Employer Group Waiver Plan Funding
Analyzing the Impact of Bid-to-Benchmark Ratios

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A. BACKGROUND

The Medicare Advantage program includes two market segments: the individual market in which beneficiaries enroll in an individual plan offering based on their personal selection and the employer / union (herein collectively referred to as "employer") group market in which groups of retired and / or active Medicare eligible employees enroll in the employer's selected Employer Group Waiver Plan (EGWP). The EGWP market segment currently covers approximately 3.4 million beneficiaries.

Historically, the federal government funding for the provision of medical benefits (Medicare Part C) for both the individual and EGWP markets has been based on a bidding process. Under the bidding process, CMS funded the plan's estimated cost of providing medical benefits to its members (bid) up to a limit based on the risk profile and residence of the members (benchmark). However, the 2017 Rate Announcement eliminated bids for the employer group market segment and replaced them with an alternative payment policy. Beginning in 2018, the EGWP funding will be based on the individual market's prior year bids relative to prior year benchmarks ("bid-to-benchmark ratios"). The 2017 Rate Announcement also included a two-year phase-in period under which, for 2017, the EGWP funding will be based on a 50% weight of the 2016 EGWP bid-to-benchmark ratios and 50% weight of the 2016 individual market bid-to-benchmark ratios.

The revised EGWP payment policy was first proposed in the 2017 Advance Notice, allowing for comments from stakeholders before the policy was finalized in the 2017 Rate Announcement. Per the 2017 Rate Announcement, a number of commenters expressed concern that "EGWP bids tend to be higher than non-EGWP bids because EGWPs are predominantly PPOs, rather than HMOs."[1] EGWP sponsors were concerned that using an aggregate individual bid-to-benchmark ratio would result in artificially low revenue for PPO EGWPs. In response to these comments, CMS noted that "basing the MA EGWP payment rates on the small number of PPO plans in the individual MA market could introduce significant year-over-year instability in future payment rates."[1] CMS did not provide any additional guidance related to what constitutes "significant year-over-year instability in future payment rates."

B. FINDINGS

At Aetna's request, we analyzed historical bid information for the individual MA market to understand the volatility in bid-to-benchmark ratios for HMO and PPO plans. Based on the data sources and analyses explained in this report, we note the following observations:

- Calculating the MA EGWP payment rates separately using HMO and PPO ratios would not introduce meaningful year-over-year instability in future payment rates. **The maximum differences in bid-to-benchmark ratios relative to the five-year average are slightly narrower for all plans combined than for HMO plans and PPO plans separately**. Specifically, the maximum difference from the mean ratio ranged from -1.9% to +1.7% for all individual plans, compared to a range of -2.7% to +2.3% and -2.2% to +1.9% for individual HMO and PPO plans, respectively (Table 1).

- The new methodology bases funding for the EGWP market (predominantly a PPO market) on the individual market (predominantly a HMO market). However, this ignores HMO vs. PPO bid-to-benchmark ratio differences in the individual market. **The five-year average bid-to-benchmark ratio for individual PPO plans is roughly 8.7% higher than that of individual HMO plans** (Table 2).

- We estimate the new CMS methodology would result in year-over-year benchmark payment changes of up to 2.6%. **This volatility in bid-to-benchmark ratios for all individual plans combined is slightly lower than the 3.0% observed in HMO plans and slightly higher than the 2.3% observed in PPO plans in the last five years** (Table 3).

[1]https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf

II. OVERVIEW

The Medicare Advantage program is a government-sponsored program that offers an alternative to traditional fee-for-service (FFS) Medicare where benefits are provided to Medicare beneficiaries by private health plans. The cost of the program is funded in large part by the federal government, with the revenue received by private plans based on laws, regulations, and an underlying bidding process established, regulated, and overseen by the Center for Medicare and Medicaid Services (CMS).

The Medicare Advantage program includes two market segments: the individual market in which beneficiaries enroll in an individual plan offering based on their personal selection and the employer group market in which groups of retired and / or active Medicare eligible employees enroll in the employer's selected EGWP.

CMS requires all Medicare Advantage Organizations (MAOs) offering individual plans to submit a bid that estimates the cost to provide traditional Medicare benefits to an "average risk" Medicare beneficiary for the coming year. A portion of any savings generated by the MAO (the savings defined as the difference between the benchmark payment rate and the bid) is returned to the plan as a rebate, which can be used by the plan to provide benefits above and beyond traditional Medicare, such as reductions to cost-sharing on Medicare services or coverage of non-Medicare services, such as dental. If a plan's total estimated cost to provide traditional Medicare and supplemental benefits (including administrative costs and profit margin) is greater than the amount of revenue received from CMS through the base revenue and rebate, the difference is funded through premiums charged to the plan's members. Until 2017, the CMS requirement to submit bids annually also applied to MAOs offering EGWPs.

This report analyzes the new waiver to the bidding process for all EGWPs, thereby eliminating bids for the employer group market segment, as well as CMS' response to certain concerns expressed relative to the new policy. For the 2017 bid year, CMS proposed (in the 2017 Advance Notice) and implemented (in the 2017 Rate Announcement) regulatory changes. CMS expressed concerns over the historical competitiveness of EGWP bids and, based on these concerns, developed a waiver to the bidding process for all EGWPs, as well as an alternative payment policy under which the EGWP funding is based on the individual market bids.

As stated on pages 28 and 29 of the 2017 Rate Announcement:

"We are finalizing the following methodology for calculating EGWP county payment rates:

- First, a weighted average bid-to-benchmark ratio will be calculated at the quartile level.

    1. For 2018 and future years, the bid-to-benchmark ratios will be calculated using individual market plan bids only. The calculation will be: (weighted average of the intra-service area rate adjustment (ISAR) adjusted county bid amounts by actual enrollment) / (weighted average of the county standardized benchmarks by actual enrollment) = percentage by quartile.

- The percentages are applied to each of the published 5%, 3.5%, and 0% bonus county rate book rates for the payment year to establish Part C base payment amounts for EGWPs based on their star rating for each county.

- In order to calculate a county rebate payment, each county level EGWP Part C base payment amount is compared to the corresponding published 5%, 3.5%, and 0% bonus county benchmarks for the payment year to determine the amount of savings. The savings amount is multiplied by the corresponding star rebate percentage to determine the Part C EGWP county level rebate amount.

- The EGWP Part C base payment amount will be added to the Part C EGWP rebate amount to establish the county-level EGWP total payment amount.

- The total payment amount will be risk adjusted in payment using beneficiary-specific risk scores. Therefore, the formula applied for payment will be: (base county payment rate + county rebate) * beneficiary level risk score."[1]

"Quartiles" are based on each respective county's overall Fee-For-Service (FFS) costs, stratified from lowest to highest, and then grouped in to four quartiles. Current payment policy provides a separate FFS cost multiplier as the basis for payment benchmarks.

In addition to finalizing the payment policy noted above, CMS published various comments it received in response to its initial proposal in the 2017 Advance Notice. The comment and response interchange below addresses how the underlying bid-to-benchmark ratio will not vary based on EGWP plan type (e.g., HMO vs. PPO), and is the focus of this report. As included on page 39 of the Rate Announcement:

> ***Comment:*** *Several commenters noted that EGWP bids tend to be higher than non-EGWP bids because EGWPs are predominately PPOs, rather than HMOs. They argue that when making an apples-to-apples comparison of EGWPs and non-EGWPs by plan type, the disparity in the bid-to-benchmark ratio shrinks significantly. These commenters argue that CMS's proposal will arbitrarily lower benchmarks for PPO products and will drive out PPO EGWPs from the marketplace. These commenters argue that the need to offer a broad network may be accounting for the rate difference, rather than the CMS assertion that the payments are subsidizing wrap-around coverage. According to the commenters, the current EGWP payment structure enables plans to recognize the impact of these various product characteristics and the impact of different cost structures between MA EGWP plans and individual market MA plans in their bids. The proposed change does not allow plans to reflect these differences in cost structures in MA EGWP specific bids and it shifts the MA EGWP funding to be based on individual plan costs (largely HMOs) despite the fact that MA EGWPs are largely PPO plans. Several of these commenters stated that if CMS should decide to proceed with the proposal that the bid to benchmark calculations be modified to account for the different ratio of HMO to PPO plans in EGWPs vs Non-EGWPs and to exclude D-SNPs from the calculations as they are not representative of the type of coverage an employer purchases, and are therefore irrelevant to the calculation.*
>
> ***Response:*** *CMS recognizes that there are a larger number of MA EGWPs that are offered as PPO plans instead of HMO plans than in the individual MA market, where the inverse is true. In finalizing this policy, CMS considered whether such an adjustment would be appropriate to account for this differential in plan offerings between the two markets. However, in the course of reviewing the data, we determined that basing the MA EGWP payment rates on the small number of PPO plans in the individual MA market could introduce significant year-over-year instability in future EGWP payment rates.*

III. RESULTS

We reviewed the historical bid and benchmark values by plan type to assess CMS' response included in the 2017 Rate Announcement. While each plan type has some volatility from one year to the next, all plan types are relatively stable over the five-year period. Table 1 below includes the bid-to-benchmark ratios for each plan type from 2012 to 2016, as well as the average and range around the average. When using all plans, the range spans 3.7% from the five-year average (Quartile 1, -1.9% to 1.7%). The alternative approach of using HMO and PPO individual plans separately produces maximum ranges of 5.1% (Quartile 1) and 4.1% (Quartile 1), respectively.

Table 1
Medicare Advantage EGWP Funding Analysis
Historical Bid-to-Benchmark Ratio for Individual Plans – Industrywide

Plan Type	Quartile	2012	2013	2014	2015	2016	5-year Average	Maximum Difference From Average
All Plans	1	0.841	0.834	0.852	0.838	0.821	0.837	-1.9% to 1.7%
All Plans	2	0.883	0.883	0.892	0.910	0.891	0.892	-1.0% to 2.0%
All Plans	3	0.906	0.905	0.902	0.924	0.900	0.907	-0.8% to 1.8%
All Plans	4	0.893	0.891	0.898	0.899	0.896	0.895	-0.5% to 0.4%
HMO	1	0.828	0.813	0.837	0.816	0.795	0.818	-2.7% to 2.3%
HMO	2	0.860	0.852	0.873	0.893	0.870	0.870	-2.0% to 2.7%
HMO	3	0.887	0.879	0.882	0.908	0.881	0.887	-1.0% to 2.4%
HMO	4	0.876	0.866	0.881	0.868	0.872	0.872	-0.7% to 0.9%
PPO	1	0.918	0.920	0.933	0.912	0.895	0.916	-2.2% to 1.9%
PPO	2	0.917	0.923	0.938	0.928	0.911	0.924	-1.3% to 1.5%
PPO	3	0.922	0.933	0.935	0.928	0.913	0.926	-1.4% to 0.9%
PPO	4	0.897	0.904	0.914	0.912	0.918	0.909	-1.3% to 1.0%

As demonstrated in Table 1, the bid-to-benchmark ratios for individual PPO plans are consistently higher than for individual HMO plans. Table 2 below shows the relativity of the PPO ratio to the HMO ratio by quartile and year. These differences in the PPO and HMO ratios for the individual market are largely driven by the respective product characteristics. For example, the network design in a PPO product typically necessitates the build-out of a broad network with the provision of out-of-network benefits. This may result in varying levels of access, clinical programs and contract negotiations that result in higher costs for PPOs relative to HMOs.

Table 2 Medicare Advantage EGWP Funding Analysis Historical PPO Bid-to-Benchmark Ratio Relative to HMO – Industrywide						
Quartile	**2012**	**2013**	**2014**	**2015**	**2016**	**5-Year Average**
1	10.9%	13.3%	11.5%	11.7%	12.6%	12.0%
2	6.7%	8.4%	7.4%	3.9%	4.7%	6.2%
3	4.0%	6.2%	6.0%	2.2%	3.7%	4.4%
4	2.4%	4.4%	3.9%	5.1%	5.4%	4.2%
Total	**7.9%**	**10.3%**	**8.8%**	**7.7%**	**8.8%**	**8.7%**

Since the new EGWP funding depends on a single year's bid-to-benchmark ratio, it is important to evaluate the year-over-year changes in the table above in addition to each year relative to the five-year average. Table 3 below contains the year-over-year change in the bid-to-benchmark ratio for each year, quartile and plan type based on the results shown in Table 1. This table also includes the 2016 Medicare Advantage enrollment for individual HMO and PPO plans. The "All Plans" also includes other plan types, such as PFFS plans.

Table 3 Medicare Advantage EGWP Funding Analysis Year-Over-Year Change in Bid-to-Benchmark Ratio for Individual Plans – Industrywide						
Plan Type	**Quartile**	**2016 Enrollment***	**2013 / 2012**	**2014 / 2013**	**2015 / 2014**	**2016 / 2015**
All Plans	1	5,405,977	-0.9%	2.2%	-1.6%	-2.1%
All Plans	2	3,102,974	-0.1%	1.1%	2.0%	-2.1%
All Plans	3	2,521,429	-0.1%	-0.3%	2.4%	-2.6%
All Plans	4	2,678,028	-0.2%	0.8%	0.1%	-0.3%
HMO	1	4,323,976	-1.8%	3.0%	-2.4%	-2.6%
HMO	2	2,096,894	-0.9%	2.5%	2.3%	-2.5%
HMO	3	1,521,507	-0.9%	0.4%	3.0%	-3.0%
HMO	4	1,588,971	-1.1%	1.6%	-1.4%	0.4%
PPO	1	734,115	0.3%	1.4%	-2.3%	-1.8%
PPO	2	722,904	0.6%	1.5%	-1.0%	-1.8%
PPO	3	805,764	1.2%	0.2%	-0.7%	-1.7%
PPO	4	891,552	0.8%	1.1%	-0.3%	0.7%

**Note: 2016 enrollment was based on the Medicare Advantage Penetration reports. Membership was mapped to 2016 counties using the CMS crosswalk file. Out-of-Area, PACE, and EGWP members were all excluded.*

Reviewing all plans, the maximum year-over-year change (positive or negative) among the four quartiles is 2.6% (Quartile 3, 2015 to 2016). Evaluated individually for HMO and PPO plans, the maximum change is 3.0% (Quartile 3, 2015 to 2016) and 2.3% (Quartile 1, 2014 to 2015), respectively. In other words, the new CMS methodology would result in a year-over-year benchmark payment change of up to 2.6% based on the last five years, while an alternative methodology that uses HMO and PPO ratios would result in a year-over-year change up to 3.0%. Alternative approaches, such as rolling averages or historical HMO vs. PPO relativities, may be used to further limit the payment volatility while still allowing EGWP payment rates to reflect the bid-to-benchmark ratio of the corresponding type of plan.

IV. METHODOLOGY

We relied on detailed Medicare Advantage plan payment data for bid years 2012, 2013 and 2014 that include rebate amounts and risk scores for every plan in the individual and EGWP markets. We also used publicly-available Medicare Advantage enrollment information to estimate the membership distribution included in the bid submissions to CMS by county for each plan. Using the membership distribution, risk score, and rebate amount, as well as the published star ratings used in bid development by plan, we calculated each year's bid and weighted average benchmark for each plan.

We relied on publicly available Medicare Advantage benefit information, as well as county-level cost information, for 2015 and 2016 since plan payment data is not available for these years. We used internal Milliman pricing tools to estimate each plan's bid using the inputs of plan design, county benchmark, county cost information, and risk score estimates. For all years, the ratio presented in Table 1 is the relationship of the calculated bid to the calculated benchmark.

V. QUALIFICATIONS, LIMITATIONS, AND CAVEATS

We, Greg J. Herrle and Brett L. Swanson, are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The material in this report represents the opinion of the authors and is not representative of the views of Milliman. As such, Milliman is not advocating for, or endorsing, any specific policies or regulations related to the Medicare Advantage program.

The information in this report was developed to help Aetna, Inc. better understand the resulting financial impact of the proposed Employer Group Waiver Plan payment policy change in the 2017 Rate Announcement. This information may not be appropriate, and should not be used, for other purposes.

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We relied upon CMS guidance and publicly available information from CMS. If any of this information is inaccurate or changes, the conclusions in this report could change.