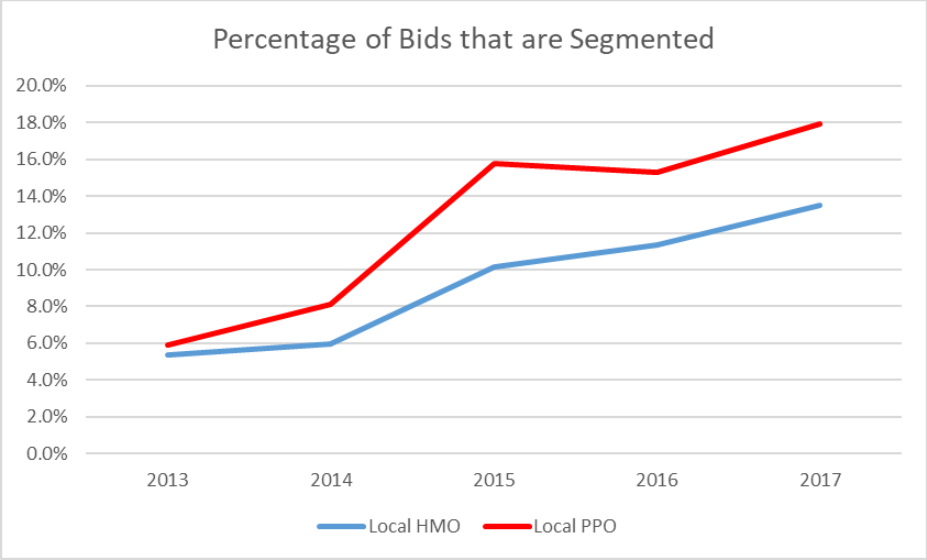
WHITE PAPER

Maximize Your Medicare Advantage Strategic Potential Through Segmentation

Brad Davis, FSA, MAAA
612.800.6587 • Brad.Davis@wakely.com

Bob Spence, ASA, MAAA
612.800.6588 • Bob.Spence@wakely.com

Over the last several years, Medicare Advantage and Part D (MAPD) carriers have increasingly used segmentation as a way to competitively price their MAPD plans throughout their service area. The chart below shows that among local HMO and local PPO bids over the last five years, the proportion of bids that are segmented has more than doubled.



So, what is driving this trend? How are plans using segments to achieve their strategic goals? Or maybe your question is, what the heck is segmentation? This paper will attempt to explain the drivers of this recent trend and provide examples of how segmentation can be used as a tool to help plans gain a competitive edge.

What is Segmentation?

A segment is a distinct portion of the service area of an MA local plan consisting of at least a full county in which benefits, premiums, and cost sharing are uniformly offered to all eligible Medicare beneficiaries residing in that distinct portion.[1] Using a general example, let's say that an MAPD carrier has a service area consisting of four counties. The carrier would like to offer one plan benefit package (PBP), but vary

[1] MA Benefit Manual, chapter 1.2

the premiums by county in order to be more competitive. The table below illustrates one way the carrier may achieve this through segmentation.

Year	Plan Name	Contract ID	Plan ID	Segment ID	Segment Area
Year 1	HMO-Plus	H9999	001	000	Counties A, B, C, D
Year 2	HMO-Plus	H9999	002	001	Counties A, B, D
Year 2	HMO-Plus	H9999	002	002	County C

In this example, the carrier would be offering the same benefit package for all four counties, but county C would have a separate bid from counties A, B, and D. Segments 001 and 002 could have separate premiums as well, allowing the carrier to better align the plan premiums with CMS revenue. Listed below are several key advantages of offering segments in this situation

- **Segments allow carriers to more accurately align costs to revenue:** Segmentation aligns premiums more appropriately by county, allowing lower cost counties to be more competitive by limiting subsidizing between counties. This is particularly true for service areas with big variation in Part C county benchmark amounts.
- **Administratively efficient:** Segmentation can allow carriers to offer the same benefits in multiple segments, eliminating inefficiencies of having multiple marketing materials or claims system adjudication algorithms.
- **Beneficiary retention:** When adding/subtracting segments, members can stay seamlessly enrolled in their current plan through a MARX cross walk, avoiding the need to inform members that their plan has changed (which is required under a traditional, HPMS crosswalk) and thus circumventing additional membership churn.
- **Product retention.** The designation of a plan as “low enrollment” occurs at the contract level, and is not applied to segments. A plan that has low enrollment, but is desirable could potentially avoid mandatory termination if it were part of a segmented product.

What are the Bidding Requirements?

When segmenting a plan, there are rules for what CMS will allow. Generally, when preparing BPTs, segmented bids must adhere to the following requirements:

- A new plan ID cannot start as a segmented plan; only active plans can be segmented. This limitation needs to be considered by carriers when making multi-year strategic plans.
- MA benefits and premiums may vary by MA segment
- When segmenting a MAPD bid, Part D bid must be identical for each segment in the same plan ID. The only item in the Part D BPT that is allowed to vary is the segment number

- Regional PPOs may not be segmented
- Certifying actuaries have discretion under the bid instructions regarding what experience to include on Worksheet 1 for new segments. For example, under the scenario listed above, the actuary may use the year 1 experience from plan 001 as the base or both segmented plans in year 2 (i.e. both segments will have the same Worksheet 1 data). Once a segment has its own experience, then that segment will use its own experience for Worksheet 1
- Margin requirements, meaningful difference, OOPC, etc. rules apply to segments as though they are separate plans when comparing to plans with overlapping service areas

A Real-life Example

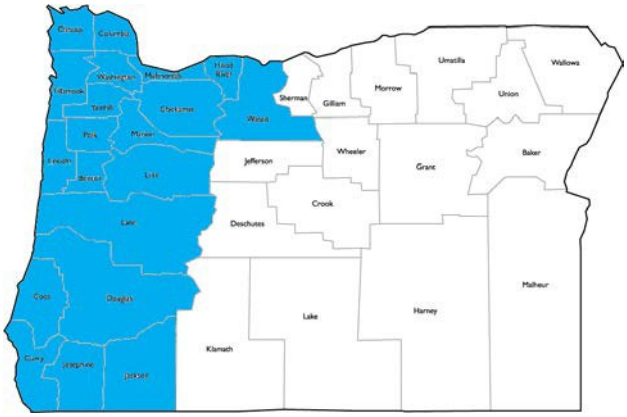
There are many factors that can cause a plan utilize segmentation. Some examples include the following:

- Claims Cost
- Contracting or provider network
- Competitive pressures
- Plan Strategy
- Varying county benchmarks; bonus counties vs. non-bonus counties
- County specific taxes and expenses

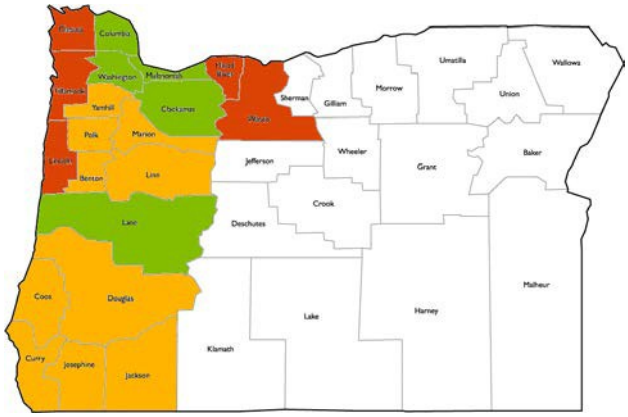
By researching publically available data, we have highlighted an example of a carrier in Oregon that used segmentation to regionally price their plans and to eventually exit high-cost, unprofitable counties. Through this process, they were able to grow their membership base by reducing premiums in profitable counties while increasing rates for less-profitable counties.

The service area of this plan is the Western portion of the state which is sandwiched between the Pacific Ocean and the Cascade mountain range. In years 1 and 2, this carrier included all of the counties highlighted in blue under one plan ID. Beginning in year 3, the carrier began segmenting their service area into the three color coded-segments green, yellow, and orange.

Years 1 & 2



Years 3 & 4



The first segment in green includes counties in urban portions of the state including Portland and Eugene. The second segment in yellow includes rural counties throughout the state and the third segment includes costal northern counties and counties in the mountains in the northern part of the state.

For the sake of this example, we will review the publically available characteristics to highlight how this particular carrier may have benefited from segmentation.

Growth Potential

The monthly premiums are summarized in the table below by segment and year. You will notice that until this plan segmented in year 3 the premiums are consistent because there were no segments.

	Premiums			
Segment	**Year 1**	**Year 2**	**Year 3**	**Year 4**
1	$53	$66	$44	$46
2	$53	$66	$82	$104
3	$53	$66	$102	n/a

From year 1 to year 2 the carrier increased the monthly premium for the entire service area by roughly 25% from $53 to $66, a $13 increase. Then in year 3 the plan was segmented and the carrier was able to significantly reduce premiums for the counties in segment one, putting themselves in a more competitive position in the most populated counties. Conversely, the carrier increased premiums by the maximum amount allowed by CMS in the high-cost costal and less-profitable northern counties. In year four, the carrier exited segment three entirely while holding premiums relatively steady in segment one. Year 4 reveals their strategy of refining their service area to exit the counties in segment three while minimizing disruption in the remainder of the carrier's service area. The table below shows the growth the plan was able to achieve by being more competitive in year 3. Year 4 shows lower levels of enrollment as the plan strategically exited segment 3 and significantly increased premiums in segment 2.

Membership				
Segment	Year 1	Year 2	Year 3	Year 4
1	11,019	12,027	15,723	14,193
2	11,847	12,833	13,744	11,775
3	1,857	2,426	2,444	n/a
Total	**24,723**	**27,286**	**31,911**	**26,254**

Without segmentation, the carrier may have had to close the plan entirely, then through an HPMS cross walk, move the remaining members from the counties green and yellow counties into new plan IDs while notifying members that their plan is being terminated and exposing the risk of losing these members.

Claim Costs

Although the claim costs for the carrier in this example are private information, the table below summarizes FFS claims expenses as a proxy for the plan's claims costs.

FFS Costs				
Segment	Year 1	Year 2	Year 3	Year 4
1	$639	$656	$635	$660
2	$632	$656	$630	$662
3	$762	$787	$764	$790

Segment 3 has much higher costs that the other two segments, which are relatively equal. Higher costs in an area do not necessarily mean it is unattractive for the plan, though. Revenue must also be considered.

Revenue

Revenue can vary, sometimes significantly, between counties in a single service area. Revenue is directly impacted by Part C county benchmarks and the risk scores of members in the county. A plan's star rating also impacts revenue, and provider behaviors that impact the contract's star rating measure can vary by area.

With respect to Part C county benchmarks, there are multiple factors that go into setting benchmarks that could affect the revenue at the county level besides the level of FFS costs:

- Double Bonus County: Certain counties were given a double bonus which would increase revenue and make these counties more attractive
- FFS Quartile Percentage
- Transition Year: 2, 4, 6 year transitions are over now but affected benchmark levels in prior years due to the weighting of pre ACA and post ACA benchmarks.

Summarized below are the MA county benchmarks for this contract by segment and year.

MA Benchmark				
Segment	Year 1	Year 2	Year 3	Year 4
1	$842	$867	$748	$830
2	$772	$820	$728	$803
3	$787	$832	$768	$790

Potential Profitability

As a proxy for profitability, we looked at the benchmarks (proxy for revenue) less the FFS costs (proxy for plan expenses) and we see that segment 1 is clearly the winner whereas the carrier's strategy for exiting segment 3 is evident by the very low potential profitability.

Benchmark less FFS Rates				
Segment	Year 1	Year 2	Year 3	Year 4
1	$203	$211	$113	$170
2	$140	$163	$98	$141
3	$25	$45	$4	$0

This is a great example of the benefit of segmentation. Here, the plan can segment their service area and strategically exit the very low profitable areas, and become more competitive in the areas with the greatest potential for profitability.

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Please contact Brad Davis at Brad.Davis@wakley.com or Bob Spence at Bob.Spence@wakely.com with any questions or to follow up on any of the concepts presented here.