several years. In 2016, risk scores calculated using the RAPS methodology are weighted at 90 percent while those using the EDS methodology are weighted at 10 percent. For 2017, these weights are 75 percent for RAPS and 25 percent for EDS. As noted by a recent Government Accountability Office report[2], there are a number of operational activities that need to be completed by CMS in order to make a successful transition from RAPS to EDS. Acknowledging MAO concerns with the potential impact of EDS on risk scores, CMS has proposed to leave the weighting for 2018 equal to the weighting for 2017. Thus, the change in weighting will have no effect for 2018.

However, we do note that plans will continue to see reductions in payment until the infrastructure is in place to make EDS reporting complete, accurate, and reliable. We estimate these reductions are between -$753M and -$1.13B for 2016 (or -0.4 to -1.6 percent of revenue) and between -$2B and -$9B for 2017 and 2018 (or -1 to -4 percent of revenue).[3]

Effective Growth Rate and Transition to ACA Rules for 2018

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 FFS Medicare spending. The ACA ultimately set county benchmarks at 95 percent, 100 percent, 107.5 percent, or 115 percent of projected (by CMS) FFS spending, with higher percentages applied to counties with the lowest FFS spending. The phase-in took place over two to six years depending on the county; as of 2017, the ACA payment structure is fully phased-in, thus all county benchmarks were calculated using the ACA methodology in 2017 and will be in 2018.

---

[2] Government Accountability Office. Medicare Advantage: Limited progress made to validate encounter data used to ensure proper payments [GAO-17-223]. January 2017.

[3] Milliman estimated the median difference in 2016 risk scores calculated using EDS vs RAPS at 4 percent; for 2016, this difference would be 0.4 percent using the 10 percent EDS blend and 1 percent for 2017 and 2018 using the 25 percent blend (see: Bell, Deana, Koenig, David, Mills, Charlie. Impact of the transition from RAPS to EDS on Medicare Advantage risk scores. *Milliman*. January 2017). Avalere Health estimated the average difference in 2016 risk scores calculated using EDS vs RAPS at 16 percent; for 2016, this difference would be 1.6 percent using the 10 percent EDS blend and 4 percent for 2017 and 2018 using the 25 percent blend (see: Avalere Health. RISE RAPS-EDS collaboration research project executive summary. January 2017).

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 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 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. MAOs use these rebates to finance additional benefits and reduced cost-sharing for their enrollees. Oliver Wyman is estimating the effect of average plan change in quality Star ratings on bonus payments between 2017 and 2018 will be **-0.4 percent** due to a decreased proportion of beneficiaries enrolled in MA plans with a Star rating of at least 4.0.

CMS is also proposing one notable change to the qualifying county bonus payment calculation. Counties must satisfy three conditions to qualify: urban floor in 2004, 25 percent penetration rate in 2009, and FFS spending that is less than the national average in 2018. Based on the first two criteria, there are 289 counties eligible to be a qualifying county and receive a double bonus payment. In 2017 and prior years, CMS calculated the national average FFS spending including graduate medical expenditures (GME), however these expenditures were excluded from the county FFS costs. For CY2018, CMS is proposing to correct the calculation to the county FFS costs to include GME. Applying this change to the CY2017 benchmarks would have resulted in 15 counties losing their qualifying county status. We have not included this reduction in our overall calculation, but in the table below we show the counties affected and the amount they would have been affected by in 2017.

Potential Counties Affected by Correction to FFS Costs

County Code	State	County	Cap Impact 5% QBP	Cap Impact 3.5% QBP
5460	CA	SAN BERNARDINO	$ (40.74)	$ (28.52)
10170	FL	FLAGLER	$ (32.58)	$ (28.69)
18180	KY	CAMPBELL	$ (35.87)	$ (28.36)
19370	LA	PLAQUEMINES	$ (39.74)	$ (27.82)
19440	LA	ST. CHARLES	$ (40.25)	$ (28.17)
26180	MO	CASS	$ (36.39)	$ (28.43)
34290	NC	DAVIE	$ (39.69)	$ (27.78)
34840	NC	STOKES	$ (39.82)	$ (27.87)
36490	OH	LUCAS	$ (39.35)	$ (27.55)
36580	OH	MONTGOMERY	$ (8.86)	$ (20.84)
39280	PA	DAUPHIN	$ (10.26)	$ (22.05)
39800	PA	YORK	$ -	$ -
41010	RI	KENT	$ -	$ -
44100	TN	CHEATHAM	$ (31.95)	$ (28.56)
45030	TX	ARANSAS	$ (40.99)	$ (28.69)

Qualifying counties for CY2018 will not be known until the final announcement is released on April 3, 2017.

Ratebook Changes for 2018

The 2018 Advance Notice included increases to both the 2018 National Per Capita Medicare Advantage Growth Percentage (NPCMAGP) and the 2018 FFS Growth Percentage. The NPCMAGP was the mechanism that CMS used in the pre-ACA benchmark calculation and reflects trends in total Medicare costs predicted for the upcoming year and "updates" to historical trends since 2004. The ACA phased in the new methodology over several years; 2017 was the sixth and final phase-in year. CMS refers to the pre-ACA payment calculation as the "applicable amount." The pre-ACA methodology is still relevant because CMS caps benchmarks at the pre-ACA methodology. In the 2018 Advance Notice, CMS stated the NPCMAGP for 2018 is projected to be 2.7 percent. CMS indicated that the 2.7 percent increase for 2018 is comprised of 2.77 percent trend for 2018 and adjustments to the estimates for prior years of -0.07 percent.

Under the ACA, MAO benchmarks are tied to projected FFS costs. The "specified amount," the benchmark calculation under the ACA, takes into consideration both a specified percentage (95, 100, 107.5 or 115 percent) of FFS costs and the quality Star bonus for each MAO contract. CMS rebased county level FFS cost projections for 2017, 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 2018. In the 2018 Advance Notice, CMS stated that the 2018 FFS USPCC growth percentage is projected to be 2.8 percent. For our analysis, we have simply increased county level FFS costs from 2017 levels using the national average trend 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 **+2.8 percent**. CMS will have the opportunity to revise the initial estimates based on updated information and public comment when the Final Announcement is made on April 3.

Employer Group Waiver Plans

CMS is proposing to continue to waive the bidding requirements for EGWPs in 2018.

In 2017, CMS made a change to the Part C payment policy it uses to reimburse EGWP plans. The new methodology follows more closely with what is in place for Part D. 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.

For CY2018, CMS is seeking comment on whether to base EGWP payment rates entirely on the bid-to-benchmark ratios for individual plans in 2017, or continue the approach used in 2017 under which EGWPs are paid on a blend of the individual and EGWP bid-to-benchmark ratios from 2016. Based on CMS' own estimate, should CMS choose to fully implement this policy, the effect between 2017 and 2018 will reduce payments to EGWPs by -1.25 percent and, when distributed across the program, would be a reduction to MA plans overall of about **-0.2 percent**. If CMS continues with the same policy for 2018 as it did for 2017, the net payment change year over year would be 0 percent.

Overall Calculation

Our overall calculation of the reduction that plans face for 2018 is summarized in the table below.

Estimated Net Revenue Impact in 2018 for MAOs

	Impact (%) Oliver Wyman	Impact (%) CMS Estimate
Change in Plan's Star Rating for 2018	-0.4%	-0.4%
Coding Intensity Change for 2018	-0.25%	-0.25%
Change in FFS Normalization for 2018	-1.9%	-1.9%
Change from RAPS to EDS Data Submission	0.0%	Not Included
Change to EGWP Payment Policy	0.0 to -0.2%	Not Included
Health Care Cost Growth for 2018 (Ratebook Change)	2.8%	2.8%
Subtotal Impact for 2018 (Excluding Health Insurer Tax)	**0.05 to 0.25%**	**0.25%**
Reinstatement of Health Insurer Tax for 2018	-2.10%	Not Included
Total Net Revenue Impact for 2018	**-1.85 to -2.05%**	**0.25%**

CMS has estimated the effects of policies proposed in the 2018 Advance Notice would increase average Medicare Advantage plan revenues by 0.25 percent. Our analysis finds these policies would reduce average Medicare Advantage net revenues by approximately -2 percent. The primary difference in our estimates is the potential effect if CMS fully implements the EGWP payment policy and the inclusion of the HIT.

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, such as changes to the calculation of FFS rates as a result of rebasing.

Considerations and Limitations

The reimbursement reductions 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 2018 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.