Medicare Advantage: Market entry variables to success

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The Medicare population is projected to increase from 54 million beneficiaries today to more than 80 million beneficiaries by 2030 as the Baby Boom generation ages into Medicare.[1] Almost one in three (31%) people on Medicare (16.8 million beneficiaries) were enrolled in a Medicare Advantage (MA) plan in March 2015—up by more than 1 million beneficiaries from 2014.[2] With this potential increase in individuals that are eligible for MA enrollment, many health plans and provider organizations may consider entering this growing market. The MA market can provide a fairly stable and predictable point of entry for new health plans due to the maturity of the MA market with well-established data, populations, and products. For established health plans, it can provide further diversification to their other lines of business.

The MA market is very competitive and highly regulated. Entry requires a thoughtful strategy around the factors necessary to achieve success. Some health plans take longer than others to implement a strategy that impacts results, so the keys to success must be identified and worked on from the early stages of entry. Successful MA carriers realize that although there are many factors that can lead to success (e.g., brand recognition, timing, etc.), the following should be part of any strategy to win in the MA market:

- Understanding the regulatory and financial requirements
- Understanding the target market
- Increasing revenue by optimizing claims coding and quality improvement
- Managing claim costs
- Minimizing administrative costs

The remainder of this paper will focus on these key elements as they pertain to the MA market, although similar strategies may also apply for other health lines of business.

UNDERSTANDING THE REGULATORY AND FINANCIAL REQUIREMENTS

The MA market is highly regulated and has many financial requirements. Carriers must have dedicated resources that monitor the existing rules and regulations and must understand the impact of any changes. Below are some items to consider when entering the MA market.

Compliance

The Centers for Medicare and Medicaid Services (CMS) has very complex compliance requirements, including requirements for detecting, preventing, and correcting fraud, waste, and abuse. The efforts to achieve optimal product performance and compliance are significant. Staff, processes, and systems to ensure effective and compliant operation of the program will need to be developed.

Carriers need to develop and implement a compliance program that meets CMS requirements. This includes appointing or hiring a compliance officer, building a compliance committee, and implementing processes to ensure that the MA carrier's program operation meet CMS requirements.

Enrollment requirements

CMS requires MA carriers to achieve minimum enrollment requirements. CMS requires the carrier to provide health insurance benefits to at least 5,000 individuals for all health benefit product lines combined for urban areas and at least 1,500 individuals for non-urban areas. There are also MA and plan specific enrollment requirements carriers need to consider.

MA carriers that do not meet the minimum enrollment at application or during the first three years of the contract may request that CMS waive the minimum enrollment requirement if the organization can demonstrate to CMS that it is capable of administering and managing an MA contract and the level of risk required under the contract, but CMS can elect not to renew its contract if the carrier fails to meet the applicable minimum enrollment requirements.

1 Medicare Payment Advisory Commission (June 15, 2015). Report to Congress: Medicare and Health Care Delivery System. Chapter 2: The next generation of Medicare beneficiaries. Retrieved February 18, 2016, from http://www.medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0/

2 The Henry J. Kaiser Family Foundation (June 30, 2015). Medicare Advantage 2015 Spotlight: Enrollment Market Update. Retrieved February 18, 2016, from http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/

Risk-based capital

Every risk-bearing entity is required by its state of domicile to maintain a level of capital to support business operations in relation to its size and risk. The level of necessary capital is measured using the risk-based capital (RBC) Ratio. The RBC ratio equals the total adjusted capital divided by the total RBC, with the total RBC calculated using risk factors multiplied by measure of volume for each risk class. RBC requirements limit the amount of risk a company can take, ensure that a company with a higher amount of risk holds a higher amount of capital, and protect a company against insolvency.

Typically, carriers must maintain an RBC ratio of at least 200% to avoid regulatory action, but this can vary by state. Some states may require minimum levels above 200% (e.g., 300%+ or even a minimum dollar amount). Most companies maintain an RBC ratio between 300% and 1,000%.

MLR requirements

MA plans are subject to federal medical loss ratio (MLR) requirements. MLR measures the share of enrollee premiums that health insurance companies spend on medical claims, as opposed to other non-claims expenses such as administration or profits. The formula is as follows:

$$\frac{\text{Claims + Allowable Expenses}}{\text{Premiums - Allowable Deductions}} + \text{Credibility Adjustment} \geq \text{Minimun Loss Ratio}$$

Claims include both medical and prescription drug (or Part D) claims while premiums include both CMS revenue and member premiums. Allowable expenses include quality improvement expenses (must be identified and allocated properly) while allowable deductions include taxes, regulatory assessments, and fees, including the health insurer fee (if applicable).

The MA MLR requirement of 85% for MA plans is based on one year of experience and is calculated at the contract level. Credibility adjustments range from +8.4% for 200 to 500 life years to +1.0% for 10,000 to 15,000 life years. Contracts with 15,000 or more life years are considered fully credible and no credibility adjustment is made. Contracts with fewer than 200 life years are considered to have no credibility and the MLR requirement does not apply to these contracts. The thresholds for standalone Part D plans are twice those of MA plans.

If the MLR is less than 85%, then the MA plan is considered non-compliant and must rebate the difference to CMS. MA plans that are non-compliant for three consecutive years are subject to a prohibition on new enrollment while non-compliance for five consecutive years can result in termination of the contract.

UNDERSTANDING THE TARGET MARKET

Whether an existing or new MA carrier, it is important to analyze the ever-changing target market where the carrier operates or expects to operate. The potential enrollees as well as the competitive landscape and types of products that currently exist within the market must be understood.

Understanding the population and service areas

As with any new product, sufficient enrollment is a necessary key to success, and as mentioned previously, a minimum level over a certain timeframe is required by CMS to continue marketing a MA plan. Therefore, it is necessary to understand the number of individuals that are potentially available to any given carrier.

Service areas for MA are identified by a group of counties, and each carrier can define the counties in the service area. The service areas can vary a great deal in terms of the number of projected Medicare eligibles and further by the penetration of eligibles that choose MA plans over traditional Medicare coverage. Determining the expected revenue versus claims costs by county is another important consideration since the amount of revenue received from CMS can vary widely by county. In addition, there are varying numbers of MA carriers that operate within each county. Understanding the volume of potential members that may be available and the expected revenue versus claims costs can help in determining the counties to enter and the number of service areas in which an MA carrier chooses to operate.

As more Baby Boomers reach age 65, the expectation is that the number of MA enrollees will increase in the future. Equally important to understanding the potential membership base is identifying which methods will be used to attract and enroll this membership. For example, a high amount of enrollment may come through the use of brokers. Established carriers may look to either their commercial or Medicaid markets as a potential pipeline of members that are nearing the age of Medicare eligibility.

Understanding product offerings

Carriers often start with a portfolio of a low premium (or no premium in some parts of the country) and a high premium option when they enter the MA market. Over time they may find that three plans are an option; however, this can be complicated due to CMS regulations requiring that product offerings be materially different from one another. Unlike commercial carriers, the CMS definition of "meaningful difference" between MA products does not allow plans to only vary by provider network. Therefore, it is necessary to create plans that have meaningfully different benefit and premium designs.

CMS has certain limitations on the amount of cost sharing that can be charged to members overall and for specific benefits; therefore, it is important to understand which benefits may already be at or near those limitations when considering potential future changes. In addition, CMS routinely changes the limits, so what may have been allowed by the competitors in a prior year may no longer be allowed in subsequent years.

To complicate matters, there are further limitations on the combined change in cost sharing and member premium that can occur from one year to the next. Therefore, consideration should be given to the levels set in the first year because these restrictions may preclude an MA carrier from making substantial changes in the following year, even if necessary to achieve profitability.

New and existing carriers should research the current plans offered by the competition to determine plan designs that will attract members. The creation of unique plans can be a good way to differentiate plans from the competition; however, if the plans are significantly different than the current market, adverse selection can occur, especially if the plan design is especially rich compared with other plans offered in the marketplace.

INCREASING REVENUE BY OPTIMIZING CLAIMS CODING AND QUALITY IMPROVEMENT

MA carriers must optimize revenue to be successful. Two of the most important areas of concentration to increase revenue are CMS' quality rating (star rating) and diagnosis coding improvement.

Optimal revenue does not happen immediately, but carriers must put processes in place immediately to ensure that the positive revenue impact due to star ratings and diagnosis coding improvement is achieved and negative impact avoided.

Star rating

The star rating program was created by CMS to "grade" MA plans, promote improvement in quality and drug adherence, and recognize primary care providers for demonstrating an increase in performance measures over a defined period of time. Star ratings are based on a rating scale of 1 to 5 (lowest to highest). An MA plan's star rating impacts revenue, benefits, and enrollment, so it is extremely important to focus on activities that increase star ratings immediately for new carriers and continuously for existing carriers.

An MA plan's star rating determines the level of quality bonus payment (QBP) included in the calculation of the revenue received from CMS. Existing plans with star ratings of 4 or more receive a QBP of up to 5% while existing plans with star ratings lower than 4 receive no QBP.[3] When carriers enter the MA market, they typically receive a 3.5 star rating and a 3.5% QBP for the first three years of operation. This is an advantage over competitor plans with fewer than 4 stars but a disadvantage compared to competitor plans with ratings of 4 stars or more.

While new MA carriers are assigned a default star rating for the first three years, the star rating in Year 4 will be based on star metrics from the initial years. Therefore, it is important for MA carriers to create a strategy from the early stages to maximize star ratings once star rating metrics are measurable. Successful MA carriers tend to be those that invest in a strong customer service department and have policies and procedures in place for continuous monitoring and improvement to the measures that impact star ratings.

There is further financial incentive to achieve a higher star rating relative to the annual benefit and premium bids plans submit to CMS. CMS defines the expected costs it expects to pay in a given county for the traditional Medicare benefits. While MA carriers will typically achieve medical cost levels below this expected level due to efficiencies in managing care, some of this savings must be used to cover their administrative costs and profits. The remaining net projected savings is shared with CMS in the form of a rebate, with the amount retained by the MA carrier varying by star rating level. Rebates are very important because they are needed in order to offer richer benefits as compared with traditional Medicare and/or lower the member's premium, which is critical to being competitive in the MA market.

The table below outlines the QBP percentage and rebate percentage for various star ratings levels.

TABLE 19

Star Rating	CY2016 QBP Percentage	CY2016 Rebate Percentage
4.5+	5.0%	70%
4.0	5.0%	65%
3.5	0.0%	65%
< 3.5	0.0%	50%
Start-up and low enrollment plans	3.5%	65%

Diagnosis coding

CMS pays MA carriers based on the health "risk" status of each enrolled member. CMS' risk model determines each member's relative risk factor based on demographic factors and the diagnoses submitted on claims and encounters by providers as well as acceptable supplemental data (e.g., medical record reviews and health risk assessments). The more health conditions a member has coded, the higher the risk score and payment from CMS. However, enrollees are often treated for conditions for which proper diagnosis codes have not been submitted. This creates a mismatch between projected future claims and revenue.

It is extremely important for MA plans to work with providers to enter proper and complete diagnosis codes to allow for the development of appropriate risk scores and revenue in relation to future projected claim costs. This requires provider education and rewards, even though a certain level likely already exists in the market. Improving diagnosis coding accuracy increases revenue with no corresponding increase in claims and typically has a higher return on investment than care management initiatives.

Risk scores are based on the current year's demographic factors such as age and gender but the prior year's reported diagnoses. Therefore, new carriers are unable to directly impact the risk scores for their enrollees in the first year of the plan.

New carriers also tend to attract new MA enrollees. Enrollees that have had traditional Medicare previously will have a risk score assigned, but members that are newly eligible for Medicare instead get only a demographic factor score based on age, gender, Medicaid, and disabled status.

CMS also periodically conducts risk adjustment data validation (RADV) audits using medical record reviews benchmarked against the data submitted to CMS to identify data discrepancies. MA carriers need to put processes and staffing in place to optimize health risk scores, while at the same time ensuring that diagnoses coding is accurate in order to minimize adverse results that may result from any RADV audits.

3 Certain counties are designated as double-bonus counties by CMS and receive double the QBP. This is also an important consideration when determining the carrier's service area.

MANAGING CLAIM COSTS

Besides increasing revenue, initiatives that manage claim costs can also be financially advantageous. This can be achieved through utilization management programs and through provider contracting.

Utilization management

Utilization management programs are essential to controlling claim costs for a health insurance carrier. These management programs come in many forms and exist even in the most loosely managed delivery systems. At a minimum, they include programs such as utilization review, preauthorization, and case management. However, well-managed delivery systems use innovative techniques and employ many methods at once. Examples of the types of additional programs that a well-managed delivery system might use are:

- Use of clinical guidelines and best-in-practice treatments
- Provider incentive/risk-sharing programs
- Primary care gatekeepers
- Disease management programs
- Integrated delivery system and sharing of medical records

Provider contracting

Most providers expect to be paid at least 100% of Medicare fee-for-service (FFS) levels, or some equivalent of this; therefore, contracting with providers on an FFS basis produces little to no savings for MA carriers. Many MA carriers have turned to arrangements where they share risk with the providers. This can have multiple impacts because many of these arrangements incentivize providers to manage care more efficiently, to improve quality and adherence for star ratings, and to code diagnosis codes more effectively for risk scores. Examples of risk-sharing arrangements used in MA might include:

- Global capitation
- Percent of premium capitation
- Bundled payments
- Witholds
- Shared risk

MINIMIZING ADMINISTRATIVE COSTS

Revenue must be sufficient to cover not only claims incurred by members but also the administrative costs that are incurred in running the MA program. These costs include direct, indirect, and sales/marketing expenses. For a new MA carrier, this may also include some very sizeable startup costs. New carriers may have difficulty in covering their ongoing administrative costs in the early years prior to the establishment of enrollment large enough to gain economies of scale.

Consideration should also be given to the types of plans that will be offered, as this can impact administrative costs. Premium products, for example, will require expenses related to the collection of premiums from members. Simple plan designs may require fewer customer-service-related expenses. Included in any market analysis should be the administrative costs that may be required for different combinations of product offerings.

There will also be administration costs associated with the star rating and diagnosis coding improvement efforts and care management initiatives. However, as previously mentioned, these initiatives and the potential return on investment of the associated administrative costs are critical to being a successful MA carrier. The administrative costs will precede the benefits, as it will take a couple of years for the positive outcomes to be realized. This lag is one of the biggest reasons behind new carriers' inability to be profitable in the first few years, so patience and continued investment in these programs is required for the future realized gain.

SUMMARY

Entering the MA market can be challenging. Carriers must quickly understand the regulatory and financial requirements and have an action plan and team that is ready to execute. Performing market research will help a carrier better understand the environment in which it will be competing for membership. It is critical to work on all of the many levers that will help to increase revenue and minimize claims and administrative expenses. Although not the only variables to success, the strategies presented here will be important for new carriers and must be monitored on an ongoing basis by even established carriers to effectively compete in the MA market.

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