Medicare Advantage Boot Camp for Health Actuaries

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Original A/B Medicare and Medicare Advantage Part C

or

Medicare Advantage—*What's* The Advantage?!?

Daniel Bailey, FSA, MAAA

Overview—Medicare in 2017

- **~55 mil Medicare beneficiaries** ("benes"): **~84%** are >=65; ~16% disabled; 0.9% ESRD. More Pt A benes than B.
- Medicare (also called Original Medicare, A/B Medicare, or FFS Medicare) is a 2-part medical plan for acute care—like Basic Hospital & Supp Major Medical
- Has **potentially** significant beneficiary cost-sharing
- Parts A & B of Medicare are not to be confused with "private" Medicare Advantage (MA) medical coverage called **Part C**—almost 1/3 of benes are enrolled in **MA Pt C**.
- (**Private drug program is Part D**) Terms: MA, PD, MA-PD, PDP

Medicare and Med Adv Part C

Overview:

1. Facts and Fundamentals of Each, Some Basic Terms; Original FFS A/B Medicare distinguished from Med Adv (Part C)
2. Enrollment; Plan Design/AV/Bene Cost-sharing; Regulation; Issues
3. Conclusion

FFS Medicare—Part A and Part B

- **Part B**: In 2017, there's a $183 ded ($166 last yr) & **20% coins** on most care. (~70% of benes pay avg ~$109/mo premium—higher income pay more)
- **Part A:** potentially high cost-sharing, esp. on long InP and SNF stays. $1,316 "ded." for <= 60 InP days…
- **Pt A has # days limits—**may have sentinel effect—disincentive to use Pt A Medicare as LTC benefit
- **There is no maximum out of pocket (MOOP) expenditure on A/B Medicare—uncapped liability**
- [NOTE: Medicare Advantage (MA) Part C plans must have a maximum OOP of $6,700 or less in 2016.]

FFS Medicare—Part A and Part B

- The traditional Medicare plan began in 1965; little change in benefit except indexing—its design is not unlike commercial health ins. plans of 1960's.
  - Odd "benefit period" definition of inpatient stays
  - # days limits on Inpatient and SNF
  - No A/B prescription drugs (small amt Pt B RX injectibles)
- Provider reimbursement structure evolved to control cost around the inherent benefit design. Plan design on Pt A is limited to acute care—there is no LTC custodial cvg. due to Part A days limits

MEDICARE PLAN DESIGN & RISK

Q: **What's the 2017 Actuarial Value of Medicare?**

A: Based on latest 2017 USPCC, it's about **83.3%** =

$825.00 / ($165.16 + $825.00) excludes ESRD benes

(Stable since A/B cost-sharing parameters are indexed)

Better than ACA "Gold". ~As "rich" as commercial group mrkt avg. **But AV alone is an inadequate measure of beneficiary cost-sharing risk because FFS MCare has NO OOP MAX.**

And don't compare with Commercial unless you add Pt D.

The cost-sharing risk to Medicare bene may arise from a long Inpatient stay during a "benefit period" (and SNF stay). A very small % of FFS benes have very high cost-sharing $ in tail of OOP distribution.

Original Medicare Cost-Sharing Risk

Without a MOOP, Medicare beneficiaries have **large cost-sharing exposure** due to possibility of a low frequency, high severity claim, esp. 365 day Inpatient stay or long SNF stay. To reduce risk, the non-Medicaid Medicare beneficiary may:

1) fill-in A/B 16% cost-sharing gaps w/ a Medigap plan (can't buy supp for commrcl Exchange plans), **or**
2) replace A/B Medicare with Part C Med Adv plan.

(Some benes already have **Employer Sponsored** coverage which supplements A/B, & hence do not need gap cvg. **ER cvg** is in decline. Pre-2006 Part D, ¾ of their cost was for pharmacy coverage.)

Original Medicare Cost-Sharing

Med Adv approximates Medicare + Medigap (and it typically throws in free Part D). Which is better? Depends on richness of MA and Medigap plans—some MA plans are close to Medicare in value, but all MA plans have a MOOP. (Consider medical only for now and ignore Pt D…)

MA plans typically have more c/s gaps than Medicare + Medigap.

- Orig MCare has no MOOP. Most Medigap sold also has no MOOP; but no need—it substantially reduces or eliminates cost-sharing. (MOOP exists on the less rich K & L Medigap plans w/ partial gap coin. on Part B coins. K & L have small market share.)

Medicare Advantage Part C

MA enrollment grew over past decade almost 3-fold:
10% each yr for past two, despite revenue concerns:

- **15+** mil Part C MA in (US + Territories)—14.5+ mil is "prepaid"; remaining ~ 500k is "Cost" plans (1876 and 1833 plans) and demos
- **~13.5** mil (88%) of MA members are in MA plans that include a Part D benefit (called MA-PD plans)
- The other 1.8 mil in plans called "MA-Only"

(Unlike Med **Supp**, MA replaces Original Medicare.)

Other Facts and Distinctions

- (Note—Standalone Part D is called PDP—**22.7 mil** beneficiaries in separate PDP (mutually exclusive of MA members w/ PD)—this is a subset of all Part D members.
- In total, there are **35.8 mil** Medicare benes w/ drug coverage through the **Part D** program which began in 2006 (35.8 = 13.1 MA-PD + 22.7 PDP). Most of others are in TriCare, FEHBP, or have ER cvg with "RDS".

Product Combinations & Sales Restrictions

WHAT IS PERMISSIBLE?

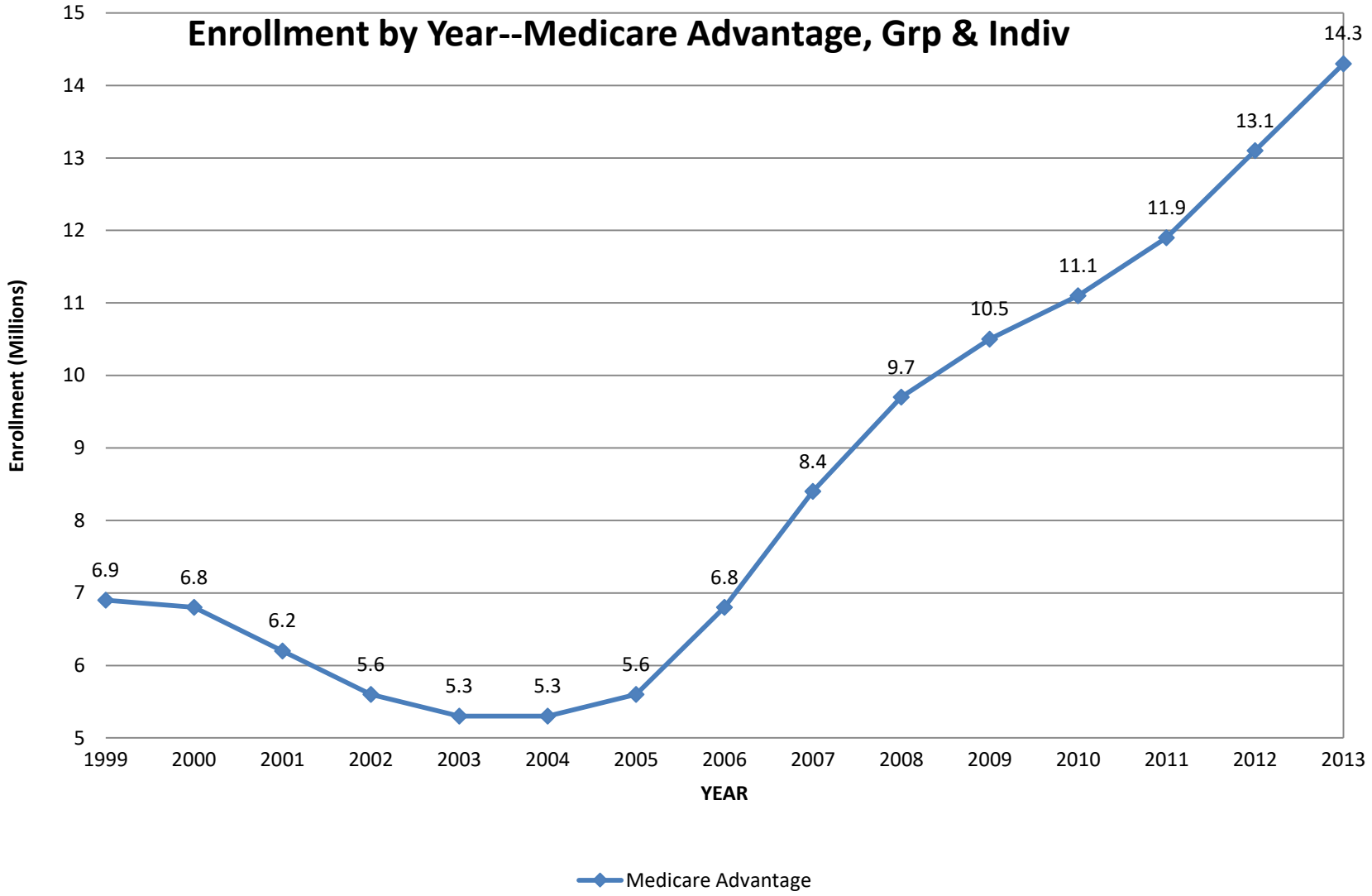
- Cannot buy Med Supp and Med Adv, and
- Cannot purchase PDP and Indiv MA-PD, but
- Can buy Med Supp + PDP (& stay in Original FFS A/B Medicare)
- Insurers cannot sell Health Exchange plans to Medicare beneficiaries

MA—Many Contract/Plan Types

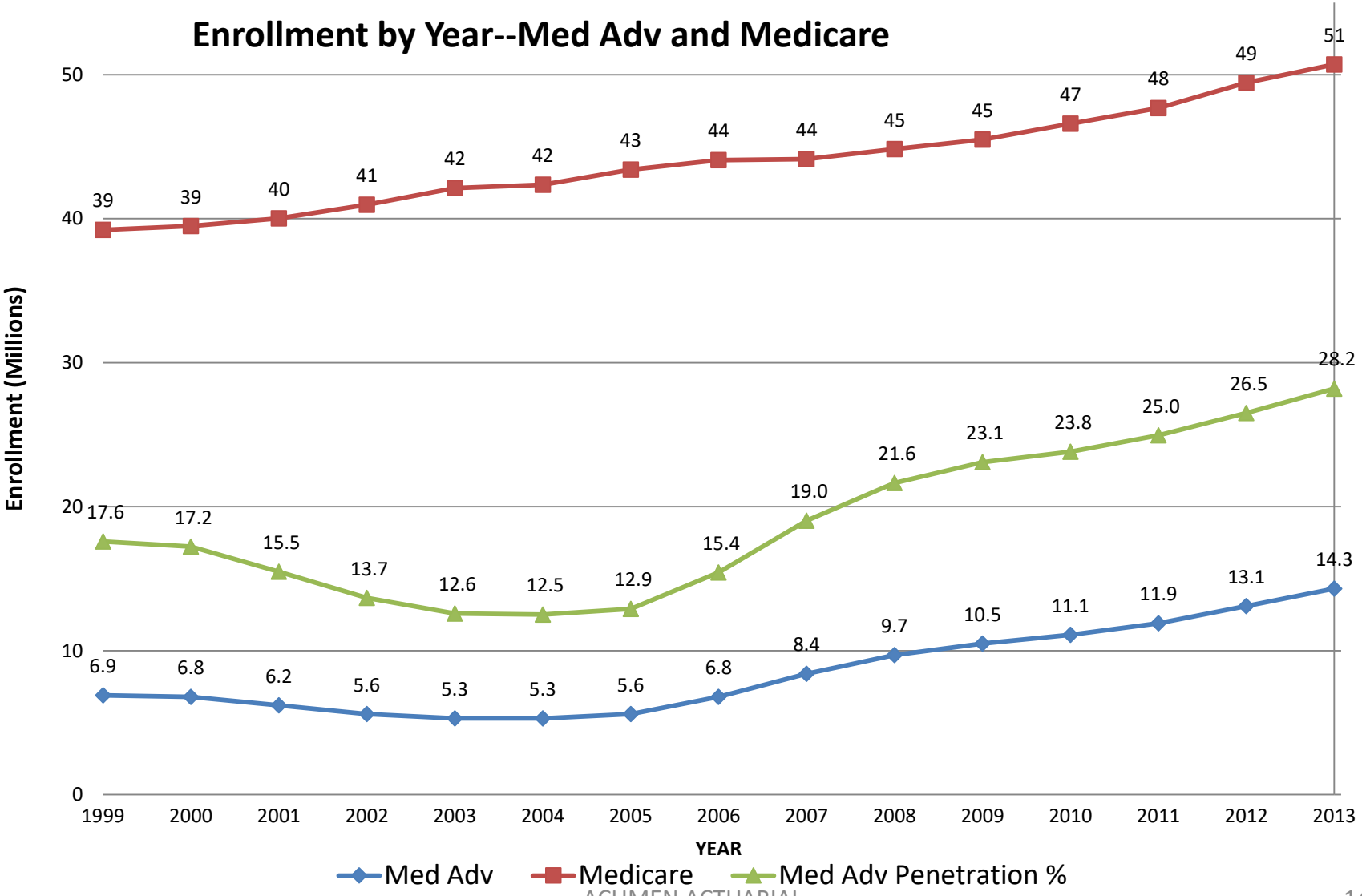
NOT ALL MA CONTRACT TYPES ARE THE SAME!!

- About **82%** members in **Individual** plans; the rest is Group (EGWP)—% varies substantially by carrier; some of Group is conversion from ER sponsored.
- **Almost 2/3 of MA membership is in HMO** plans; the rest is mostly PPO, most of which is **L**PPO (PFFS transitioned/ing into **R**PPO)
- Almost **93%** are **Local** plans (HMO and **L**PPO)
- About **12%** of MA members are in Special Needs Plans (**SNP**s)—higher morbidity (risk scores) & greater opportunity of coordinated care savings

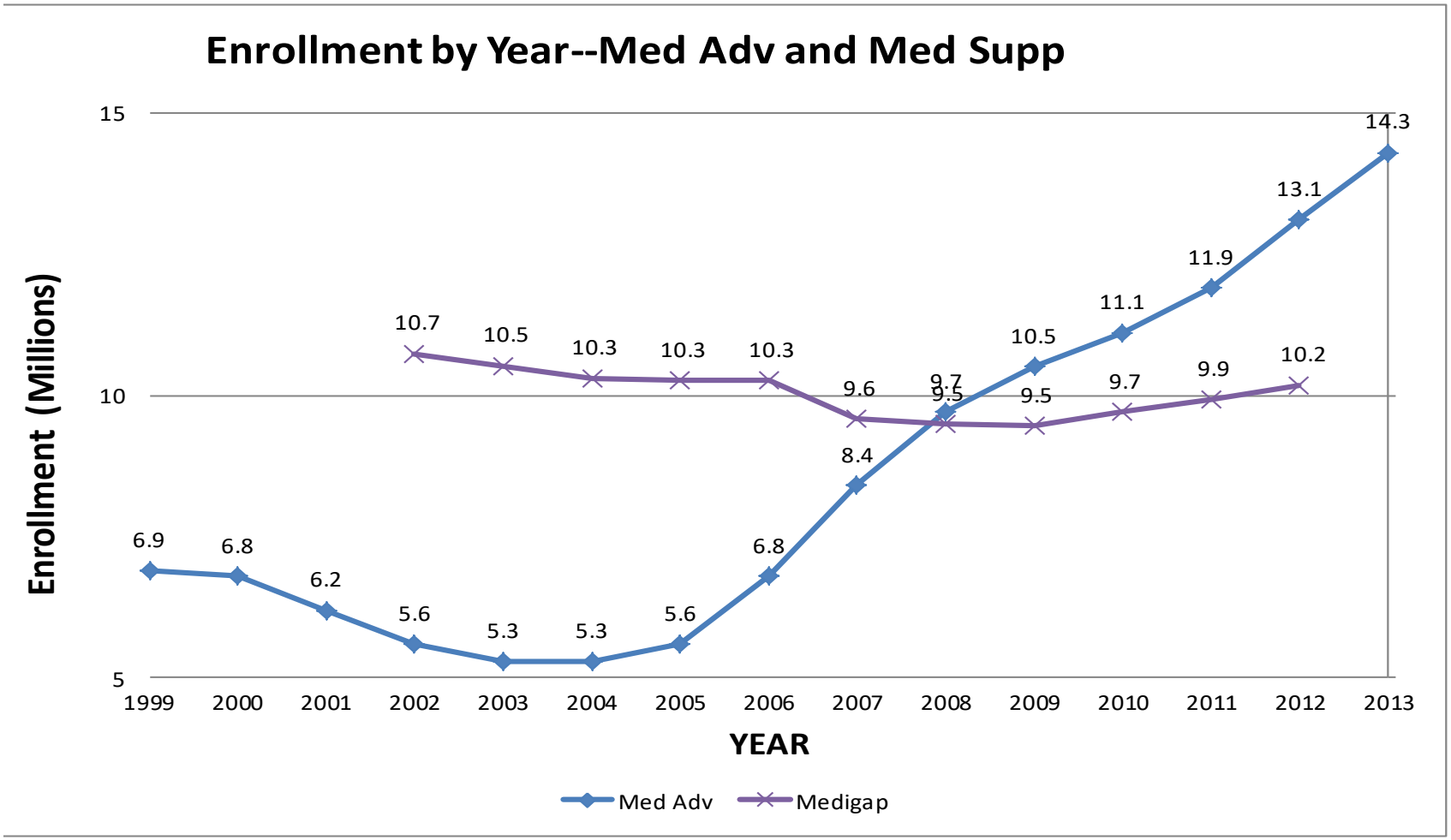
All Medicare Advantage Part C Members



Med Adv, Medicare, & MA Penetration %



Med Adv and Med Supp



Part C Plan Design

- MA must cover everything Medicare does; (perhaps also give extra benefits that Medicare does not); MA cost-sharing must be actuarially equiv or better than FFS A/B
- Extra benefits, depending on rebate amount, are either:
  1. **reduced member cost-sharing on Medicare cvd benefits**
  2. additional benefits that Medicare does **not** cover, such as pharmacy, eyeglasses, hearing aids, dental; Unltd InP days, broader chiro than A/B covers, out-of-country health care, …
- $0 premium MA plan could also pay for some or all of member's Part B premium (if sufficient rebate permits)
- **MA plan value decreases each year as lift declines:**
  - **$0 prem plans becoming more scarce,**
  - **monthly member premium is increasing.**

Part C Plan Design—AV

Q: What's the Actuarial Value of Med Adv? (N/D)

A: **It depends on the MA plan.**(What's in the Dnmtr? Is it FFS A/B Medicare, or is it the Med Adv plan?)

If Denomtr is MA, it varies. What's cvd? Benft differences?

Case 1: Same N and D—Same plan of benefits & cost sharing— about **84%.**

Case 2: Enhance N—Less member cost-sharing but no additional non-cvd benefits. 84% to 100% (theoretically). Like Medigap

Case 3: Enhance D—Additional non-Medicare covered bens, but actuarially equiv cost-sharing on all else. (Depends on the delta in each of N and D—cost-sharing on extras? …)

Case 4: Enhance N and D: (Dade county). Low c/s + big D.

Member Cost-Sharing for the Medicare Elderly & Disabled Population

- Cost-sharing matters more for the MCare pop. because benes have 1) more medical spending, and 2) less income
- Ded, Coin, and Copays act as deterrents to marginal or unnecessary utilization, but have decreasing efficacy as member income/wealth increases. (Bill Gates is not likely deterred by a $45 spec. copay as much as the avg. bene.)
  - **1/2 of Medicare benes live on less than $23k annually!**
  - Benes may receive Medicaid to fill-in A/B cost-sharing gaps (if they qualify based on income-assets test) and LIS for Pt D, …)
- **Cost of premium is also an issue!**
- What's the AV of **FFS A/B + Med Supp?** (C/S is complement)
- IT IS DIFFICULT For BENEs To SEE TOTAL COST PICTURE!

Which Original Medicare Benes Have The Most Cost-Sharing?

- On avg, Pt A AV is 90.6%; Pt B—78.5% (CMS "Announcement")
- **Pt B**: Due to 20% coins and indexed ded, cost shrng is close to 20% of cost. (No c/s on preventive, Home Hlth)
- **Pt A** c/s amounts are also COL indexed, but per day c/s amt. increases in steps for InP and SNF stays, and cuts off entirely at 90 – 120 days. < 20% for Inp & SNF on average (~7%, ~14%: Wks 5)—but can be substantially more for some individuals with long duration InP & SNF stays.
- 2013 Cost by Age Study sponsored by SOA shows oldest benes w\ highest allowed cost have a disproportionately large portion of cost shrng. "**Health Care Costs From Birth To Death**"—SOA report and data.

Regulation—Medigap v. MA

- **Medigap** is regulated by & filed w/ **state**—varies state to state; some federal rules (Guar Issue)
- Some states have **COMMUNITY RATED Med Supp…**
- **Med Adv (MA)** is regulated by & filed w/ **federal government** via CMS under HHS (85% MLR)
- Complexity of bidding has increased as MA-PD regltn has evolved; in addition to claims projection, risk score & revenue projection complicates MA further
- Multiple constraints on Med Adv bids—very time-bound, total benefit change (TBC) is limited yr to yr, MOOP, MSP, DE#, permissible plan differences, margin guidelines, MLR, dynamics of updated factors, mid-bid- season regltry changes, etc …

MA Advantages over Med Supp

Two Primary Advantages:

1. **Cost savings** attributable to medical management & coordination of care.
   (But PCMH and ACO are now growing in FFS Medicare space)
2. **Lift** in county-specific benchmark revenue rates (which are decreasing over time in a complicated manner).
   (Which quartile does the county fall in, and is transition 2, 4, or 6 yrs?)

Med Supp vs. Med Adv

Med Adv, MA-PD

- Copays vary by type of service– Prof (Pt B) copays usually less than 20%
- **Includes** PD (often free!)
- Includes OOP Max $6,700 or less
- Premiums do not vary by age--CMS revenue does! Age is part of Risk Score

Med Supp, Plan F

- Covers all cost-sharing for Parts A & B including deductibles and coins
- Does NOT include PD
- NO OOP Max, but not necessary
- Premium varies by age, unless COMMNTY RTD—NJ 65 yr old cost << 85 yr

MORE ODIOUS COMPARISONS…

MED ADVANTAGE

- 3x growth in 10 yrs
- MLR of 85%, hence compression on cost
- 3% Profit on $900 PMPM revenue is better than Med Supp
- May be a network
- Ongoing challenge of Payment Reform

MED SUPP

- Was eclipsed by MA-PD
- Much lower MLR, but market forces LR higher.
- A 8% profit on $150 PMPM premium is less than MA-PD
- Has Medicare ntwk
- Poor Value Proposition, but improving…

Medicare Advantage— What's The *Advantage*?!?

- Was title of my 2006 MA presentation around theme of "The MMA— One Year Later"—MA utilizes med mgmt that did not exist in Orig Medicare at that time… **hence MA can reduce cost & offer richer benefits than Orig MCare**.
- ***But*** under MA, bene gives up the freedom to use any provider who takes MCare assignment; and must use MAO's CCP network.
- ***And*** MAO has significant admin cost handicap to perform at overall cost parity with Medicare.

Part C Issues and Challenges

- **STARS Ratings** are a proxy for total Quality—high quality contracts have a competitive advantage for two primary reasons:
  1. Bonus = > higher PMPM benchmark revenue
  2. Larger bid "rebate" as percentage of savings

All else equal, plan w/ higher STARs rating is preferred.

4-Star Cliff in 2015—5% **or** nothing (unless demo extended)

- Difficult MA-PD bid reallocation last August (and the two Augusts before)—Some surprised by PD #s released.

  (See next page about bid reallocation.)

Part C Issues and Challenges

- **Benchmark Revenue Rate and Lift Compression**— Revenue is county-specific; "Lift" in each county's benchmark rate has been decreasing in a complicated way—the 4 Quar-tiles; 2, 4, or 6 yr transitions (ends in 2017) …
- Stuff happens—sequestration; ICD-10; where can we find several $ of bnft cuts in Aug. PD re-alloc?
- Marketplace actions, reactions: acquisitions, …
- The list goes on … and changes over time

CONCLUSION

- **Original Medicare** is a generous plan w/low avg cost-shrng, but **high c/s risk** for a very small portion of benes due to no MOOP. Medicare population has limited means; c/s hits benes harder; (this is a fundamental financial security issue all nations with aging pops must address)
- In most places, **Med Adv** is usually a **better $ deal (more affordable and more low-cost options)** than staying in FFS Medicare and buying Med Supp and PDP:

  -- This is currently more true in urban locations where Indiv MA-PD plans are plentiful and networks are robust. Later?

  -- "Better deal" is less prevalent in rural areas where there's less geo-access to mgd care MA networks; counties in 4th Quartile will ultimately have 15% lift in lowest cost counties—other factors play a role. Later?

Although some growth in group is simply conversion, given MA's enrollment growth in past decade, we've come a long way since the managed care backlash in the late 1990's.

Enjoy Your Stay in New Orleans

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