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BONUS!

THE ACA REDUCED MEDICARE ADVANTAGE BENCHMARK PAYMENT RATES … HOW MUCH HAVE MEDICARE ADVANTAGE ORGANIZATIONS EARNED BACK THROUGH QUALITY BONUS PAYMENTS?

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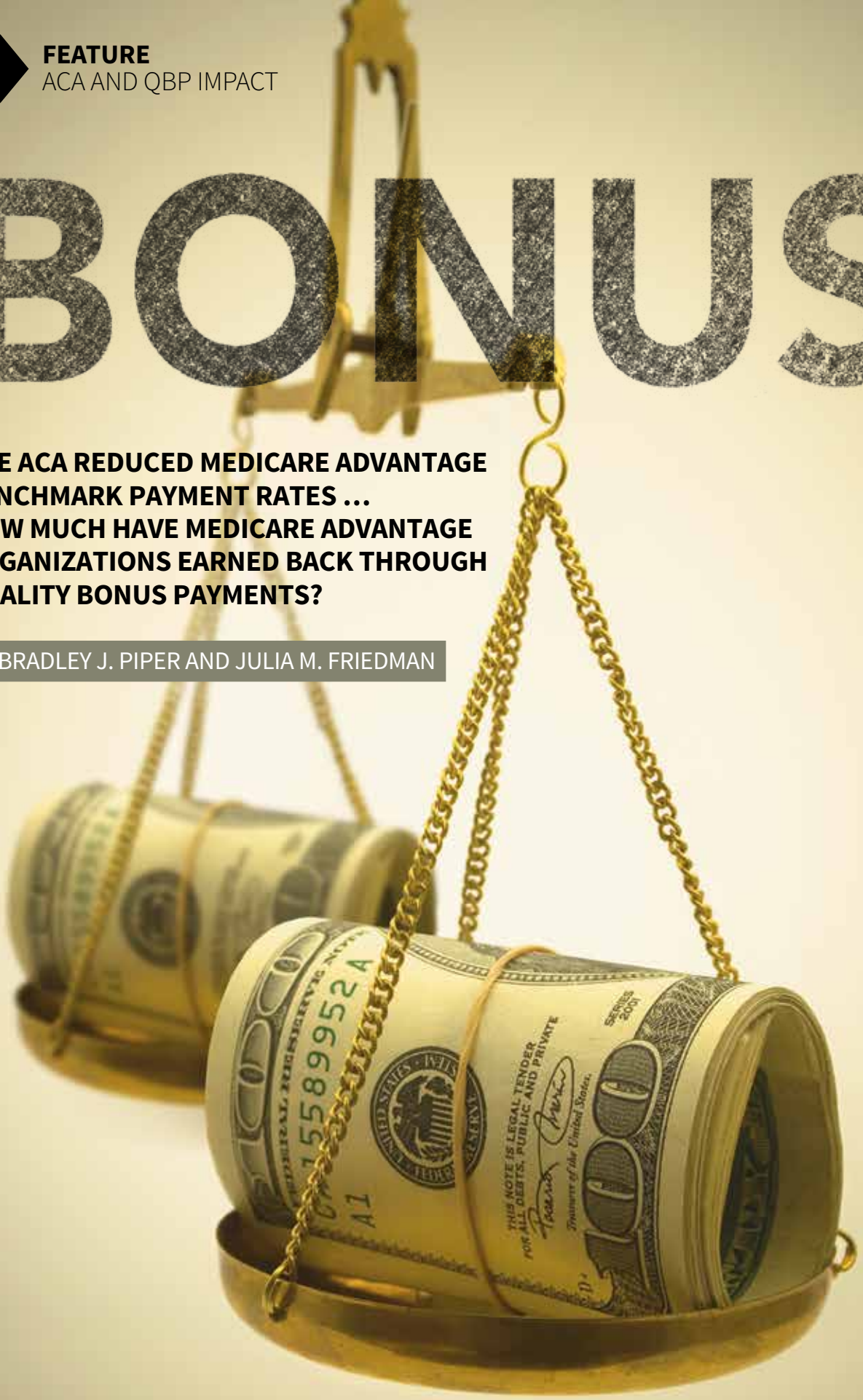


As most are aware, the passage of the Patient Protection and Affordable Care Act (ACA) had a significant impact on the health insurance market in the United States. The Medicare Advantage market was no exception, as the law reduced benchmark payment rates to health plans sponsoring Medicare Advantage plans. The Medicare Advantage (MA) program allows private insurers (as opposed to the federal government) to provide Medicare-eligible individuals (generally U.S. citizens over age 65, as well as some disabled citizens) with traditional Medicare benefits (and, often, benefits that are better than traditional Medicare benefits) as an alternative to traditional Medicare.

As background, traditional Medicare is a public health care program funded in part by the federal government, payroll taxes and member premiums, whereby Medicare-eligible individuals are provided health insurance coverage. The government created MA to allow for managed care in the Medicare framework and to put the onus on health plans to achieve cost-reducing efficiencies within the Medicare market. The MA program charges the health plans with improving care for members through better management of care, more individualized attention, community supported programs and by offering enhanced benefits that are aligned more closely with their members' health care needs. Most plans also offer pharmaceutical coverage, or Part D.

> "While the ACA did reduce the benchmark payment rates, many MAOs are meeting the criteria in the quality bonus program to recoup some of the lost revenue."

As a testament to the popularity of the MA program, MA enrollment in 2015 grew by 7 percent compared to 2014 enrollment, and its 16.8 million beneficiaries represented about 31 percent of the total Medicare-eligible population in 2015.[1] This article explores how deeply the ACA reduced the MA benchmark payment rates and quantifies how much of that reduction Medicare Advantage Organizations (MAOs) earned back through quality bonuses.

THE RESULTS

The implementation of the ACA reduced the benchmark payment rate for each county (ignoring annual trend). This began in 2012 and occurred over a two-, four- or six-year time frame, depending on the size of the reduction (counties receiving the largest reductions are being phased in over a six-year period). Thus, today's 2016 benchmark payment rates include a reduction that is either fully phased in (for two-year and four-year counties), or five-sixths phased in (for six-year counties). As of 2017, the reductions will be fully phased in, and in 2018 and beyond, annual benchmark payment rates are scheduled to trend at the same rate as expected Medicare cost (i.e., revenue trend and cost trend generally are expected to be the same).

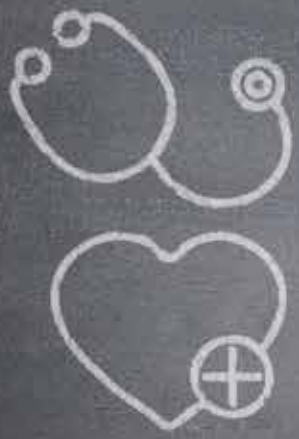
The benchmark payment rate is the maximum amount per member per month (PMPM) the Centers for Medicare and Medicaid Services (CMS) is willing to pay an MAO to provide traditional Medicare benefits. By reducing the benchmark payment rate, the ACA reduced the amount of revenue each MAO received. Based on calculations outlined in this article, the nationwide aggregate 2015 benchmark payment rate amount was 9.3 percent lower than the corresponding nationwide aggregate benchmark payment rate amount using 2015 pre-ACA payment rates (i.e., the 2015 payment rates if the ACA had not been implemented). This 9.3 percent reduction corresponds to nearly an $80 PMPM decrease in the 2015 benchmark payment rate amount (on a nationwide basis, assuming a 1.00 risk score).

However, at the same time, the ACA also introduced quality bonus payments (QBPs). QBPs are additional bonus payments MAOs can earn if they achieve high scores on a variety of quality metrics (commonly known as the MA star rating). MAOs use these additional bonus payments to offer enhanced benefits to their beneficiaries. For 2015, MAOs achieving a high star rating (4.0 or above) received a 5 percent add-on to the benchmark payment rate for each county. On the other hand, MAOs achieving a lower star rating (3.5 or less) earned no additional revenue bonus in 2015. Organizations that are new to the MA program and organizations with enrollment that is too low to be assessed a star rating are awarded a QBP of 3.5 percent. Based on calculations outlined in this article, the QBPs allowed MAOs to increase the nationwide aggregate 2015 benchmark payment rate amount by roughly 2.5 percent,

or about $21 PMPM, relative to what the benchmark payment rate amount would have been had all MAOs received a 0 percent QBP.

These calculations indicate that while the ACA did reduce the benchmark payment rates, many MAOs are meeting the criteria in the quality bonus program to recoup some of the lost revenue.

FIGURE 1 indicates the distribution of 0 percent, 3.5 percent and 5 percent QBPs.



We also summarized the results by region (**FIGURE 2**) and organization size (**FIGURE 3**) to understand if there were regional and/or size-based differences in the results.

As shown in **FIGURE 2**, Puerto Rico incurred the greatest benchmark payment reduction due to the ACA implementation. Further, Puerto Rico experienced almost no improvement via the QBP program. The results for other regions differ substantially from those for Puerto Rico, but generally are similar to each other.

As **FIGURE 3** illustrates, results do not differ significantly by organization size, though small organizations, on average, realized a modestly smaller

FIGURE 1 DISTRIBUTION OF 0 PERCENT, 3.5 PERCENT AND 5 PERCENT QBPs

Measure	0% Bonus Payment	3.5% Bonus Payment	5% Bonus Payment
Based on contracts	42.1%	28.9%	29.0%
Based on members	45.6%	3.2%	51.2%

FIGURE 2 IMPACT OF ACA AND QBP BY REGION

Region	Benchmark Payment Reduction Due to ACA	Benchmark Payment Earned Back Due to Bonus Payment
Nationwide	9.3% ($79.21) PMPM	2.5% ($21.06 PMPM)
South	9.8% ($86.85) PMPM	1.8% ($16.03 PMPM)
Midwest	6.7% ($53.38) PMPM	3.1% ($24.78 PMPM)
Northeast	9.6% ($83.13) PMPM	2.5% ($21.78 PMPM)
West	9.3% ($80.11) PMPM	3.3% ($28.21 PMPM)
Puerto Rico	14.8% ($90.84) PMPM	0.0% ($0.14 PMPM)

decrease in the benchmark payment rates and smaller bonus payments.

The Medicare Advantage market experienced terminations and consolidations of health plans year over year due in part to the increased pressure of the reduced MA benchmark payment rates and their effect on the viability of specific health plans. However, health plans also are entering the market each year, so a pure exodus out of MA is not necessarily the case. Health plans are finding ways to improve the cost and revenue relationship through reduction of administrative expenses, increased member premiums, improvement in star ratings and engaging providers to

FIGURE 3 IMPACT OF ACA AND QBP BY ORGANIZATION SIZE

Size	Benchmark Payment Reduction Due to ACA	Benchmark Payment Earned Back Due to Bonus Payment
All	9.3% ($79.21 PMPM)	2.5% ($21.06 PMPM)
Jumbo (at least 250,000 members)	9.2% ($79.25 PMPM)	2.2% ($19.25 PMPM)
Large (50,000–250,000 members)	9.8% ($80.26 PMPM)	2.9% ($24.08 PMPM)
Medium (5,000–50,000 members)	9.1% ($77.25 PMPM)	3.0% ($25.52 PMPM)
Small (fewer than 5,000 members)	8.5% ($71.86 PMPM)	1.6% ($13.23 PMPM)

enter shared-risk arrangements (such as capitation rates), to name a few ways.

PAYMENT RATES ARE NOT THE ONLY COMPONENT OF MAO REVENUE

To be clear, this article compares various benchmark payment amounts under different scenarios. This article does not comment on the *actual* CMS revenue changes to MAOs because:

- Actual revenue paid to MAOs is not the same as the benchmark revenue amount. As noted earlier, the benchmark revenue amount is the maximum amount CMS is willing to reimburse an MAO for providing traditional Medicare benefits. However, through the Medicare Advantage bidding process, MAOs submit their estimates (i.e., their bids) for how much traditional Medicare benefits would cost to provide. For nearly all MAOs, the bid amount is less than the benchmark revenue amount. In these cases, CMS pays the MAO its bid amount plus a percentage of the difference between the bid and the benchmark. This difference (known as the Part C rebate) then is used by the MAOs to enhance the benefits offered to the member. Because 2015 bid amounts are not public information, we did not evaluate the "true" revenue paid to MAOs, but rather focused only on the benchmark revenue.
- Actual revenue is risk-adjusted, meaning an MAO that enrolled a higher-risk population would, in theory, capture higher member risk scores and thus would receive larger revenue payments. Because MAO-specific risk score information is not publicly available, we also did not attempt to risk-adjust our analysis. Instead, we assumed a 1.00 risk score for all MAOs, given we are measuring benchmark payment rate relativities.
- Many MAOs also provide Part D (pharmacy) coverage and, as a result, receive Part D revenue from CMS. Part D revenue payments were not considered as part of this analysis.

PUBLICLY AVAILABLE CMS DATA WAS USED IN THIS ANALYSIS

Our analysis used information published by CMS. Specifically, we relied on the following:

- September 2015 MA membership by county and MAO contract. For purposes of this analysis, we excluded enrollment in the following plan types: employer group waiver plans (EGWPs), prescription drug plans (PDPs), cost plans and Medicare-Medicaid plans (MMPs). We also excluded American Samoa, Guam, the Northern Mariana Islands and the Virgin Islands.
- 2014 star ratings (which impact 2015 benchmark payment rates) for each MAO contract.
- Four different 2015 benchmark payment rates for each county:
  1. The pre-ACA rate
  2. The post-ACA rate with a 0 percent quality bonus
  3. The post-ACA rate with a 3.5 percent quality bonus
  4. The post-ACA rate with a 5 percent quality bonus

METHODOLOGY

To calculate the magnitude at which the ACA reduced the 2015 benchmark payment rates, we first calculated the aggregate monthly benchmark revenue payment using the pre-ACA rate (i.e., the county-specific benchmark revenue rates if the ACA never had been implemented). This was calculated by multiplying the September 2015 MA membership in each county by each county's PMPM pre-ACA benchmark payment rate (assuming a 1.00 risk score). We then summed across all counties to achieve a nationwide amount for September 2015.

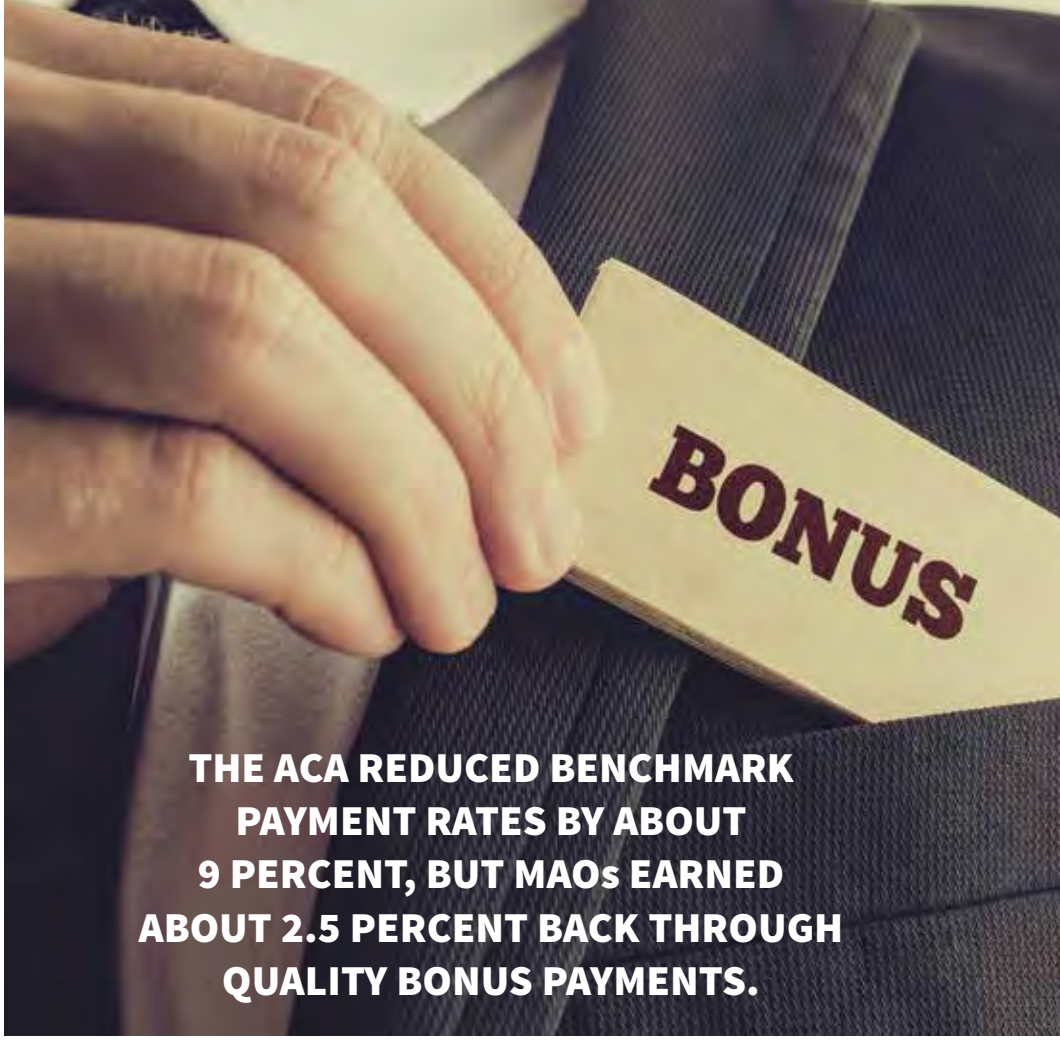
Next, we calculated the aggregate monthly benchmark revenue payment using the post-ACA rate with a 0 percent quality bonus. This approach is the same as above, but swaps the pre-ACA rate for the post-ACA 0 percent quality bonus rate in each county. This calculation indicates the nationwide aggregate post-ACA benchmark payment rate amount (at a 0 percent QBP) is 9.3 percent lower than the nationwide aggregate pre-ACA benchmark payment rate amount.

We then calculated a third value—the nationwide aggregate post-ACA benchmark payment rate amount, inclusive of the actual QBP each MAO earned. As mentioned earlier, CMS publishes benchmark payment rates at each of the QBP levels (0 percent, 3.5 percent and 5 percent) for each county. These published rates reflect the payment rate limits imposed by the ACA (which can lower, or even entirely eliminate, the QBP depending on the county).

By using published CMS data, we further stratified the MA membership by county and by QBP. That is, for each county, we identified the number of members enrolled in MAOs earning a 0 percent bonus, 3.5 percent bonus and 5 percent bonus. With the membership stratified in this format, we multiplied membership by the benchmark

payment rates at the three different bonus levels to yield the post-ACA benchmark payment rate inclusive of the QBPs earned. After summing across all counties, this nationwide amount was 2.5 percent higher than the previously calculated amount (i.e., the amount using the post-ACA benchmark payment rate with a 0 percent quality bonus). This indicates the QBP program is responsible for a 2.5 percent increase in benchmark payment rates.

CMS identifies new contracts in one of two ways: new contracts under new parent organizations or new contracts under existing parent organizations. The distinction is important, as new contracts under new parent organizations receive a 3.5 percent QBP, while new contracts under existing parent organizations receive the average star rating of the contract(s) under the parent company and, subsequently, the quality bonus associated with that average star rating. However, the CMS source file used for this analysis did not differentiate between the types of new contracts. Thus, for purposes of this analysis, we assume all new contracts received the 3.5 percent QBP.



THE ACA REDUCED BENCHMARK PAYMENT RATES BY ABOUT 9 PERCENT, BUT MAOs EARNED ABOUT 2.5 PERCENT BACK THROUGH QUALITY BONUS PAYMENTS.

CONCLUDING CAVEATS

In performing our analysis, we relied on data published by CMS. We have not audited or verified this data. If the underlying data is inaccurate or incomplete, the results of our analysis likewise may be inaccurate or incomplete.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Brad Piper and Julia Friedman are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this article. ■

Reference

[1] http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update

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