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Medicare Advantage—Future Benchmarks

by Daniel Bailey

Editor's note: Some of the material included in this article previously appeared in the author's presentation at the 2007 SOA Annual Meeting in Washington, D.C. last October.

Here in early January 2008, as membership in Medicare Advantage (MA) soars to a new all-time high, small and large organizations alike wait with apprehensive anticipation to learn more about the future funding of MA. Many companies that offer MA Part C would like to better understand what the future holds in the way of county-specific payment rates or "benchmarks" for 2009 and beyond. The 2009 benchmarks will be officially released on April 2, 2008. CMS will issue their annual 45-day notice in mid-February, at which time they provide a strong preliminary indication of where final payment rates will land. By the time this article is published, the 2009 rates will be known and the discussions concerning MA funding in 2010 and beyond should have progressed considerably. In the meantime, via national conference call on Dec. 17, 2007, CMS announced that it would propose to rebase the county-specific Medicare FFS costs. This would introduce more variability into the 2009 county-specific changes in margin than in 2008. There are other variables that affect the revenue level of MA plans, such as risk-adjustment, but in this article I will confine the subject primarily to MA payment rates and MedPAC's stated intent to make them equal to FFS Medicare costs in each county.

The logic behind county payment rates has become increasingly complicated and difficult for carriers to follow due to changes in the minimum funding level for each county brought on by legislation over the past decade. As a result of the Medicare Modernization Act (MMA) passed in December 2003, however, MA carriers have enjoyed significantly higher funding. Consequently, more private carriers have once again become involved, especially in Private Fee for Service (PFFS) , a relatively new MA product enabled by the BBA in 1997. These carriers are the private-sector companies that participate in Medicare Advantage—elsewhere they are also referred to as insurers, MAOs (Medicare Advantage Organizations), or plans.

CMS provides annually updated MA benchmarks as well as the corresponding county-specific Medicare FFS (Fee for Service) costs for each of the 3,200+ counties of the United States, Puerto Rico, Guam, and the Virgin Islands. The difference between the two is typically referred to as "lift" or margin, and it too varies by county. In fact, margins have been substantial enough to encourage even some less experienced players without networks to enter the MA market. Now that many carriers have returned to the managed Medicare market and other new carriers have joined, they all want to know how future MA funding will affect their future.

About half of the MA membership growth over the past few years has been in PFFS. The other half has been mostly in HMO plans, which are still the long-standing primary benefit form of managed Medicare for reasons of efficient delivery. In some counties, the difference between the MA benchmark and the FFS cost of traditional A/B Medicare is negligible; in others, the benchmark may be substantially greater than the FFS cost. According to MedPAC, the congressional advisory council on the funding of Medicare, CMS pays MAOs 12 percent more to

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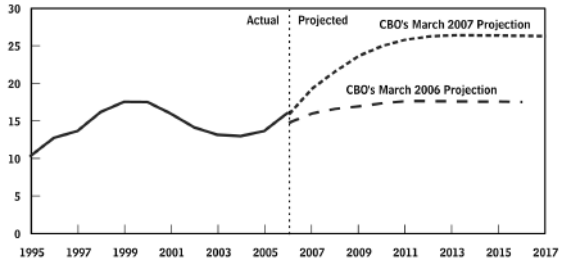
deliver MA than CMS would pay if the same members had remained in traditional A/B FFS Medicare. This breaks down into 10 percent more for HMO and 19 percent for PFFS. That disparity has attracted attention because a health plan's "efficiency" helps to drive that difference. From 2000 to 2003, MA enrollment had declined by about one- fourth. Post-MMA, the enrollment has risen to a record level. The Congressional Budget Office has projected continued growth, but at a decreasing rate in years to come:

Figure 1.

Enrollment in Medicare Advantage as a Percentage of Total Enrollment in Medicare, 1995 to 2017

(Percentage of Part A enrollment)



Source: Congressional Budget Office based on data from the Centers for Medicare & Medicaid Services.

Note: The figure shows fiscal year averages calculated as a percentage of Part A enrollment.

All else equal, the more margin that is embedded in the MA benchmark, the more benefits an MAO can offer to its members relative to traditional Medicare. Even without medical management savings, there are many counties in which an MAO can profitably offer an attractive zero premium PFFS plan with a richer package of benefits than traditional Medicare. It goes without saying that the administrative costs of an MAO per member are greater than those of the government. Even so, there is enough margin in some county rates to overcome this hurdle. And, for those MAOs that can deliver medical management savings, there is opportunity to profitably offer MA in many counties. Later in this article, we will return to the concept of "efficiency." For now, let's say a private plan is more efficient than Medicare, this means that it can manage the claims costs associated with the standard package of Medicare A/B benefits and all its administrative cost to a lower level than Medicare can. PFFS is typically a less efficient delivery mechanism than HMO or PPO, and is closer to traditional indemnity than a PPO or HMO.

Over the past several years, MedPAC has expressed concern over the post-MMA level of MA funding. When their concern initially surfaced, it was difficult to conduct a fair comparison between the per member cost of MA vs. traditional Medicare. They could not draw a firm conclusion without actual member risk score data. In preparing their June 2007 report, however, MedPAC had obtained the necessary risk score data and completed their analysis. Their two-fold conclusion was clear—the government pays more per member under MA than Medicare, and this should be addressed by Congress. Industry proponents of MA are quick to point out that MA members generally get more benefits under MA than they would or do under traditional Medicare. That is, MA is like traditional Medicare plus a free or low-cost supplemental benefit plan. Many of the current MA members have limited incomes, moreover, and cannot otherwise afford to buy a supplemental benefit plan. Also, if an MA plan is not entirely free (in the form of a "zero premium" plan), then the MA member premium amount is usually low and attractive, relative to a Medicare Supplement premium. If not, the plan could not survive in the competitive MA market.

The fact that the 119 percent PFFS benchmark average is higher than the 110 percent HMO reflects the fact that the take-up rate for PFFS tends to be higher in those counties where there is higher margin. After all, these are the counties in which the additional benefits of MA seem richest in comparison with traditional Medicare. HMOs, on the other hand, are located where carriers have their networks, and that tends to be in urban more so than rural locations. For this reason, PFFS has come to serve Medicare beneficiaries in rural counties that previously had no MA plans offered. Many of the counties with large margins are rural "floor" counties, and their

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"Actuaries will play an important role. Our profession will be called upon to help solve a significant and complex social problem..."

payment rates were on average about 134 percent of FFS Medicare; this compares with roughly 121 percent for urban floor counties.

The MedPAC Report

In their June 2007 report to Congress, MedPAC proposed that CMS reduce MA benchmarks to the same level as FFS cost in each county. This recommendation is of enormous import and will have a dramatic effect on the managed Medicare market. MedPAC suggested four different methods that CMS might employ. Since MA rates are updated annually, there are a few variables that can be used as adjustment levers to achieve this end:

- Time—over how many years should margins be reduced to 0?
- Rate of decrease—constant, accelerating, decelerating?
- Which counties are affected when—counties with highest margins first, all counties by the same amount, all counties by same percentage, etc.?

MedPAC suggested four possible methods to reduce rates:

1. Freeze Benchmarks where they are now.
2. Cap Benchmarks at some maximum percentage of FFS Cost.
3. Phase in a blend of MA Benchmark with FFS Cost.
4. Competitive Bidding.

The proposed endgame is the same for each of the four methods—MA payment rates that equal the Medicare FFS costs in each county.

1. Under Method 1, medical trend would cause the FFS cost level to rise until it is as great as the frozen MA rate. The margins in counties whose MA rates are already close to FFS cost would be affected first and most in terms of margin reductions expressed as a percentage of FFS cost. Those counties that have the highest margins could still have higher MA rates than FFS cost for many years. You could think of this as the "Highest Margins Stay Highest" approach.

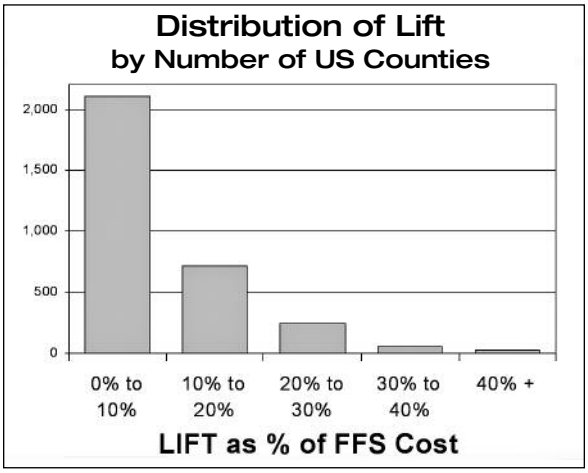
2. Under Method 2, all counties whose MA rates are in excess of the cap in year one, say 130 percent of the FFS cost, would be cut to 130 percent. All the counties below 130 percent remain untouched. Assuming linear decreases to the maximum over a four-year period, under method 2 the caps might decrease systematically, such as 130 percent in year one, 120 percent in year two, 110 percent, and 100 percent. Think of this as the "Highest Margins Reduced First" approach.

3. Method 3 would implement the margin cuts by blending MA Rate with FFS cost over time, such as 75/25, 50/50, 25/75, and 0/100 over four years. According to this formula, a county at 140 percent in year zero goes to 130 percent in year one, 120 percent in year two, 110 percent, and 100 percent.

4. The fourth approach is harder to envision and explain. RPPO and PD rates are set with competitive bidding, so this could involve a blend of bids and MA rates, which seems counterintuitive—the plans with the lowest bids that deliver care most efficiently would seem to be reduced more and thus penalized for it.

As MA rates move to the FFS level, the effects of reduction will play out differently by geography—some states affected more than others. For example, states with the highest margins in their county rates will be affected more. In order to visualize the aftermath of reductions in margins, it is helpful to look at the

distribution below of the number of counties by margin percentage:



- Reconsider method 1 first. The distribution is right-skew and the majority of counties have margins less than 10 percent of FFS cost. If medical trend is five percent in year one, then the counties with margin greater than five percent will decrease by that percentage; and the counties that have less than five percent margin in year zero will have no margin in year one. At the other extreme, a county with a margin of 50 percent in year zero will go to about 45 percent.

- Method 2 starts with the counties that have the greatest margin and reduces them to some maximum level. Using the example above of 130 percent, 120 percent, 110 percent, and 100 percent, all the bars to the right of the annual maximum will move to the left and stack on top of that bar. If the year one cap is a maximum of 130 percent, then the two bars for 30 percent to 40 percent and 40 percent + will stack on top of the 20 percent to 30 percent bar with a probability mass at 130 percent. In year two, there will be two bars only, etc. According to this method, it seems that most of the counties will not be affected until year four. In fact, the counties with the greatest margins tend to be rural counties with relatively low population, so it is important to also consider the margin distribution based on the number of Medicare eligibles.

- In order to understand method 3, consider two different counties: Country A has margin of 10 percent and Country B has 60 percent. A 75/25 blend in year one reduces their margins to 7.5 percent and 45 percent respectively. With each passing year, the right-most bars become shorter and the left-most bars get taller.

- Method 4 is somewhat similar to method 3, but instead of blending the county-specific benchmark with 100 percent of FFS cost, I suspect that the benchmark would be blended with the average bid in that county. Bids are typically less than benchmarks—this is one of the favorable results of managed competition. A simplified example (assuming an average risk score of 1.0) helps explain how this would work for two different carriers in the same county with a 25 percent margin in year zero. Both carriers' plans are assumed to be zero premium to the members:

  a. The first carrier is an HMO that can deliver the exact same MA services as

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A/B Medicare using Medicare reimbursement to providers and 20 percent utilization savings due to effective coordination of care. Consequently it generates savings and a rebate of $120 (just a guess). It gives the rebate back to its members in the form of a richer MA benefit plan than the traditional A/B Medicare plan—an MA plan with lower member cost-sharing (than traditional A/B) and a few additional benefits such as vision, preventive dental, and a standard Part D drug plan.

b. The second carrier bids a PFFS plan that is identical to A/B, and the second carrier delivers no utilization savings. After it incorporates the cost of administration and profit into its bid, the second plan has no rebate. Consequently, the second carrier's actual benefit plan is far less rich than the first's. Carrier two has standard Medicare cost-sharing, and no standard drug, etc.

Carrier one has a bid that is $160 less than the benchmark; carrier two's bid equals the benchmark. It seems that blending the benchmark with the HMO plan's bid drives the adjusted benchmark (per method 4) to a lower level than would occur if blending the benchmark with the second carrier's bid. This is why, as stated above, this approach seems counter-intuitive.

The last point to cover in this article is the relative "efficiency" of MA HMO vs. PFFS. The following table shows that HMO is more efficient than traditional Medicare, but PFFS is not:

MedPAC on PFFS in MA—Efficiency

As % of FFS Cost	ALL	HMO	PFFS
BENCHMARK	116%	115%	122%
BID + REBATE	112%	110%	119%
BID ONLY	99%	97%	109%
REBATE	13%	13%	10%

Despite having to pay commissions, higher administrative expenses, and a profit charge, private MA HMO plans still manage to provide a benefit plan equivalent to A/B Medicare for a cost that is three percent less on average than the government pays to deliver the same. Note, however, that the same is not true for PFFS—after all the claims and expenses are paid, PFFS plans spend 10 percent more than the government to deliver the same level of benefit as Medicare A/B. Typically, HMO, PPO, and PFFS plans provide a richer benefit than traditional Medicare. Some of this extra benefit may be subsidized, at least in part, by the margin in the payment rate; based on the efficiency data, this occurs more for PFFS than HMO & PPO.

Should 100 percent of FFS cost be the upper limit of MA benchmarks? Benchmarks levels have risen and fallen with changes in political and market conditions over time. The debate may be over, however, and if the reduction of benchmarks to 100 percent of FFS cost is a foregone political conclusion, then it seems to me that MedPAC will need to formulate a margin reduction strategy that 1) does not disproportionately penalize more efficient plans, and 2) maintains the other goals and objectives of the MA program, such as offering choice to Medicare beneficiaries in urban and rural locations alike.

As Congress decides how to contain increasing Medicare cost and, more specifically, restrain MA funding levels via margin reductions, the issue of equity will be a critical consideration. Actuaries will play an important role. Our profession will be called upon to help solve a significant and complex social problem that will require advanced quantitative capabilities. We are well-equipped to meet this professional challenge.