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Considerations for plan segmentation in Medicare Advantage bids

Julia Friedman, FSA, MAAA
Sam Smetek, ASA, MAAA

Milliman

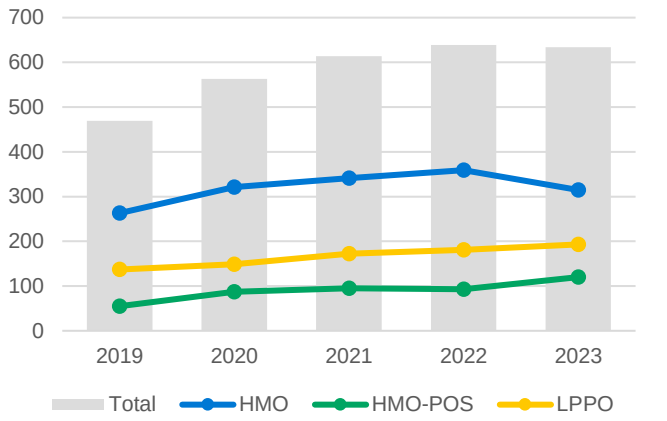
Market summary

Over the last few years, Medicare Advantage organizations (MAOs) have been adding benefit plans (defined as Plan Benefit Packages, or PBPs) with segments to their plan portfolios to take advantage of plan segmentation, which we outline in more detail below in the Mechanics of Plan Segmentation section.

We reviewed the available information published by the Centers for Medicare and Medicaid Services (CMS) and note the following metrics of interest regarding segmented plan trends:

- Figure 1 shows the growth in the number of segmented plans has stabilized after considerable increases between contract years (CY) 2019 and CY 2022. This is mostly due to a significant decrease in segmented plan offerings for health maintenance organizations (HMO) products in CY 2023. HMOs with a point of service (HMO-POS) option and local preferred provider organization (LPPO) products maintained slight increases in the number of segmented plans in CY 2023.
- About 11.2% of all individual Medicare Advantage plans are considered segmented in CY 2023, down slightly from its highest point in CY 2020 at 13.2%.
- Most segmented plans are HMOs. In CY 2023 about 11.3% of HMO plans were segmented, while about 13.4% of HMO-POS option were segmented. For LPPOs, approximately 10.1% of plans are segmented. While the number of segmented plans has grown over the past four years, the percentage of plans that are segmented has steadily decreased since CY 2020.
- The majority of segmented plans are general enrollment plans, although a very small number of dual eligible special needs plans (D-SNPs) and chronic special needs plans (C-SNPs) were segmented in CY 2023, at 6.1% and 7.2%, respectively. Only 1.6% of institutional SNPs (I-SNPs) were segmented in CY 2023.

FIGURE 1: COUNT OF MEDICARE ADVANTAGE BIDS THAT ARE SEGMENTED, 2019-2023



What is segmentation and why would an MAO consider implementing it?

Under the Medicare Advantage (MA) program, MAOs can offer a variety of PBPs. In MA, each plan has a defined service area consisting of one or more counties. When a plan is segmented, the service area is split up into segments consisting of a set of counties (including at least one full county in each segment), chosen by the sponsoring MAO within the service area. Each of these segments is considered a distinct PBP, where each PBP is identified by an alphanumeric contract number (e.g., H1234), a three-digit plan number (e.g., 123), and a three-digit segment number. For segmented plans, each segment of the particular plan will be assigned a non-zero segment number, e.g., “001,” “002,” or “003,” and each segment of the plan is offered in a nonoverlapping set of counties within the service area. The counties in segments do not have to be the same across the MAO’s plans. Non-segmented plans are identified as segment “000.”

Prior to CY 2019, MAOs that offered segmented plans were required to offer the same benefits within each segment of the plan, while still being allowed to vary the cost sharing of those benefits as well as the premium between segments. In the CY 2019 Call Letter issued by CMS on April 2, 2018, CMS reinterpreted the regulations governing plan segments and announced that MAOs can vary supplemental benefits, e.g., dental, vision, over-the-counter (OTC) drug cards, etc., in addition to premium and Part C (medical) member cost sharing, within each segment of a plan. Benefits, premiums, and cost sharing must be uniformly offered to beneficiaries within each of those segments—that is, each segment within a plan must offer the same benefits, premiums, and Part C cost sharing to all beneficiaries enrolled in that segment.[1] Note segmenting only applies to Part C bids (or the medical portion) and thus Part D benefits and pricing are identical for all segments within a given plan. If desired, an MAO can differ the Part D buy-down applied to segments within a plan as part of targeting a specific total premium. Further, the plan intention for the Part D basic premium in the Part C bid form can also be varied.

As an example, assume an MAO has a current service area of nine counties. Reviewing the market, the MAO recognizes that its competitors in two of these counties have strong value propositions with lower premiums than the rest of the market. Further, three other counties within this service area are trending toward only high premium offerings. The MAO would like to offer one PBP, but vary the premiums, cost sharing, and supplemental benefits for these three distinct sub-service areas. The MAO is able to do this through segmentation, with a simple illustration demonstrating the premium differentials laid out in Figure 2.

There are additional reasons an MAO may want to introduce a segmented plan into its plan offerings. In this paper, we review the considerations when looking at adding a segmented plan to an MAO portfolio as well as the bid requirements for segmented plans.

Mechanics of plan segmentation

There are numerous items to consider when segmenting a plan within an MAO's portfolio of PBPs, relative to the alternative of offering separate PBPs to achieve strategic objectives.

Variation of premiums, supplemental benefits, and Part C cost sharing

As stated above, the ability to vary premiums and Part C cost sharing between plan segments is one of the main reasons an MAO may want to segment a plan. As of CY 2019, CMS also allowed plans to vary the supplemental benefits (e.g., dental, vision, hearing, nonemergency transportation, OTC drug cards, etc.) between segments. It should be noted that variation of these items can be done without segmentation within a plan; however, an MAO usually creates a segmented plan that allows these variations because of market research, as previously noted.

Low-enrollment plan reviews

CMS reviews MAO plan offerings as they relate to CMS's low-enrollment thresholds. A low-enrollment plan is defined as a plan that has been in existence for three or more years and has fewer than 500 enrollees for a non-SNP or fewer than 100 enrollees for a SNP. The review is done annually, and CMS sends notices in March of each year to plans that are identified as having low enrollment (with limited exceptions).[2]

The MAO must 1) confirm to CMS how these plans will be eliminated or consolidated for the upcoming bid year, or 2) provide justification that must be accepted by CMS to allow the plan to be offered in the upcoming bid year. If CMS does not accept the justification, then the plan must be eliminated or consolidated. This review of low enrollment is done at the plan level and not the plan-segment level, so it may be desirable for an MAO to combine a number of counties into a segmented plan where differing premiums, supplemental benefits, and/or medical cost sharing are offered to align with the competitive position in each segment's service area. As a result, the MAO may avoid having the plan eliminated by CMS after the three-year window is complete as long as the total beneficiaries among all segments within the plan are greater than the thresholds noted above.

[1] CMS (April 2, 2018). Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Retrieved February 22, 2023, from https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/announcement2019.pdf.

[2] CMS (April 20, 2022). Final Contract Year 2023 Part C Benefits Review and Evaluation, Retrieved February 22, 2023, from https://www.cms.gov/files/document/finalcy2023partcbidreviewevalmemorandum.pdf.

Beneficiary retention

If an MAO wants to move a particular county or counties from a current segment to either a new segment or an existing segment, membership does not need to be formally cross-walked through the traditional Health Plan Management System (HPMS) cross-walk process and can be achieved using the Medicare Advantage and Prescription Drug system (MARx) cross-walk.[3] The HPMS cross-walk process can make beneficiaries actively choose to enroll in a new plan, which can be a detriment to beneficiary retention. On the other hand, the MARx cross-walk moves a beneficiary between segments within the plan based on the county of residence when the service area is redefined, without requiring any decisions by the beneficiary.

FIGURE 2: EXAMPLE OF PLAN SEGMENTATION

PLAN SEGMENT	REASON FOR SEGMENTATION – PREMIUM DIFFERENTIALS	COUNTIES	PREMIUM TARGET
Plan 123, Segment 001	Low competitive premium offerings	A, B	$0
Plan 123, Segment 002	Market average	C, D, E, F	$49
Plan 123, Segment 003	High competitive premium offerings	G, H, I	$95

Alignment of cost and revenue

There are a number of items to consider when trying to align costs and revenue to maintain or achieve a competitive position:

- If an MAO reviews risk-adjusted medical costs and medical loss ratios (MLRs) at the county level, underperforming counties with high MLRs and counties that are performing well with low MLRs will become apparent, with the latter set of counties effectively subsidizing the poor medical cost experience (or poor risk scores, or poor provider networks, etc.) in the high-MLR counties.

  Therefore, the MAO may want to consider using plan segmentation and place the underperforming or high-MLR counties into their own segment, which can then charge a higher premium and/or implement leaner Part C benefits that could alleviate the financial pressure of the higher costs in these counties. However, the MAO should be careful not to make extreme changes each year such that only high-cost beneficiaries stay in the plan, as it may lead to a plan that is not financially supportable in the long term. Similarly, the counties that currently have low MLRs may be able to achieve a better competitive position if the premium can be lowered and/or Part C benefits improved to achieve higher membership in these counties. Again, the MAO will want to balance the competitiveness of the plan and the beneficiary premium revenue lost when reducing premium in order to remain competitive and not induce anti-selection due to offering benefits that are too rich relative to the competition.
- To maximize Part C revenue, an MAO should also understand the variation in the Part C benchmarks for each county in its service area, as well as whether any of the counties in the service area qualify for the "double bonus." If there is considerable difference in benchmark rates within a service area, it may make strategic sense for an MAO to consider segmenting the counties that are considered low-revenue and those considered high-revenue in order to offer richer Part C benefits and/or lower premiums in the high-revenue counties.
- An MAO should balance the marketing strategy of keeping contiguous counties in the same segment versus the profitability analyses by county when deciding how the counties will be included in each segment—oftentimes there is a rationale for keeping similar counties grouped in the same segment in order to *not* differentiate benefits and/or premium.

This exercise can be performed on non-segmented plans as well, of course. However, the key to the above discussion is that, from year to year, an MAO can much more easily shift counties and beneficiaries between segments than between plans without segments. The cross-walking efficiency of segmenting likely makes it more preferable than applying to CMS for a formal cross-walk after the bids are submitted.

Allowance for future benefit or premium changes

Often, MAOs will start new plans with multiple segments that do not differentiate premiums or Part C benefits between the segments. In doing so, they are preserving the ability to change the benefits for each segment based on the future claims experience of the segment. It is important to consider the long-term strategic goals for each new plan offered and where segmentation can assist in achieving those goals.

Marketing simplicity

MAOs can utilize the same marketing material for a larger service area, only differentiating the cost sharing and premium that varies by county, as long as the benefit offerings and cost-sharing structures remain similar.

[3] CMS (February 2022). Instructions for Completing the Medicare Advantage Bid Pricing Tools for Contract Year 2023. Retrieved February 22, 2023, from https://www.cms.gov/files/document/draft-instructions-completing-medicare-advantage-bid-pricing-tools-cy2023.pdf.

While the above outlines a number of reasons why it may be appropriate to consider segmenting plans, there are considerations one must make when implementing segmenting, which are addressed below. Depending on the goals of the MAO, some of these considerations below may outweigh the items mentioned in this Mechanics of Plan Segmentation section, such as the need for Part D benefits to be identical between segments and that often creating segmented plans can result in additional administrative burden.

Requirements for the bid process

There are a number of items to keep in mind when creating a bid that contains multiple segments.

Part D benefits must be identical between segments

Per CFR § 423.265, Part D benefits are not permitted to vary by segment. If it is desirable to alter Part D benefits by segmented service areas consistent with the Part C benefit differentiation, then plan segmentation does not allow an MAO to achieve this goal and keeping each plan separate with no segments is preferable. The only item in the Part D bid form that is allowed to vary between segments is the segment ID itself. Membership, both base period and projected, within each of the segmented Part D bids must be equal to the sum of the enrollment in the Part C segmented bids. All other components of the Part D bid must remain identical between the segments. Note the buy-down of the Part D premium for each segment within the MA bid form can vary at the discretion of the MAO, and it is permissible to vary the plan intention for the Part D basic premium in the Part C bid form by segment as well.

CMS does not allow MAOs to segment an existing non-segmented plan without formally cross-walking those beneficiaries

That is, an existing plan with the "000" segment suffix is not allowed to become a segmented plan in the next year without a formal HPMS cross-walk (which would effectively reassign a new plan-segment ID regardless). MAOs should consider the long-term goals of plan offerings when creating new plans to determine whether segmentation makes sense or not. Note, if a segmented plan is created, then it needs to include at least two segments (i.e., a segmented plan with only one segment is not allowed).

Regional PPOs are not allowed to offer segmented plans

According to the Medicare Managed Care Manual, regional preferred provider organization (RPPO) plans must offer uniform benefit packages across the entire service area.[4]

All other bid requirements must still be met at the bid level (e.g., contract-plan-segment)

All bid requirements other than those outlined above in the Mechanics of Bid Segmentation section still need to be met when preparing a bid. Mainly, this will consist of margin tests and total beneficiary cost (TBC) testing.

- CMS states in the bid instructions that profit margins are not allowed to be combined for bids in segmented plans to satisfy the gain/loss margin tests; each segment must stand alone when margin tests are applied.[5] That is, Part C segments within the same plan are not allowed to be combined to meet the Part C versus Part D margin requirements (Part D margin must be within +/-1.5% of Part C margin). Each Part C segment would be required to meet the +/-1.5% margin requirement if the MAO varies the Part D profit by bid (versus using the same Part D profit for all bids).
- Generally, MAOs are not allowed to increase premiums or reduce benefits for a plan by more than the limit set out in an annual memo from CMS[6] (approximately $41 for CY 2023). If an MAO wants to increase premiums and/or reduce benefits in a segment due to poor experience or low benchmark rates, as outlined above, then it will need to make sure that the TBC test is not violated year-over-year in order to achieve the desired premium levels in that segment.

For non-segmented plans formally cross-walked to segmented plans in the following year, or for counties that move between segments, the TBC for each segmented plan will be compared independently to the prior year non-segmented plan, which may mean making county-by-county comparisons to ensure the TBC test is met in all counties in the revised segment.

The certifying actuary can determine the level of significance as to what membership to include in the base period experience for the plan segment

The CY 2023 bid instructions state "base period data for one or more MA CY 2021 contract number-plan ID-segment ID must be reported on Worksheet 1 of the bid into which the beneficiaries are cross-walked…when the proportion of beneficiaries in a bid that are cross-walked into existing or new plans via MARx enrollment transactions…is greater than or equal to the MA level of significance determined by the certifying actuary."[7] The threshold must be the same for each of the bids that the MAO's actuary certifies. However, if the actuary determines that the level of significance is not met, then Worksheet 1 would not need to include the MARx cross-walked membership. If cross-walked membership is not

[4] CMS (February 10, 2017). Medicare Managed Care Manual: Chapter 1, General Provisions. Retrieved February 22, 2023, from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c01.pdf.

[5] CMS (February 2022), Instructions, op cit.

[6] CMS (April 20, 2022), Final Contract Year 2023, op cit.

[7] CMS (February 2022), Instructions, op cit.

included, then the bid requires a manual rate. Use of a manual rate would require more documentation and actuarial justification. Also, the certifying actuary would still need to consider any population changes or other adjustments that would be prudent for the additional plan membership when projecting experience, so oftentimes it is easier to include the cross-walked population in Worksheet 1 as it allows for fewer complications in the projection of that experience. CMS offered more specific guidance and its preferred approach on this subject in its response to a question on the April 13, 2016, Actuarial User Group Call.

Data sources

The analysis provided in this report is based on publicly available CY 2019 through CY 2023 benefit data information for individual MA plan offers provided by CMS. We excluded any plans that are classified as Program of All-Inclusive Care for the Elderly (PACE), Cost, Medical Savings Account (MSA), and Medicare-Medicaid Plans (MMPs). Plan data was summarized from the Milliman MACVAT®.

Caveats, limitations, and qualifications

This report is intended to summarize the benefits and requirements of plan segmentation in Medicare Advantage. This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit, and assume no duty or liability to, any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs.

In preparing this analysis, we relied upon public information from CMS, which we accepted without audit, and experience working with Medicare Advantage clients. This information was reviewed for general reasonableness and appropriateness, in compliance with generally accepted standards of actuarial practice and relevant actuarial standards of practice (ASOP). If the underlying data or information is inaccurate or incomplete, then the results of the analysis may likewise be inaccurate or incomplete. Milliman has developed certain models to estimate the values included in this report. The intent of the models was to develop statistics on segmented MA plans between CY 2019 and CY 2023. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice. The opinions included here are the opinions of the authors and not necessarily those of Milliman.

Julia Friedman and Sam Smetek 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 information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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CONTACT

Julia Friedman
julia.friedman@milliman.com

Sam Smetek
sam.smetek@milliman.com