OLIVER WYMAN

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MEDICARE ADVANTAGE INSIGHTS

2019 OPEN ENROLLMENT AND PREPARING FOR 2020 AND BEYOND

From October 15, 2018 through December 7, 2018, nearly 60 million seniors and people with disabilities will have the opportunity to assess their current Medicare coverage. There is no penalty for an eligible member to change between Medicare Advantage plans (MA) or between MA and Medicare fee-for-service (FFS) during this period.[1] Currently, there are roughly 20 million Medicare enrollees that purchase their medical coverage from private health plans in MA.[2]

1 Enrollees with Medicare Supplemental coverage would be subject to underwriting if they attempt to change plans after the first 6 months from turning 65

2 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf (Table IV.C1. – Private Health Plan Enrollment)

MARSH & McLENNAN COMPANIES

In the competitive MA market, health plans need to differentiate themselves from competitors across several dimensions – brand recognition, provider network, benefits, cost-sharing and premium. Health plans continuously work on optimizing their brand recognition and provider network. However, for benefits, cost-sharing and premium, Medicare Advantage organizations develop a cost bid that is submitted to the Centers of Medicare and Medicaid Services (CMS) seven months prior to the calendar year. This bid will define what benefits will be offered, the cost-sharing required by the member and premium the member will be charged. Submitting a market leading benefit plan at a competitive premium could be the difference in the member's decision to purchase your MA plan versus a competitor's plan. The pricing and success of an MA plan are influenced by many factors. The focus of this newsletter is twofold. First, it focuses on star ratings and their impact on revenue MA plans receive from CMS. Second, we address new innovative supplemental benefits that health plans have introduced in the market in 2019.

SHOULD A HEALTH PLAN INVEST IN ACHIEVING A 4-STAR CONTRACT?

With the passage of the Affordable Care Act (ACA), CMS made several changes to how plans are paid for offering medical services (Part C). Specifically related to quality, health plans that maintain a star rating of 4 or higher receive a quality bonus payment (QBP) of 5% on the county benchmark.[3] However, the ACA capped the county benchmark at the pre-ACA rate, potentially limiting the value of good performance on quality measures. It is imperative for health plans to understand the financial gain from attaining a 4 star and how benchmark caps may limit this gain. In addition, health plans should use this knowledge to evaluate and improve on service area alignment within their product offerings.

Although CMS recently released the star rating that impacts 2020 pricing, the window to impact the star rating for 2021 pricing is quickly closing.

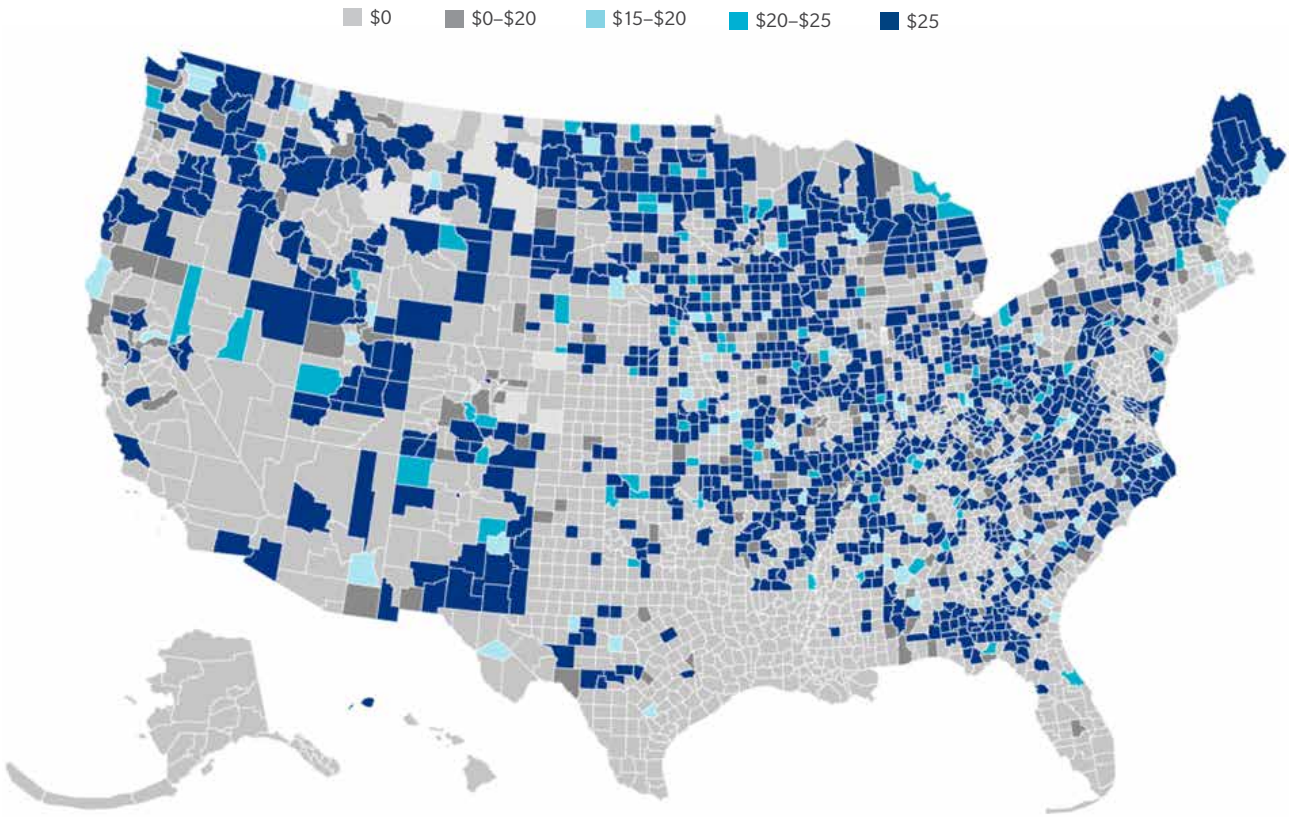
SOURCE	MEASURES COUNT	DATE RANGE
HEDIS/Other*	29	1/2018 to 12/2018
HOS	5	4/2018 to 7/2018
CAHPS	9	3/2019 to 5/2019

* There are two "HEDIS/Other" categories that have their complete capture period in 2019

3 Some counties qualify as "double bonus" and receive a 10% QBP

For every dollar in QBP, the health plan keeps a 65% (4-star plan) or 70% (4.5 and 5-star plan) rebate to provide additional benefits, lower cost-sharing or lower premium to their members. Prior to the ACA cap, the QBP varies from $30 per member per month (PMPM) to $88 PMPM in CY2019 with an average QBP of $47 PMPM. At a 65% rebate, this average QBP would give a 4-star health plan more than $30 PMPM above what a 3.5 star or lower plan would receive. This additional revenue would clearly allow a plan with a QBP to differentiate their benefits and premium when compared to competitors with a star rating below 4. However, because of the ACA cap on the county benchmark, roughly 50% of all counties have their QBP reduced. A majority of the counties have their benchmark reduced by more than $25 PMPM as shown in Exhibit 1.

Exhibit 1: CY2019 ACA Cap on Part C County Benchmark



Before allocating limited resources to improving star ratings, health plans must consider the cost and potential return on this investment. In certain parts of the country, investing in star rating improvement would lead to little or no improvement in Part C revenue from CMS.

For those MAOs that have achieved a 4-star quality rating, they should consider how to geographically configure their plans so that they get the most value out of their star rating relative to their competition. Offering a single plan across multiple counties may be the least administrative burdensome approach, but it also may limit the competitive advantage your MAO has achieved by becoming a 4-star plan. To illustrate, consider Hennepin and Dakota counties in Minnesota.

Exhibit 2: CY2019 County Benchmark

COUNTY	5% QBP BENCHMARK	0% QBP BENCHMARK	QBP
Hennepin	$889.98	$889.98	$0.00
Dakota	$910.92	$870.44	$40.49
Average	$900.45	$880.21	$20.24

Assume there are three MAOs that all offer products in Hennepin and Dakota counties and assume their projected membership is the same in each county. MAO A is a 4-star plan that offers one plan design across both counties. MAO B is a 4 star-plan that offers two different plans, one for each county. Lastly, MAO C is a 3.5-star plan that offers different plans in Hennepin and Dakota counties

Exhibit 3: Illustrative CY2019 Benchmark Calculation (Minnesota)

COUNTY	MAO A	MAO B	MAO C
Hennepin	$900.45	$889.98	$889.98
Dakota	$900.45	$910.92	$870.44

Through this configuration, MAO A has given itself (intentionally or not) a revenue advantage in Hennepin county, while MAO B has given itself a revenue advantage in Dakota county.

The geographic configuration of each plan benefit package can enable MAOs to target certain markets more effectively. Every MAO should evaluate their plans' service areas, and part of this evaluation should consider their competition's star rating and geographic configuration.

CY2019 HEALTH RELATED SUPPLEMENTAL BENEFITS

Starting in 2019, CMS has expanded the definition of allowable supplemental benefits to include services or items that can be defined as "primarily health related" even if those services or items are for daily maintenance. Specifically, supplemental benefits must "diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization."[4] However, the guidance from CMS was broad, allowing health plans to propose

4 https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

Overall, carrier response to CMS's new benefit flexibility appears to have been lukewarm and limited by the late delivery of additional guidance. However, as plans begin to examine the new benefit flexibility and consider how that flexibility will require changes in product design, marketing, and member outreach, we expect to see new perspectives on member valuation.

supplemental benefits that met CMS's terminology. Much of the guidance was also delivered relatively late in the bidding cycle.[5]

On October 1, 2018, CMS published the 2019 benefit plans that will be offered in MA. A review of the benefit categories that CMS highlighted in its April 27, 2018 guidance (i.e., "other supplemental services", categories 13d, 13e, and 13f) produces some compelling insights. First, national carriers[6] show a much higher proportion of plan benefit packages with other supplemental services. We can summarize the new data like the following:

Exhibit 4: 2019 Benefit Plan Options Offering New Supplemental Benefits

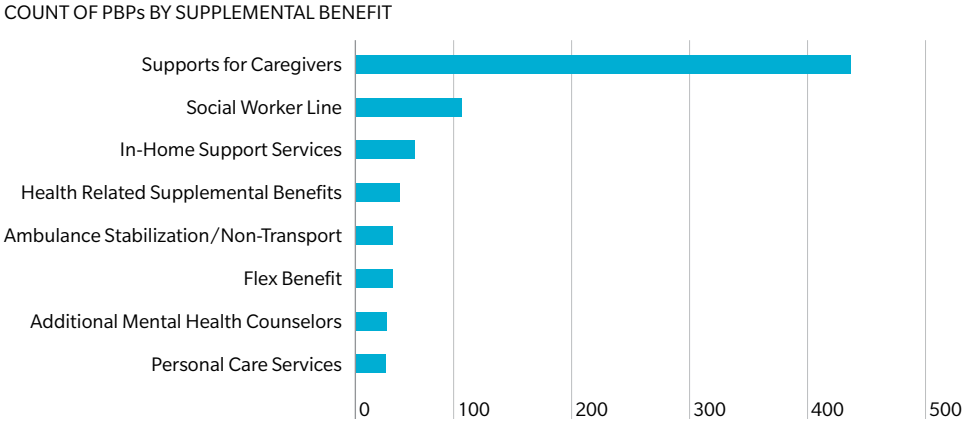
	PBPS	NEW SERVICES	PCT
National	2,258	630	28%
Blues	387	34	9%
Regional/Local	1,180	138	12%

The national carriers have nearly 30% of plan benefit packages with other supplemental services, while the Blues and regional/local plans were, on average, much less aggressive about changing benefit packages under CMS's new flexibility. Given the latitude around services and descriptions, the data also make it challenging to assess any potential overlap across carriers. The PBP data for categories 13d, 13e, and 13f reflect 40 new services ranging from respite care to massage therapy to Alzheimer/dementia bracelets. Exhibit 5 shows the services that have the highest representation across PBPs; please note that many of these services are only offered by a single organization.

5 "Reinterpretation of "Primarily Health Related" for Supplemental Benefit", April 27, 2018

6 National Carriers: Aetna, Anthem, Centene, CIGNA, Humana, Kaiser, Molina, UHC and WellCare

Exhibit 5: Top 8 Additional Services Added by Health Plans in 2019



Some of these services are not well characterized in the PBP data. However, they seem to broadly fall into categories of respite care, in-home services (i.e., to support with ADLs, reducing fall risk, making the home more amenable to wellness, etc.), and areas where current coverage requirements may include gaps (e.g., residential substance abuse treatment, back-up support for medical equipment).

We also examined the pre-defined Chapter 4 Supplemental Services to see if the discussion of primarily health related services might prompt additional offering rates for those benefits. Generally, the Chapter 4 Supplemental Services showed growth in certain categories, but this growth was not much faster than in the preceding year.

There was strong net growth in fitness benefits and remote access technologies; however, both services are already widely offered. Only personal emergency response systems (PERS) stood out as growing meaningfully. The number of PBPs with this PERS benefit are effectively doubling in 2019.

Overall, carrier response to CMS's new benefit flexibility appears to have been lukewarm and limited by the late delivery of additional guidance. However, as plans begin to examine the new benefit flexibility and consider how that flexibility will require changes in product design, marketing, and member outreach, we expect to see new perspectives on member valuation. New benefits may enable carriers to pursue strategies that:

- Attract profitable member segments with specific chronic conditions
- Promote utilization of new services to enable lower cost of care elsewhere
- Increase probability of coding multiple chronic conditions that may have been missed otherwise

Gaps in knowledge across the industry about product design options will create opportunities for insurers that are investing in data driven analytics and actuarial modeling. While there is still a great deal of uncertainty around benefit options, there should be new and significant opportunity to differentiate benefit plans to target member enrollment.

ABOUT OLIVER WYMAN

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For more information, please contact:

Josh Sober, FSA, MAAA
Principal
josh.sober@oliverwyman.com
+1 414 223 2298

Randall Fitzpatrick, FSA, MAAA
Principal
randall.fitzpatrick@oliverwyman.com
+1 414 277 4605

www.oliverwyman.com

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