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MEMORANDUM October 5, 2018

To: Honorable Steve Daines
Attention: Darin Thacker

From: Paulette C. Morgan, Specialist in Health Care Financing,
Jameson A. Carter, Research Assistant,

Subject: **Medicare Advantage Benchmark Cap Statistics for 2018**

You requested specified Medicare Advantage (MA) statistics related to the number of enrollees and counties affected by the MA benchmark cap in 2018.[1] The "Findings" section contains the answers to those questions. This memorandum also includes a "Background" section that describes how MA plan payments are determined, including calculation of the benchmarks and caps. As these questions arose in the context of an analysis of H.R. 908, the "Medicare Advantage Quality Payment Relief Act of 2017," the memorandum also includes a brief summary of that bill. Finally, the "Methodology" section includes detailed definitions and a description of how the requested statistics were calculated.

Because the issues addressed in this memorandum may be of general interest to Congress, information included in this memorandum may be provided to other congressional requesters, or incorporated into a CRS report for general distribution. Your identity as a requester would not be disclosed in either case.

Findings

- In 2018, approximately half of all counties had a *high quality* or *low-enrollment/new-contract* benchmark that was affected by the cap.

Based on enrollment as of June 2018, and star quality ratings for 2017,[2]

- Approximately 78% of MA enrollees are enrolled in high quality plans.
- Approximately 23% of MA enrollees are both enrolled in a high quality plan and living in a county with a *high quality* benchmark cap.
- Approximately 16,000 Medicare beneficiaries in Montana are enrolled in a high quality plan and living in a county with a capped *high quality* benchmark.

[1] You specifically asked for: (1) the proportion of counties subject to the benchmark cap; (2) the proportion of MA enrollees in high quality plans; (3) the proportion of enrollees in high quality plans subject to a benchmark cap; and (4) the number of such enrollees in Montana.

[2] As explained in the "Background" section of this memorandum, the star quality ratings published in October of 2016 for CY2017 beneficiary enrollment decisions are the basis for the quality adjustments to MA benchmarks in CY2018.

Background

Medicare Advantage is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. The Secretary of Health and Human Services (HHS) determines a plan's payment by comparing its bid to a benchmark. A *bid* is the private health plan's estimated cost of providing Medicare-covered services (including the cost of medical services, administration, and profit).[3] In general, the Secretary of HHS has the authority to review and negotiate plan bids to ensure that they reflect revenue requirements. A *benchmark* is the maximum amount the federal government will pay for providing those services in the plan's service area.[4] If a plan's bid is less than the benchmark, the plan's payment equals its bid plus a portion of the difference between the bid and the benchmark, which is referred to as a *rebate*. The rebate must be returned to enrollees in the form of additional benefits, reduced cost sharing, reduced Medicare Part B or Part D premiums, or some combination of these options. Starting in 2012, the size of the rebate depends on plan quality; rebates range from 50% to 70% of the difference between the bid and the benchmark.[5] If a plan's bid is equal to or above the benchmark, its payment equals the benchmark amount; and each enrollee in that plan will pay an additional premium that is equal to the amount by which the bid exceeds the benchmark.[6] Finally, payments to plans are risk adjusted to take into account the demographic and health history of those who actually enroll in the plan.

Calculation of the Benchmark

Separate benchmarks are calculated for each county. The methodology for calculating the benchmarks is applied consistently across counties. The level of the benchmark in any particular county can be affected by the practice of medicine in original fee-for-service (FFS) Medicare, and how that affects spending in original Medicare in the county relative to other areas of the nation. This section discusses the calculation of the benchmarks.[7]

[3] The capitated payment for MA plans, as explained in this memorandum, does not include payment for the hospice benefit otherwise covered under Medicare Part A. If an MA enrollee chooses the hospice benefit, the MA plan is paid on a fee-for-service basis to provide that benefit.

[4] In general, a plan's service area is defined by zip code and may consist of a county, groups of counties, whole states, or the entire nation, unless the plan is participating in the Regional MA program, in which case the plan's service area consists of a region, or multiple regions, as defined by the Secretary of HHS. Benchmarks are calculated on a county-by-county basis. A plan submits a single bid for its service area, and the Centers for Medicare & Medicaid (CMS) calculates a single benchmark for that plan based on the counties included in the plan's service area.

[5] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) benchmark changes made plan payments dependent on plan quality for the first time. Plan quality affects payments in two ways. First, it determines the size of the rebate when a plan bid is below the benchmark. Second, it increases the benchmark if the plan quality is of a sufficient level. For example, in general, in CY2018, a 4-star plan that bid below the benchmark would receive a 5 percentage point quality adjustment to the benchmark and would receive 65% of the difference between its bid and the benchmark as a rebate; a 3-star plan that bid below the benchmark would not qualify for a quality adjustment to its benchmark but would receive 50% of the difference between its bid and the benchmark as a rebate.

[6] Though plans are required to use their rebate to provide extra benefits, reduce cost sharing, or reduce the Part B or Part D premium, any plan, regardless of whether the bid was above or below the benchmark, can include extra benefits that are paid for entirely through a premium increase.

[7] For a detailed description of the calculation of benchmarks, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*. The ACA changes to the MA benchmark methodology are fully phased in for 2018.

The MA county benchmarks are set at a percentage of per capita FFS spending in each county. Per capita FFS spending is based on a five-year rolling average of claims data for beneficiaries in original Medicare living in each county, and includes weighting for enrollment and average risk scores.

Three adjustments are applied to the per capita FFS estimates of spending for each county for the benchmark calculation. First, FFS estimates for each county are multiplied by a percentage specified in statutes—95%, 100%, 107.5%, or 115%—with higher percentages applied to counties with the lowest FFS spending.[8] In other words, the 25% of counties with the lowest FFS spending will receive the highest percentage (115%) of per capita FFS as their MA benchmark. The 25% of counties with the highest FFS spending will receive the lowest percentage (95%) of per capita FFS.

Second, benchmarks are adjusted by plan quality.[9] Starting in 2012, plans with at least a 4-star rating on a 5-star quality-rating scale established by the Centers for Medicare & Medicaid (CMS) receive an increase in their benchmark. In 2018, a plan receiving 4, 4.5, or 5 stars on a 5-star quality-rating system may receive a 5 percentage point increase in its benchmark.[10] This means that in 2018, a plan that might otherwise have had a benchmark of [100% × per capita FFS] could receive a benchmark set at [105% × per capita FFS] if the plan had a star quality rating of 4 or more stars. The benchmark quality increases are doubled for qualifying plans in a qualifying county.[11]

In specified circumstances where a quality rating for a plan cannot be generated, a plan may be determined to be a *qualifying plan* and receive a 3.5 percentage point increase in its benchmark.[12] Specifically, a *new plan* refers to a plan offered by an organization that has not had another MA contract within the previous three years.[13] Additionally, a *low-enrollment* plan is one that does not have a sufficient number of enrollees to have fielded the Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) surveys from which a portion of the quality metrics for the 5-star quality rating are based.[14] An MA plan that simply does not submit quality data, but for which it is possible to

[8] The Secretary of HHS will occasionally recalculate (or *rebase*) county-level per capita FFS spending. When this happens, a county could transition from being a 100% of FFS spending county, for example, to being a 95% of FFS spending county. If a county quartile designation switches, the county will have a one-year transition to the new county designation. In this example, the county benchmark would be set at 97.5% of FFS spending for one year before the full transition to being a 95% of FFS spending county.

[9] See CMS, "Part C and D Performance Data," at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

[10] Star ratings published in 2017 are the basis of quality-adjustment in the 2018 benchmarks.

[11] A *qualifying county* is defined as a county with (1) lower-than-average per capita spending in original Medicare; (2) 25% or more beneficiaries enrolled in MA, as of December 2009; and (3) a payment rate in 2004 based on the minimum amount applicable to a metropolitan statistical area (i.e., an urban floor rate). The first of these three criteria is updated each year, and, depending on the results, a county may or may not meet that criterion in any one year. The remaining two criteria are based on historical data; a county must meet both of those criteria if it is ever to be a qualifying county.

[12] Social Security Act §1853(n)(4).

[13] If a contract is offered by an organization that had offered other MA contracts within the prior three years, the quality measure for the new contract is based on a weighted average of the measures for the other contracts offered by the parent organization. In this case, any adjustment to the MA benchmark is based on the calculated quality measure and not assumed to be a 3.5 percentage point adjustment otherwise available to new plans. As discussed in more detail in footnote 24, star quality data available for download does not reflect whether a "Plan too new to be measured" is or is not offered by an organization that had contracts in the prior three years upon which a quality measure could be based for benchmark adjustment purposes.

[14] See, Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter*, February 1, 2017, pp. 11-12, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2018Advance.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending.

calculate quality data, receives a star rating of 3.5 stars and does not qualify for any benchmark adjustment.[15]

As such, there are three different benchmarks calculated for each county: (1) a high quality benchmark which consists of a benchmark with a 5 percentage point increase available to plans receiving a 4, 4.5, or 5 stars rating; (2) the new/low-enrollment benchmark which consists of a benchmark with a 3.5 percentage point increase available to (a) plans with low enrollment for which a quality rating cannot be calculated and (b) new plans for which a quality measure cannot be calculated; and (3) a benchmark that is not adjusted by quality, which applies to plans that receive 3.5 or fewer stars.

Third, the Patient Protection and Affordable Care Act (P.L. 111-148, ACA, as amended) requires that benchmarks (including any quality adjustment or adjustment based on being a new plan or a low-enrollment plan) be capped at the level they would have been in the absence of the ACA.[16] In 2018, in half of U.S. counties, the 5 percentage point quality bonus adjustment to the MA benchmark is constrained by the pre-ACA benchmark cap. In some cases, this means the quality bonus for plans with 4 or more stars may be less than 5 percentage points (or possibly no increase at all). In other cases, the benchmark for plans with less than 4 stars (either benchmarks for new/low-enrollment plans, or benchmarks for plans without any quality adjustment) also may be constrained by the pre-ACA benchmark levels. When a benchmark is constrained by the cap, the methodology used to calculate the benchmark is based on the methodology that applied prior to the enactment of the ACA.

Summary of H.R. 908

H.R. 908, the "Medicare Advantage Quality Relief Act of 2017"[17] would, effective January 1, 2018, amend current law such that the MA benchmark cap would be calculated without taking into account any increase based on plan quality, or a plan being a new or low-enrollment plan. In other words, the benchmark cap would only apply to the base calculation of the benchmark (i.e., the calculation of per capita FFS and the relevant percentage adjustment), but would not apply to the 5 percentage point quality benchmark adjustment, or the 3.5 percentage point adjustment for new or low-enrollment plans.

Methodology

To calculate the requested statistics, three datasets available on the CMS website were merged and analyzed using the software Rstudio:

1. 2017 Part C and D Medicare Star Ratings Spring Release;[18]
2. June 2018 Medicare Advantage Enrollment by State/County/Contract file (Abridged);[19] and
3. 2018 Medicare Advantage Rate Calculation Data file.[20]

[15] Social Security Act §1853(o)(4)(B).

[16] Social Security Act §1853(o)(3)(A).

[17] https://www.congress.gov/bill/115th-congress/house-bill/908?r=1.

[18] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html. Accessed 9/21/2018.

[19] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract-Items/MA-Enrollment-by-SCC-2018-06.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending. Accessed 9/21/2018.

[20] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data-

This process yielded a file containing the enrollment in MA contracts[21] in each county in June 2018, the 2017 Star Rating upon which the 2018 benchmark determination was made, and whether the county in question had a capped 5 percentage point or 3.5 percentage point benchmark for 2018.

Only plan types paid through capitation for which the benchmark policy would be relevant were retained in the file; those plan types included Regional Coordinated Care Plans (Regional CCP, consisting of regional preferred provider organizations), Local Coordinated Care Plans (Local CCP, which include health maintenance organizations, preferred provider organizations, and provider sponsored organizations), and Private Fee for Service Plans (PFFS). These plan types account for roughly 75% of all contracts with quality ratings in 2017 and roughly 95% of enrollees covered by MA plans in 2018.[22] Plan types that are not paid on a capitated basis and would not be affected by a policy changing the cap on benchmarks were excluded from the file.

Consistent with statutes, contracts with an overall star rating of 4, 4.5, or 5 were then designated as high quality.[23] The Medicare Star Quality Rating Spring Release file designates certain contracts as *plan too new to be measured* and *not enough data available*. In those circumstances, contracts were treated as ineligible for the 3.5 percentage point quality benchmark in this analysis because the Part C and D Medicare Star Ratings do not reflect whether a plan that was *too new* would be subject to the 3.5 percentage point benchmark based on whether the Parent Organization offering the contract had offered contracts within the prior three years or not.[24]

Limitations

Results reported in this memo reflect a certain subset of MA plans and enrollees. First, CMS interprets the Health Insurance Portability and Accountability Act of 1996 (HIPPA) privacy laws as prohibiting publication of enrollment totals with values of 10 or less. The abridged enrollment file used for this analysis excluded observations where there are 10 or fewer enrollees. The

Items/2018Rates.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending. Accessed 9/21/2018.

[21] The body of this memorandum uses the term "MA plan" as that is the popular description. However, technically, star ratings are calculated on the *contract* level and the enrollment estimates used for this analysis also based on the *contract* level. A Managed Care Organization may have one or many contracts with CMS. Each contract may contain one or many plans. A plan is a specific set of goods and services, with a uniform premium and cost sharing requirements, offered in a specified location.

[22] CRS Analysis. There were 466 regional coordinated care plans (Regional CCP), local coordinated care plans (Local CCP), and private fee-for-service (PFFS) contracts represented in the 2017 Star Ratings file out of 606. Contracts included in the Star Ratings file that were not included in this analysis include Part D (only) prescription drug plans, Reasonable Cost Plans, demonstrations, and medical savings accounts. Twenty two contracts appear in the 2018 enrollment file but do not appear in the 2017 star rating file; those contracts are assumed to be new contracts for which star quality rating data are not available. There were 20,034,157 people enrolled in Regional CCPs, Local CCPs, and PFFS in 2018, out of 21,146,929 in MA plans.

[23] Social Security Act §1853(o)(1)(C).

[24] CMS indicated in communication with authors that, ""Plan too new to be measured" is assigned for the Star Ratings displayed on Medicare Plan Finder [https://www.medicare.gov/find-a-plan/questions/home.aspx] when the contract is too new to have submitted data to be rated in the summary or overall levels. For Quality Bonus Payment purposes, if it is a contract under an existing parent organization, it would get the enrollment weighted Quality Bonus Payment rating of the other star rated MA contracts under that parent organization. If it is a completely new parent organization, it would be treated as a qualifying plan for Quality Bonus Payment purposes and get the 3.5 percentage increase." The data displayed in the Medicare Plan Finder for the CY2017 service year was published on October 12, 2016. The CY2017 star ratings are the basis of the CY2018 payment adjustments, however, determination of whether a new contract had been offered by a parent organization in the previous 3 years might not be reflected in the data available for download. For purposes of this analysis CRS assumed *plan too new to be measured* would never result in the 3.5 percentage point increase in the benchmark; this may result in an under-estimate of the number of affected enrollees. However, enrollment in such designated contracts that would be subject to a 3.5 percentage point benchmark cap represents approximately 1% of total MA enrollment. Contracts designated as *not enough data available* in the available quality rating data would be subject to the 3.5 percentage point benchmark; enrollees in contracts designated as *not enough available data* living in counties with a 3.5 percentage point benchmark cap, however, represent 0.1% of MA enrollment.

comparable unabridged file contains observations, however, enrollment data itself is suppressed in that file. If enrollment data were not suppressed, results of this analysis could differ, but as all publically available enrollment data contains the same omissions, this analysis will not differ from other public analyses based on this fact.

Second, results in this memorandum may differ from other published results if, for example, additional plan types were to be excluded; it is not uncommon for analyses of plan quality to exclude (1) MA contracts sponsored by an employer or union exclusively for their own retirees or members (Employer Group Waiver Plans or EGWPs), or (2) Special Needs Plans (SNPs) which are MA plans that limit enrollment to beneficiaries with specified characteristics, such as beneficiaries who live in institutions, or those who are eligible for both Medicare and Medicaid. However, as both EGWPs and SNPs receive capitated payments for which the benchmark could be affected by the payment cap and by any policy that could change it, we did not exclude them from our analysis.