SOCIETY OF ACTUARIES

Article from:

Health Watch

May 2012 – Issue 69

SOCIETY OF ACTUARIES Health Section

ISSUE 69 MAY 2012

Health Watch

The Medicare Advantage 5-Star Rating Program and Its Implications for Actuaries

By Gabriela Dieguez, Brad Piper, and Adrian Clark

The introduction of a five-star quality rating system by the Affordable Care Act (ACA) will lead to important changes in the Medicare Advantage (MA) market. Starting in 2012, the Centers for Medicare and Medicaid Services (CMS) payments to MA organizations are linked to their quality ratings. The financial implications are substantial, and ignoring them is not a wise long term strategy for any MA organization. Actuaries can help organizations understand and assess the financial implications and evaluate strategies to remain profitable.

Determining Medicare Advantage Revenue

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established the Medicare Advantage (MA) program. MA organizations contract with CMS to provide their Medicare-eligible enrollees with benefits that are at least as rich as traditional Medicare Parts A and B (commonly referred to as "Part C"). MA organizations may also offer prescription drug benefits (Part D) alone or in combination with medical benefits. In return, they receive revenue from CMS to fund their benefit offerings.

MA organizations must submit an annual bid to CMS for each benefit plan offered. The bid is a projection of the plan's cost to provide Medicare-covered benefits (including adminis-

CONTINUED ON **PAGE 6**

trative expenses and profit) to its Medicare-eligible members. Bids reflect a population's geography and its relative health status (commonly referred to as a "risk score"). Bid amounts are compared to the CMS-published benchmark payment rate (adjusted for area and risk score) to determine CMS revenue for the plan.

Every year, CMS determines the benchmark payment rate for each county based on historical fee-for-service (FFS) costs. The benchmark payment rate is the maximum that CMS will pay an organization to provide traditional Medicare benefits in a given county. Plans that span multiple counties receive the membership-weighted average benchmark payment rate. CMS uses a risk adjustment model to account for the varied health status of the Medicare Advantage enrollees. The plan-wide benchmark payment rate is therefore multiplied by the plan's expected risk score to determine the maximum payment rate from CMS for each plan.

The CMS revenue that a plan receives depends on the bid and MA benchmark payment rate amounts. Plans that bid under the benchmark (which is what commonly occurs) also receive a portion of the difference ("savings") as a "rebate" from CMS. This rebate is not profit—it must be used to provide additional benefits, reduce member cost sharing, or reduce member premiums, all of which create competitive advantages. If the value of the benefits offered exceeds the CMS revenue, the MA plan charges the difference to members as a premium.

Figure 1
Quality Bonus Payment by Star Rating

YEAR	2.5	3.0	3.5	4.0	4.5	5.0
2012	0.0%	3.0%	3.5%	4.0%	4.0%	5.0%
2013	0.0%	3.0%	3.5%	4.0%	4.0%	5.0%
2014	0.0%	3.0%	3.5%	5.0%	5.0%	5.0%
2015+	0.0%	0.0%	0.0%	5.0%	5.0%	5.0%

Figure 2
Rebate Percentage by Star Rating

YEAR	2.5	3.0	3.5	4.0	4.5	5.0
2012	66.7%	66.7%	71.7%	71.7%	73.3%	73.3%
2013	58.3%	58.3%	68.3%	68.3%	71.7%	71.7%
2014+	50.0%	50.0%	65.0%	65.0%	70.0%	70.0%

How does the five-star rating system impact CMS revenue?

As part of the ACA, CMS introduced a quality bonus payment (QBP) for MA organizations. Under this initiative, each MA contract receives a quality star rating from 1 to 5, at half-star increments. All plans (i.e., benefit offerings) under a single MA contract receive that contract's quality star rating. MA organizations that operate different contracts have separate quality ratings for each contract. For example, an organization that has three plans under one contract will have only one rating.

Plans receive a bonus payment based on their quality star rating equal to a percentage increase in the plan-wide benchmark payment rate[1]. This bonus payment increases the CMS revenue that a plan will receive. The bonus payment percentages by star rating are shown in the table in Figure 1.

The percentage of the savings a plan receives (i.e., the rebate) also depends on the contract's quality rating. The bonus payment and rebate percentage are combined in the bid process to determine the expected CMS revenue for each MA plan. The rebate percentages by star rating are shown in the table in Figure 2.

Special rules apply to low-enrollment and new contracts for assigning a quality star rating. In 2012, low-enrollment contracts receive a 3-star bonus payment and a 4.5-star rating for rebate purposes (in 2013, the rebate star rating is reduced to 3.5). New contracts under existing MA organizations are rated using the member-weighted average quality star rating across all of the organization's rated contracts. New contracts under new MA organizations receive a 3-star rating for bonus payment and a 3.5-star rating for rebate percentage in 2013.

How are CMS star ratings calculated?

The star rating system impacts CMS revenue only for plans offering Part C benefits, whether medical

only (MA-only plans) or medical and prescription drugs combined (MA-PD plans). The star ratings do not impact Part D revenue.

The QBP rating is the final score that impacts an organizations' revenue, and is equal to the overall rating for existing contracts that don't have low enrollment (see above rules for low-enrollment or new contracts). The overall rating, in turn, is calculated as the weighted average of the Part C and Part D summary ratings, plus an "i-Factor." The i-Factor is a sophisticated statistic designed to reward contracts with both high and stable relative performance. The i-Factor is calculated as an add-on to the summary and overall ratings based on a combination of the mean and variance of a contract's stars across measures.

For an MA-only contract, the Part C summary rating is also the overall rating. Likewise, the Part D summary rating is the overall rating for a contract with only stand-alone prescription drug plans (PDP). Note, however, the Part D summary rating currently does not impact the revenue of a PDP plan. The MA-PD overall rating is calculated as the weighted average of the individual Part C and D measures. In 2012, there were a total of 53 individual measures, described at a high level as follows.

For the 2012 ratings, the Part C summary rating consists of 36 individual measures, which are categorized into five separate domains. The domains are as follows:

1. Staying Healthy: Screening, Tests and Vaccines

2. Managing Chronic (Long-Term) Conditions

3. Ratings of Plan Responsiveness and Care

4. Member Complaints, Problems Getting Services and Choosing to Leave the Plan

5. Health Plan Customer Service

The 2012 Part D summary rating consists of 17 individual measures for a Medicare Advantage Prescription Drug (MAPD) plan and the same 17

measures for a PDP, which are categorized into four separate domains. The domains are as follows:

1. Drug Plan Customer Service

2. Member Complaints, Problems Getting Services, and Choosing to Leave the Plan

3. Member Experience with Drug Plan

4. Drug Pricing and Patient Safety

Plan measures cover five broad categories: outcomes, intermediate outcomes, patient experience, access, and process measures. Beginning with the 2012 star ratings (which will be used to determine the QBP rating for the 2013 bids), outcomes and intermediate outcomes received three times the weight as process measures. Patient experience and access measures are weighted 1.5 times as much as process measures. Thus, some categories have more influence on the final average score than other categories.

Not all contracts will receive a rating for every measure. For example, contracts with low enroll-

CONTINUED ON **PAGE 8**

The star ratings and QBPs will have a substantial impact to the Medicare Advantage market.

ment or inadequate data will not be rated on some measures. Also, rounding rules can play a role in a contract's final overall rating.

On Dec. 20, 2011, CMS published proposed changes to the 2013 plan rating methodology that would impact the 2014 bids. Final guidance is anticipated to be published in the final 2013 call letter, expected by April 2, 2012. An interesting proposed change in the announcement pertains to a new proposed measure of "statistically significant" quality improvement. This new measure would reward plans that show gains in annual star ratings. CMS also indicated that they are considering how this measure would be applied to plans that are already achieving high scores across most measures.

Implications for actuaries

The star ratings and QBPs will have a substantial impact to the Medicare Advantage market. The changes described in this article are already impacting the revenue received by MA organizations, and will continue to do so. Actuaries are in a unique position to analyze and communicate the impact of these changes. In particular, actuaries involved with MA products should consider the following:

- *You can't manage what you can't measure.*

It seems sensible that the first step to improving a contract's star rating is to first understand which components are driving the result.

- *Not everyone can be better than average.*

Because many of the cut points for the component measures are based on distributions of plans' actual experience, even if the measure stays the same from one year to the next, simply improving your organizations performance may not translate into a higher star rating. While improvement without payoff can be frustrating, this dynamic also underscores the importance of simply improving.

- *Financial modeling can help assess the impact on the MA product's profitability.*

A revenue and expense projection for the next three to five years under different star rating scenarios can illustrate the impact of the QBP system on the product's profitability. Sensitivity testing around the star rating assumption can indicate what star rating level needs to be achieved, and by when, to operate profitably. This analysis would also illustrate the consequences to an organization of not achieving a target quality score: besides reduced profits, reduced CMS revenues generally mean leaner benefits or higher member premiums, which can harm competitiveness.

Financial modeling should include separate trends for revenue and benefit costs, as the interrelation of these can have a significant impact on the results, especially if CMS revenue does not increase as fast as benefit expenses. Results from this modeling can also be used to inform cost/benefit analysis for proposed initiatives aimed at improving a contract's star rating.

- *The benefits of increasing a contract's star rating are not linear, and generally depend on the current star rating and the level of improvement.*

Improvements in the quality star rating result in additional quality bonus payments, but the mag-

nitude of the impact varies. As shown in Figure 1 for 2013 there is only a 0.5 percent increase to the QBP when moving from 3.5 to 4 stars (from 3.5 percent to 4 percent bonus). When moving from 4.5 to 5 stars, however, there is a 1 percent increase to the QBP (from 4 percent to 5 percent). There is no change in the QBP when the star rating increases from 4 to 4.5 (both have a 4 percent bonus).

Improvements in the quality star rating also increase the rebate percentage, resulting in stepwise increases in rebate revenue. However, this portion can be relatively small, because the rebate percentage only applies to the portion of the Part C benchmark that exceeds the bid. For a plan with a bid that is within a few percentage points of the benchmark, moving from 3.5 stars to 4 stars in 2013 will likely have a greater impact (a 0.5 percent QBP increase, from 3.5 percent to 4 percent, but a 0 percent increase in rebate percentage) than moving from 4 stars to 4.5 stars (a 0 percent QBP increase, but a 3⅓ percent increase to the rebate percentage, from 68⅓ percent to 71⅔ percent).

- *Five-star plans can benefit from year-round enrollment*

It may appear that, by 2014, there is little benefit to achieving a 5-star rating, because the quality bonus payment (Figure 1) is the same for all star ratings at or above 4.0, and the rebate differences (Figure 2) are relatively minimal. However, CMS awards organizations achieving a 5-star rating with the additional benefit of year-round enrollment.

Typically, members elect their Medicare Advantage plan during the annual enrollment period (mid-October through early December). However, members enrolled in a 4.5-star plan or less can disenroll from their current plan and join a 5-star plan in the same service area throughout the year, due to a special enrollment period created for 5-star plans. This important "reward" could be a valuable tool for organizations looking to grow their membership. By analyzing the cost it would take to achieve a 5-star rating and the potential membership gains that are possible, actuaries can assist an organization in determining if it is advantageous to put resources toward achieving the 5-star rating.

- *A small increase in revenue can be a significant advantage in a competitive market.*

In certain competitive markets, achieving an extra 1 percent of revenue over competitor organizations may be just enough to offer an extra benefit or lower premium to make an MA product more attractive.

- *The lag between experience, reporting, and quality rating has additional implications for new and existing plans.*

Star ratings for a given plan year are based on relatively lagged data. For example, star ratings for the 2013 plan year were released in October 2011, and were based on data from 2010 and 2011. This long data lag means that existing plans must work diligently now to improve their star rating, which will impact the 2014 plan year at the earliest.

Low-enrollment plans and new contracts under new MA organizations will receive "default" bonus payments in 2013. However, these plans must also work quickly to achieve a relatively high star rating (as opposed to operating under the default star rating) as these incentives may disappear by 2015.

- *Improvement is a proposed new measure.*

Based on draft guidance, CMS may include a new measure that rewards statistically significant improvement. This provides additional incentives for quality improvement and could help some contracts gain additional revenue through a higher star rating.

Caveats

The opinions expressed are those of the authors and do not reflect that of their employer. No part of the content of this article should be viewed as being endorsed by their employer. ■

END NOTES

[1] For certain counties, this percentage is doubled.

Gabriela Dieguez, FSA, MAAA, is a consulting actuary at Milliman in New York City. She can be reached at *gabriela.dieguez@milliman.com.*

Bradley Piper, FSA, MAAA, is an actuary at Milliman, Inc. in Milwaukee. He can be reached at *brad.piper@milliman.com.*

Adrian Clark, FSA, MAAA, is a Consulting Actuary at Milliman, Inc. in Seattle. He can be reached at *adrian.clark@milliman.com.*