# Impact of Proposed Change in Medicare Advantage Payment

*by Brian Weible and Kirk L. Shanks*

The Centers for Medicare and Medicaid Services (CMS) currently bases Medicare Advantage payments on county benchmarks. The benchmarks are determined as the greatest of three values:

1. The national growth percentage in per capita Medicare spending (multiplied by previous year's per capita Medicare spending)
2. A minimum percentage increase from the prior year's payment rate of 2 percent
3. 100 percent of projected fee-for-service (FFS) Medicare costs, with direct medical costs excluded and including a VA/DOD adjustment

Congress has been debating a revision to Medicare Advantage payments including limiting payments to the Medicare Fee-For-Service (FFS) cost. Wakely has performed a county-specific impact study to the benchmark payment rates for each county nationally based on the FFS limitation criteria. This article includes results for Florida, California, Pennsylvania and New York. Results for additional states can be found at: *http://www.wakelyconsulting.com/research.htm*

The charts in Table 1 on pages 24 and 25 show the estimated reduction in the 2008 Benchmark per member per month if limited to the 2008 projected FFS costs.

The following table shows the percentage of counties and MA enrollees that would be affected by this change in each of the four sample states.

| State | % of Counties Affected* | % of MA Enrollees Affected* |
|---|---|---|
| California | 98% | 100% |
| Florida | 84% | 64% |
| New York | 94% | 63% |
| Pennsylvania | 97% | 98% |

*2007 Profile of Medicare Advantage, CMS

The maps in Table 2 on page 26 summarize the county specific impact from Table 1.

The legislation would significantly impact the total revenue Medicare Advantage plans receive. The impact of this legislation, if approved, would have two primary impacts in the marketplace:

1. Fewer managed care choices for beneficiaries in counties where the updated payment rate was below Medicare Advantage Plans' costs for offering the standard benefit with reasonable enhancements to attract members.
2. Less rich benefits for members in counties where Medicare Advantage plans would continue to operate.

While it can be argued (and is being argued) that the current payment calculations result in a windfall to Medicare Advantage plans, the primary results of the higher payment rates under the current methodology are increased choice and benefits to Medicare beneficiaries. Competition among Medicare Advantage plans and the structure of the Medicare Advantage bidding and enrollment process limit the relative profit that Medicare Advantage plans can realize.

Data sources and assumptions include –

1. 2008 Medicare Advantage Ratebook.
2. 2007 Fee-For-Service costs reported by CMS (normalized to a 1.000 risk score).
3. National Medicare growth percentage for 2007 to 2008 of 5.71percent as calculated by CMS.
4. Budget neutrality adjustment of 1.0169.

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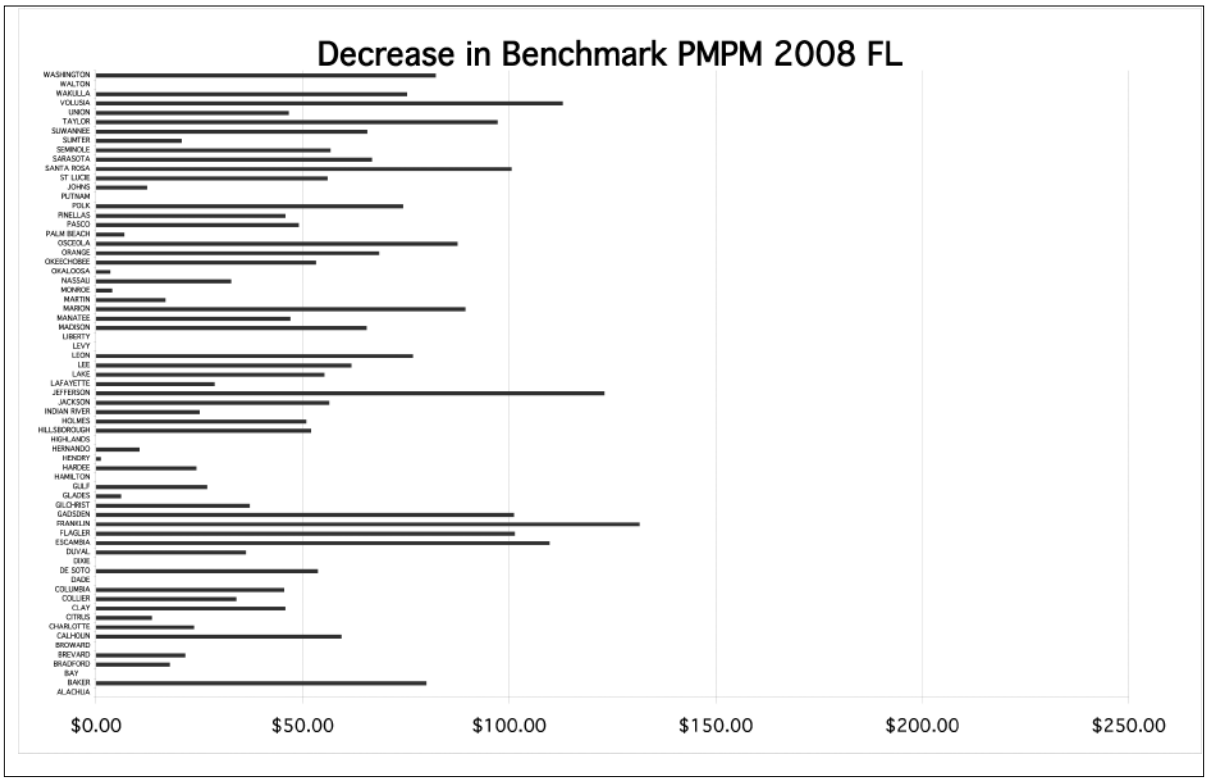
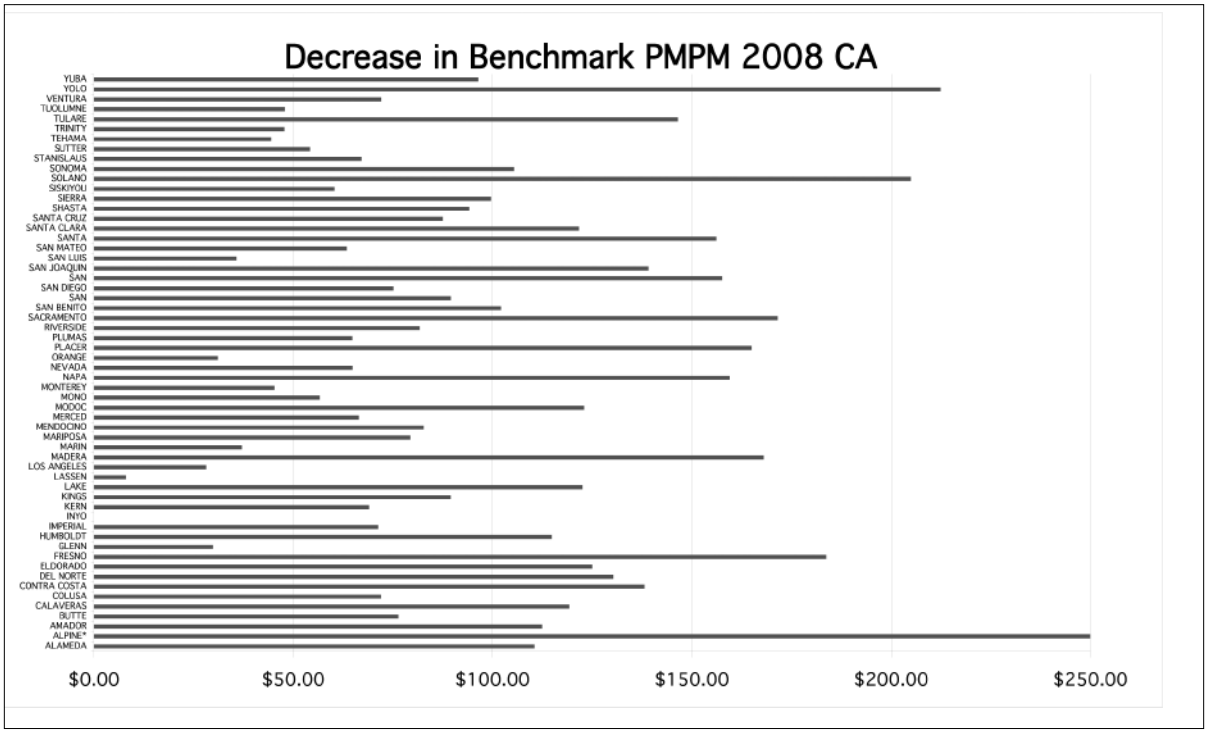
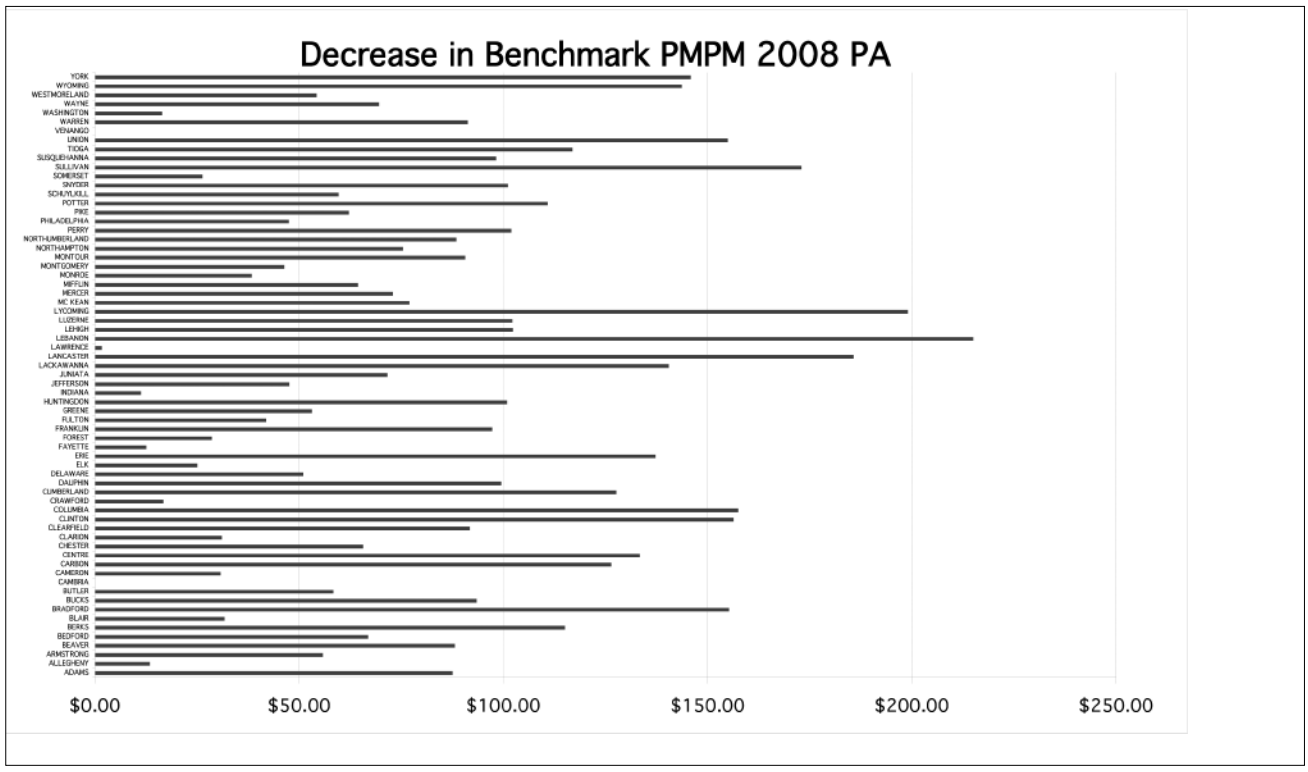
## Table 1

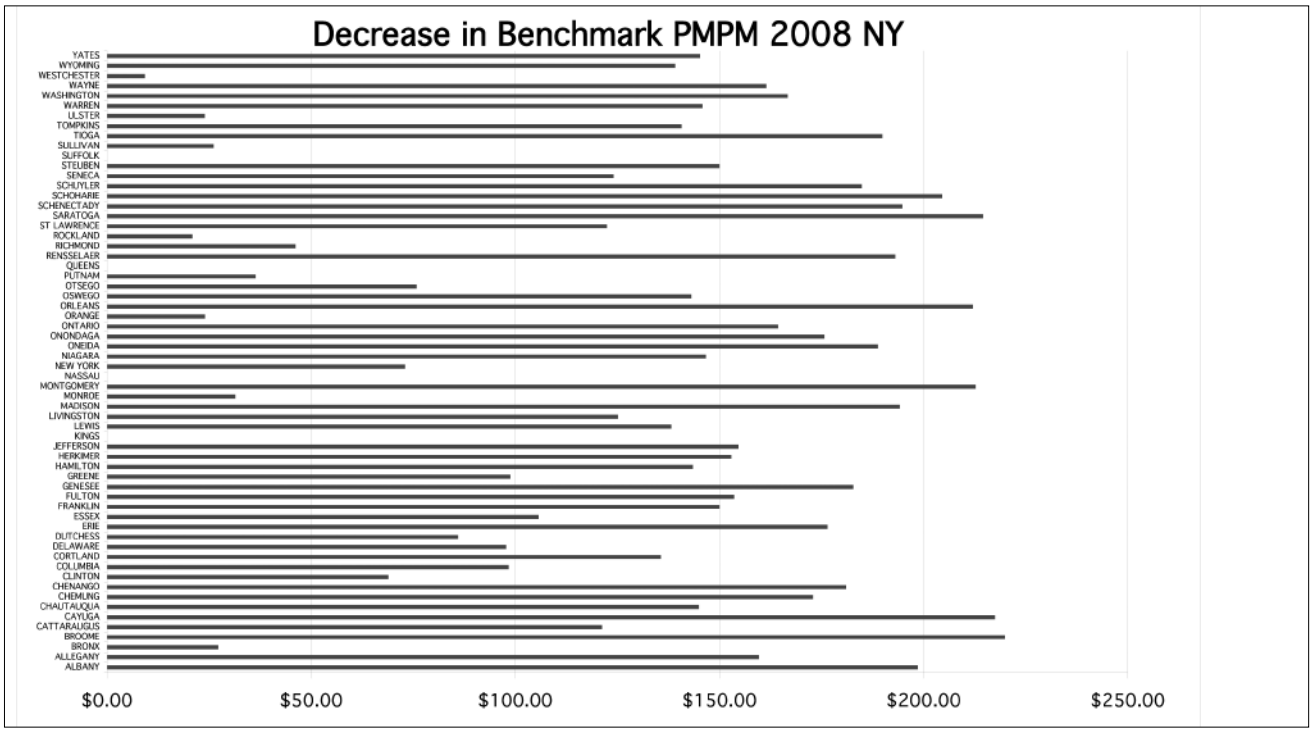



* Alpine County, California is an outlier with a Value of $507.23.

## Table 1 (Cont.)

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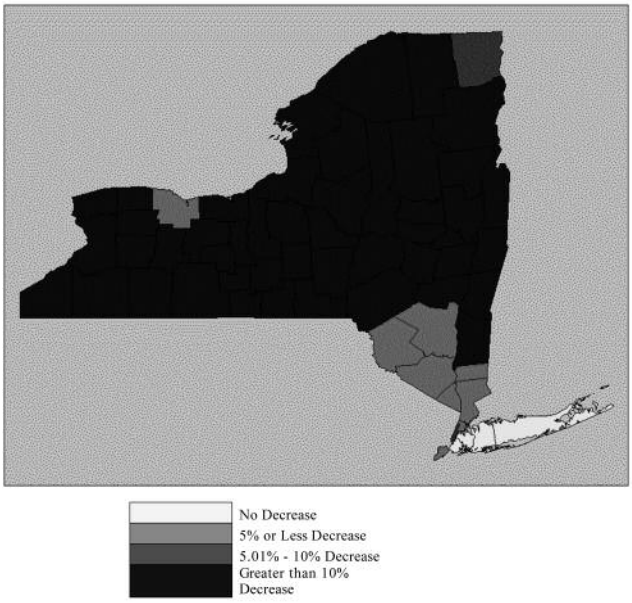
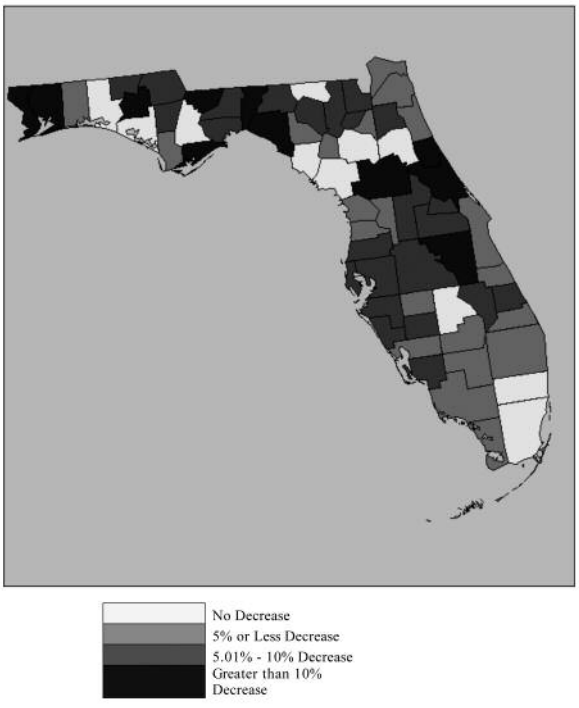
## Table 2

**Decrease in Benchmark PMPM 2008 for Pennsylvania**

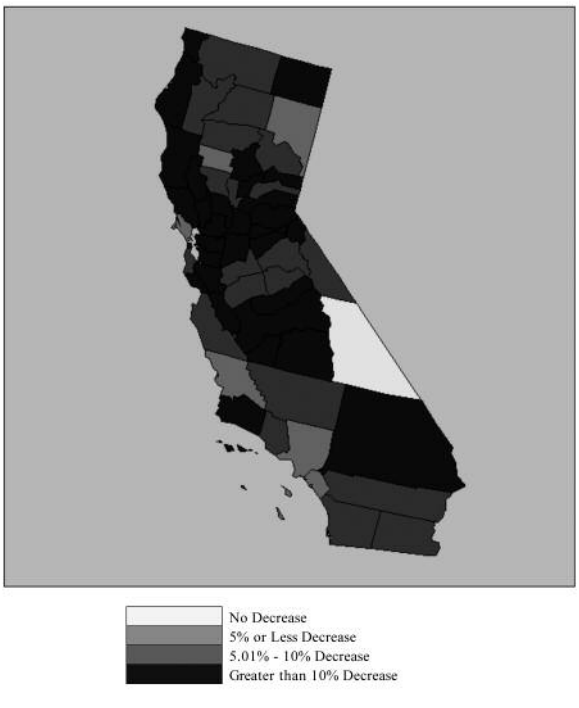

**Decrease in Benchmark PMPM 2008 for New York**




**Decrease in Benchmark PMPM 2008 for Florida**




**Decrease in Benchmark PMPM 2008 for California**



Premiums are waived for individuals who earn up to 150 percent FPL. The plan design for people earning less than 100 percent FPL was established by Chapter 58 and includes very little cost sharing. Plans for those earning more than 100 percent FPL include modest cost sharing at various levels based on plan choice.

Since passage of the Act, premiums have been set and enrollment has been significant. For the lowest cost plans that require an enrollee contribution (i.e., adults with income between 150 percent and 300 percent FPL), premiums vary by income and range from $35 to $105 per month. The enrollment for Commonwealth Care took place in waves. The first wave began with those individuals earning less than 100 percent FPL and started in October 2006. In January 2007, the program began enrolling adults with income between 100 percent and 300 percent FPL.

As of October 2007, there are approximately 76,000 people with income at or below 100 percent FPL enrolled in Commonwealth Care. In addition, after first charging a premium to individuals with income between 100 percent and 150 percent FPL, the Board decided to eliminate the $18 monthly premium for this group, effective July 1, 2007. As a result, enrollment in this category has increased significantly since July, and as of October 2007, there are an estimated 25,000 people enrolled in this second category. Finally, there are approximately 25,000 individuals enrolled who pay some premium.[2]

Enrollment has grown steadily in the greater than 100 percent FPL group. However, it is too early to tell if these individuals are newly insured or had been previously insured. It is also too early to tell if the costs associated with this new population will resemble either the Medicaid or commercial populations.

## Insurance Market Reforms

The Act merged the non-group and small group markets in July 2007. An actuarial study of the merging of the two insurance markets was completed in December 2006. This study estimated that premiums for the non-group market would decrease 15 percent and increase 1 percent to 1.5 percent for the small group market.[3] Along with merging the market, the Act revised the rating rules for the newly merged market. Limits to group size adjustment were expanded from [0.95 to 1.05] to [0.95 to 1.10]. In addition, the group size adjustment was excluded from the 2:1 rating band. Prior to the reform, the group size adjustment had to be within the 2:1 band. This allows carriers to surcharge groups of one to compensate for the increases associated with the small group market in the newly merged market.

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Many states today are considering merging their individual market with their small group market to allow for more affordable premiums in the individual market. While merging these market segments may have been appropriate for the state of Massachusetts, it may not be appropriate for other states. Some characteristics of the Massachusetts market that supported the merger are:

- The non-group market is less than 10 percent of the total merged market. Since the small group market is much larger in market share, it is able to absorb the higher costs of the non-group market without creating a rate shock for the small employer market. [4]
- Plan designs within the non-group and small group market are not vastly different.

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[2] Commonwealth Health Insurance Connector Authority, "Commonwealth Care Progress Report," Oct. 11, 2007.

[3] Gorman Actuarial, et al, "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets," Dec. 26, 2006.

[4] Ibid

According to an actuarial study, there was approximately a 7 percent difference in actuarial value between the two markets. The small group market's benefits were only slightly richer. [5]

- Rating rules within both markets were quite similar before the merger. Both populations were allowed to vary rates by age and geography. Neither market allowed for health underwriting. Both markets had guaranteed issue. However, the small employer market was allowed to vary rates by industry and group size. Both markets were subject to an overall 2:1 rating band.

- Unlike most states, sole proprietors could purchase insurance in the small group market prior to the market merger.
- The morbidity of the non-group market was estimated to be 30-40 percent higher than the small group market. This difference is significant, but if the morbidity differences were vast (i.e., two times greater), the small group market would have experienced much larger rate shocks. [6]
- The Massachusetts uninsured population is younger and wealthier than the average U.S. uninsured population. This may indicate that their morbidity is healthier than the insured population. An increase in the insured pool may have a positive impact on premium.

In the current market, individuals and small employers are offered the same products and their rates are based on a combined pool. It is still too early to tell if there has been a significant premium impact to both markets. Finally, it is unknown at this time if the morbidity of the uninsured will have a negative or positive impact on the insured population.

## Commonwealth Health Insurance Connector

The Commonwealth Health Insurance Connector (the Connector) was created as a new quasi-state authority which connects individuals and small businesses with health insurance products. Functions include allowing the portability of insurance as individuals move from job to job, permitting more than one employer to contribute to an employee's health insurance premium and facilitating the implementation of Section 125 plans for employers.

The Connector was established in the summer of 2006 and is responsible for the administration of the new subsidized program, Commonwealth Care as well as the non subsidized program, Commonwealth Choice. The products approved by the Connector are certified as products of high value and good quality. The Connector allows for one-stop shopping and tools to allow individuals to compare all products offered through the Connector. However, not all products are offered through the Connector and individuals and small businesses can still contract directly with insurers. The Connector is overseen by an appointed Board of 10 public and private representatives. The Board has one actuary that is appointed by the governor. Together, they have made decisions and have encountered issues which may impact the rating environment. Some of these actuarial issues are:

[5] Ibid

[6] Ibid

- Product Selection: Currently the Connector offers up to 42 different products representing six carriers. An individual can log on to the Web site, answer a few questions, and receive up to 42 rate quotes.[7] Along with rate quotes, the individual can compare benefits quite easily. There are significant advantages with this type of centralized information for the consumer. There are disadvantages as well. The rate variance between the lowest rate and highest is over 250 percent. This kind of choice can create an adverse selection issue among the carriers. The richest products with the highest rates may attract a less healthy risk pool.
- List Billing vs. Group Rating: The intent of the Act was to allow individuals as well as small employers to purchase insurance through the Connector. Current rating practice in Massachusetts allows for age rating. Generally, carriers calculate a composite age factor for a small employer which is then applied to a base rate by tier (Individual/Family). This age factor is subject to a 2:1 rating band. These adjusted rates are the same for all employees from the same employer. The Connector would like to allow employees of small employers to have greater choice in their health plan selection and have the premiums reflect the product choice and the individual employee's age. In other words, these rates would be "list billed." By varying the rating practice, i.e., Group Rating vs. List Bill Rating, a selection dynamic may occur. If groups are savvy enough, they will purchase insurance from the distribution system that results in the lowest overall rates for the employer (either direct from the carrier or through the Connector). However, under today's rating environment, if employers choose to purchase their insurance through the Connector, individual employees will receive the highest group size surcharge for groups of one. Due to this rating rule, the selection issue (Group Rating vs. List Bill Rating) may be mitigated.

**The Connector would like to allow employees of small employers to have greater choice in their health plan selection and have the premiums reflect the product choice and the individual employee's age.**

- Employer contribution: If the Connector allows employees to pick and choose products, it is difficult to calculate the up-front employer contribution. Current practice in the small group market allows an employer to know what their monthly obligation for health insurance premiums will be prior to enrollment. The employer can then develop a budget to determine the employer contribution. It is generally a fixed percentage, or fixed dollar amount. Under the Connector environment, if employees are allowed to choose their own products, total premium may not be known until after enrollment. However, the Connector is developing a mechanism by which employers will be able to select a "benchmark" plan, to which the employer will fix his/her contribution. While employees will be able to select a carrier of their choosing, the employer's contribution will be tied to the "benchmark" and the employer's budget can then be set prior to enrollment.
- Administrative Charge to Carriers: The Act provided the Connector $25 million to assist with start-up costs and operation in its first two-to-three years. The Connector will earn future revenue by charging an administrative fee that will be a percent of premium. It

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[7] Because some carriers are regional and their service area is limited, consumers have fewer than 42 options from which to choose.

is too soon to tell if this charge will increase overall premiums or replace existing administrative expense.

This list is a sample of the complex issues the Connector has encountered while implementing the Act. Due to the complexities, there has been a delay in enrolling contributing employers through the Connector.

Along with decisions regarding the above issues, the Connector and its Board were also charged with defining Minimum Creditable Coverage. This is the minimum level of benefits that each individual in Massachusetts must have to avoid penalties under the individual mandate. Some of the guidelines that have been established include requiring deductibles no greater than $2000/$4000 (Individual/Family), out of pocket maximums no greater than $5000/$10,000 and at least three preventive office visits for individuals (six for family).[8] While the Connector has made great strides in defining this level of coverage, they are still in the process of considering what constitutes a minimum level of pharmacy benefit. This process has been difficult, since there is a portion of the insured population today that does not have a pharmacy benefit. A pharmacy benefit requirement could result in a premium increase of approximately 15-18 percent for a portion of the currently insured population.[9] It is estimated that some 160,000 insured individuals do not have pharmacy coverage today.

## New Products

The Act expands the small group product offerings to the non-group population and also introduces a Young Adults Plan. Individuals without access to employer-sponsored health insurance, aged 19-26 are eligible for this plan, which is a low cost product specially designed for this age cohort. The Young Adults Plan can only be purchased through the Connector. The intent of the Young Adults Plan is to attract the younger uninsured population, which should help improve the risk pool.

As of October 2007, enrollment in the Young Adult Plan is approximately 1,700 members.[10] It is not known if these individuals were previously insured.

## Individual Responsibility

The Act requires that, as of July 1, 2007, all adult residents of the Commonwealth must obtain health insurance coverage. One of the goals of the "individual mandate" is to strengthen and stabilize the insured risk pool. In order to implement the individual mandate, the Connector developed a sliding "affordability" scale. This scale will be revised annually and is posted on the Connector's Web site. Individuals can easily determine whether the mandate applies to them based on their age and income. If there are no plans available that meet the affordability criteria, they will not be assessed a penalty.

Residents will need to confirm that they have health insurance coverage on their state income tax forms filed starting in 2008, for tax year 2007. Coverage will be verified through a database of insurance coverage for all individuals. The Massachusetts Department of Revenue will enforce this provision with financial penalties beginning with a loss of the personal exemption for tax year 2007 and then increasing in subsequent years up to as much as 50 percent of what an individual would have paid toward an affordable premium.

As of Oct. 1, 2007 there are 8,306 individuals who have purchased unsubsidized health insurance through the Connector. It is not clear if these individuals came from the current non-group population or if they were previously uninsured. Health plans are also enrolling individuals directly and have reported a net increase in enrollments since the start of 2007, but the number of newly insured is not yet known.

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[8] "956 CMR 5.00 Minimum Creditable Coverage," *http://www.mass.gov* (Oct. 28, 2007).

[9] Bob Carey, *"Prescription Drug Coverage – Alternative Plan Designs,"* Memo to the Commonwealth Connector Board of Directors, Oct. 5, 2007.

[10] "Commonwealth Health Insurance Connector Authority," Commonwealth Choice Progress Report, Oct. 11, 2007.

## Employer Responsibility

The Act established responsibilities for employers, including what is called the "Fair Share Contribution." This is the assessment on employers who are not currently offering health insurance to their employees. The surcharge is no more than $295 per full-time equivalent employee (FTE) per year and applies to employers with 11 or more FTEs. A state agency (Division of Health Care Finance and Policy) defined "fair and reasonable" through regulation as ***either:***

- 25 percent of full-time employees participate in the employer's group health plan ***or***
- An employer contribution of at least 33 percent toward a health plan premium for all full-time employees who are employed more than 90 days

In addition to the assessment, employers with 11 or more FTEs must also offer Section 125 plans to most of their employees, including part-timers and others not eligible for employer-sponsored insurance. These plans allow employees to purchase health insurance through payroll deduction on a pre-tax basis. The typical employer saves 7.65 percent on FICA and employees save approximately 41 percent of their premium payments due to reduced federal and state taxes, and lower FICA contributions. If employers do not make this available to their employees, the employer may be responsible for some portion of health care expenses incurred by their employees and their employees' dependents. This feature of the law is called the Free Rider surcharge. Imposition of the surcharge will be triggered when an employee or their dependents receives free care more than three times, or a company has five or more instances of employees or their dependents receiving free care in a year. The surcharge will range from 10 percent to 100 percent of the state's costs of "free care" services provided to the employees or their dependents, with the first $50,000 per employer excluded.

Although the deadline for employers to set up Section 125 plans was July 1, 2007, the collection of these surcharges begins with this hospital fiscal year beginning Oct. 1, 2007. There are no estimates on how much revenue this provision will generate for the state.

## Conclusion

Within a year, the state of Massachusetts implemented legislation that changed the landscape of the health insurance market. The challenges in implementation were many and there are still many to resolve. It will be interesting to see what kind of impact the legislation will ultimately have on the market and on the uninsured. It is not known how many of the approximately 135,000 members enrolled through the Commonwealth Connector were previously uninsured. It is also too soon to understand the risk profile of these people and the adequacy of current funding levels. The Connector and the Commonwealth of Massachusetts still have many challenges ahead. A year from now, we will only begin to understand the impact.

For purposes of discussing the pros and cons of each general approach, we use the following naming convention:

**Individual –** risk adjustment system where risk scores for individuals are calculated during the experience period. These risk scores follow beneficiaries through the system. The risk adjustment factor for a given MCO is the weighted average of the risk scores for the beneficiaries enrolled during the rating period.

**Aggregate –** risk adjustment system where the average risk score for enrollees during the experience period is assumed to represent the average risk of enrollees during the rating period.

The UMBC paper discusses the individual and aggregate approaches and generally favors the aggregate approach. The key advantage of the aggregate approach discussed in the paper is that the aggregate approach assigns a claims based risk score to new enrollees (although this risk score assignment is at the average risk score of other members).

It is important to lay out the approach each method typically uses for new and existing enrollees.

| Type of enrollee | Individual | Aggregate |
|---|---|---|
| New | Demographic enrollee | Experience period average |
| Existing enrollee | Individual Prospective | Experience period average |

Therefore, the pure individual approach typically uses a demographic factor for new enrollees, while the aggregate approach assigns a factor equal to the average risk factor for all existing enrollees.

Rather than discarding the individual approach altogether because of this issue with new enrollees, it is important to consider a potential fix and then make a choice as to which approach to use. For new enrollees, a risk factor either equal to the average of the existing enrollees, equal to a demographic factor, or something in between could be used. With this modified approach, the assumption as to the portion of the variation in risk due to systematic issues could be separately identified. The individual approach has the major advantage of recognizing shifts in enrollment, which is an especially important issue during the initial roll-out of a managed care program.

The UMBC paper also identifies the improved accuracy of concurrent models compared to prospective models and definitively links concurrent models with the aggregate approach and prospective models to the individual approach. The reason prospective risk adjustment models are linked to the individual approach is that the rating period represents a future period compared to the experience period. However, in the aggregate approach, the rating period still represents a future period. The individual approach is not inherently inconsistent with the assumption that MCOs systematically attract certain types of risk. The problem may lie in how states have historically implemented the individual approach. Modifications along the lines of the adjustment for new enrollees might address the concurrent versus prospective issue.

## Customization of Risk Weights

Customization of risk weights is often necessary for a state Medicaid risk adjustment system based on differences in the state program as compared to the population underlying the development of the risk adjustment system:

1. Benefit carve-outs
2. Data coding differences
3. Regional practice and patient utilization patterns
4. Regional differences in costs among specialties and care settings
5. Differences in the number of eligibility categories and sub-categories and the criteria for assigning individuals into those categories.
6. The need or desire to include individuals with limited exposure (demographic risk

weights would increase if risk models are customized to appropriately reflect the risk for these individuals).

Birth and delivery "kick" payments are examples of benefit package carve-outs that many states employ and which fundamentally affect the risk adjustment system. It is not appropriate to capture risk differences due to pregnancy or newborn status and then make a separate payment on that basis. Mental health benefit and pharmacy benefit carve-outs also require customization of the risk weights. The calibration step should exclude direct mental health or pharmacy benefit costs. However, because the presence of mental health conditions has been shown to exacerbate some medical conditions, mental health services should be left in the data for purposes of assigning members into their condition categories.

## Criteria for Including Individuals

A decision on which specific individuals to include in the risk adjustment system needs to be made in addition to which eligibility categories to include. The criteria should include duration criteria and be consistent with the rate development and MCO contracts. Many states require at least six months of eligibility exposure in the experience period to be included in the risk adjustment calculations. Pharmacy based models require fewer months of eligibility to provide meaningful predictions (because of the frequency of pharmacy utilization and the faster completion).

All else being equal and without customization of risk weights, risk scores will decrease as the number of months of data decreases from the 12 month standard. Ideally, different risk weights should be developed which reflect the amount of experience each individual has in the system. The demographic risk weights will increase as the number of experience period months decrease, and the condition risk weights may increase or decrease. Alternatively, it is important to analyze the average number of months of experience across sub-populations to ensure that one MCO does not have a higher or lower average number of months of experience per enrollee than other MCOs and/or the state.

## Phase-in and Risk Corridors

The purpose of phase-in and risk corridor provisions is to moderate the impact of the implementation of risk adjustment, both as MCOs refine data and understand the impact, but also as the state and their technical support staff are able to refine the risk adjustment process.

Phase-in refers to the portion of differences in risk adjustment which are applied to the MCO's capitation rate. For example, if the phase-in for a particular year were 80 percent and the relative risk adjustment factor for a particular MCO was 0.95, then the phase-in risk adjustment factor for that MCO would be 0.99 [0.95 x 0.80 + 0.05 x 1.00].

Risk corridors are often used in the initial roll-out of a Medicaid risk adjustment system to ensure that a particular MCO does not experience too large of an upward or downward adjustment to revenue. For example, a risk corridor of +/- 5 percent would mean that a risk adjustment factor of 0.92 would be increased to 0.95, and a risk adjustment factor of 1.10 would be reduced to 1.05.

It is important to recognize that risk corridors could cause payments to be asymmetric, and therefore could cause the overall risk adjustment system to not be budget neutral.

## Other Considerations

There are a number of other considerations that need to be made during implementation of a risk adjustment system, including the following:

1. **Budget neutrality** – It is important that the state does not create an adjustment that changes the overall payment, since risk adjustment is intended to re-distribute funds according to the relative risk being covered

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by the MCOs and state. Phase-in and risk corridors that vary according to how long an MCO has been active have the potential to adversely affect this neutrality.

2. **Timing of updates** – A survey conducted as part of the UMBC survey determined that 70 percent of states updated risk scores annually, 20 percent updated semi-annually, and 10 percent updated quarterly. The characteristics of the population and risk adjustment system should be reviewed to determine the frequency of risk score updates.
3. **Data testing and validation** – Data quality drives the risk adjustment models, and resulting adjustments. Therefore, it is important to have robust data testing and validation process. The UMBC paper outlines a number of methods to test and validate the data going into the risk adjustment system. However, probably no issue is more important than the comparability and quality of encounter data, especially where capitated provider contracts exist. If the state does not intend to penalize MCOs for incomplete encounter data, then adjustments to the standard risk adjustment calculations need to be made and sufficient time and education needs to be provided so that MCOs can improve their data quality.
4. **HIPAA considerations and controls** – Risk adjustment factors inherently contain information on the health of each individual and should be considered Personal Health Information and should be protected as such.
5. **Newborns** – Several states have begun to introduce risk adjustment systems for the TANF populations. However, due to the unique nature of their expenditures and limited months of eligibility in a fiscal year, modifications to the risk adjustment systems may need to be implemented. For example, the six month minimum enrollment requirement should be removed for newborns. Additionally, a prospective payment system would not capture newborn costs. The newborn costs would need to be paid through a concurrent system or through a newborn "kick" payment.

## Conclusion

Risk adjustment is an important tool to align incentives between health plans and state Medicaid managed care programs, as well as reward stakeholders who perform well. It is important to recognize and address differences in how the models were built and how each model may be implemented. Some of these differences have important implications. Due to the financial implications associated with the risk adjustment system implementation methodologies, all stakeholders need to work collaboratively to openly share and discuss data and implementation decisions.