WHITE PAPER

CMS Proposes Medicare Advantage Changes that Could Jeopardize the Future of Its Value-based Insurance Design Model

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

The Centers for Medicare and Medicaid Services (CMS) recently released its 2019 proposed policy changes to the Medicare Advantage and Part D (MAPD) program[1]. Among the purported changes, CMS is proposing to relax the uniformity rule for all MA plans, allowing carriers to offer a varying set of MA benefits within the same plan ID[2] (previously all members within a plan ID must have the same level of cost-sharing). Prior to this proposed rule, only plans who requested a waiver of the uniformity rule through participation in the MAPD value-based insurance design model (VBID) were allowed to offer varying benefits within a plan ID. This subtle change could have major implications on the viability of the VBID program as well as modifications to the 2019 bid submissions. This paper will discuss the differences between the VBID demonstration and the proposed rule, as well as potential pitfalls to the 2019 bidding process.

What is VBID?

CMS, through its Center of Innovation, began allowing MAPD carriers to participate in VBID on January 1st, 2017. Once a carrier completes the application process and is approved by CMS, carriers are allowed to offer plans which reduce cost-sharing for high-value benefits to members with certain targeted conditions (e.g. diabetes, COPD, etc.) compared to the standard benefits for the plan. The plans with multiple tiers of benefits are considered non-uniform since the cost sharing levels within the plan ID differ. Under the VBID contract, the types of benefits that CMS will allow plans to vary are:

- Reduced cost-sharing for high-value benefits (e.g. podiatry for those with diabetes)
- Reduced cost-sharing for high-value providers (e.g. heart facilities for members with CHF)
- Reduced cost-sharing for members who participate in a disease management program
- Offering supplemental benefits for members with targeted conditions

In 2017, VBID plans were limited to five specific states. For 2018, CMS increased the VBID opportunity to ten states and for 2019 CMS is opening up VBID to carriers in a total of twenty-five states. CMS plans

[1] https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-25068.pdf
[2] Or Plan Benefit Package (PBP)

to test the VBID program over a period of five years, hypothesizing that VBID will lower overall costs and improve morbidity levels.

What is in the Proposed Rule?

The 2019 proposed rule includes language that will allow all MA carriers to offer reduced cost-sharing for certain covered benefits or offer specific tailored supplemental benefits based on a member's health-related factors.

This sounds a lot like VBID, doesn't it? There are a two distinct differences between VBID and the proposed rule, and there is a lot of ambiguity that CMS has yet to finalize.

Key Differences

1. VBID allows for plans to vary Part D benefits for members with targeted conditions whereas the proposed rule is specific to MA benefits.
2. VBID allows for plans to target members for reduced cost sharing based on participation in a disease management program. The proposed rule only allows for reduced cost sharing for beneficiaries meeting specific health-status factors (i.e. participation in a disease management program alone will not qualify members for increased benefits).

Key Unknowns

- Marketing Restrictions: Under VBID, carriers are not allowed to market the additional VBID benefits. Rather, carriers need to inform beneficiaries that they are eligible for VBID benefits once he/she obtains the condition which the VBID targets. The 2019 proposed rule does not specify whether marketing of the additional benefits will be permitted.
- Targeted Conditions: Under VBID, carriers had to select specific health conditions (defined by CMS) for their VBID program. For 2019, CMS has broadly expanded the targeted conditions to include carrier-defined conditions (based on ICD-10 diagnosis codes). The 2019 proposed rule does not comment on restrictions of targeted conditions.
- Future of C-SNP Plans: The proposed rule allows for any plan to include enhanced benefits for chronic conditions. Depending on how the final rule defines the marketing rules, this change in the uniformity rule could jeopardize the future of chronic special needs plans (C-SNPs) since, effectively, any MA plan could tailor a subset of benefits for any condition.
- Impact on Bids: It is unknown how this will impact bids, other than increased plan costs (at least in the short term) due to subsets of increased plan benefits. There are other potential impacts. One long term outcome is that carriers could use non-uniformity to improve star ratings as a result of improved quality performance. If marketing of enhanced benefits is allowed, some carriers could see significant anti-selection depending on how the additional benefits are structured and the conditions to which they apply. Plans with non-uniform benefits could also see a backlash

from beneficiaries who do not qualify for the targeted conditions as they may perceive that they are subsidizing some of the cost for these additional benefits.

- Future of VBID? Flexibility introduced by the 2019 proposed rule may result in unintended consequences of cannibalizing the existing VBID program and also lead to anti-selection.

Comments for the 2019 proposed rule are due to CMS on January 16, 2018 with the final rule expected to be released around March.

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About the Author

Brad is a Senior Consulting Actuary in the Minneapolis office of Wakely Consulting Group. He joined the Minneapolis office of Wakely in 2013 and has 15 years of healthcare actuarial consulting and client management experience. Brad has developed and certified Medicare Advantage and Part D bids since 2007. Additionally, Brad has certified ACA-compliant individual rates for organizations in several states. He has worked directly with payers, providers, employers, and government departments to perform actuarial analyses in the form of reserving, provider contracting and reimbursement, data and trend analytics, risk-based capital testing, pricing strategy, Medicaid rate adequacy analyses and wellness initiatives. He also has served as the client lead actuary for smaller insurance companies, performing all aspects of actuarial work.

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