

# Advantages of creating plan segments in Medicare Advantage bids

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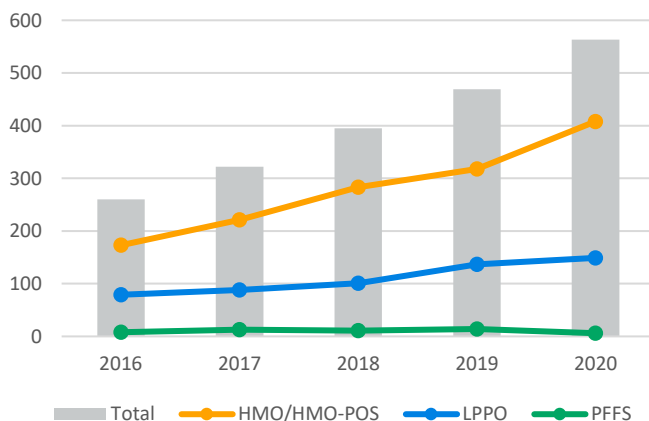
## Market summary

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

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 number of segmented plans has increased considerably, at around a 20% growth rate each year since 2016.
- About 13.2% of Medicare Advantage plans are considered segmented in contract year (CY) 2020, up from about 9.8% in 2016.
- Most segmented plans are health maintenance organizations (HMOs) or HMOs with a point of service (POS) option. In CY 2020 about 9.5% of HMO and HMO-POS plans were segmented, while a smaller proportion of local preferred provider organization (LPPO) plans were segmented—about 3.5%.
- 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 2020, at 0.4% and 0.2%, respectively. No Institutional SNPs (I-SNPs) have historically been segmented.

**FIGURE 1: COUNT OF MEDICARE ADVANTAGE BIDS THAT ARE SEGMENTED, 2016-2020**



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

Under the Medicare Advantage (MA) program, MAOs can offer a variety of PBPs. 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 members 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 members enrolled in that segment.<sup>1</sup> 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 well as vary the plan intention for the Part D basic premium in the Part C bid form.

<sup>1</sup> 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 August 1, 2019, from <https://www.cms.gov/medicare/health-plans/medicareadvgtgspec/ratestats/downloads/announcement2019.pdf>.

As an example, say 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 advantages of adding a segmented plan to an MAO portfolio and the bid requirements for segmented plans.

## Advantages of plan segmentation

There are numerous advantages to 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 would 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 arrives at the decision to create 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).<sup>2</sup>

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 gather 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 members among all segments within the plan are greater than the thresholds noted above.

### Beneficiary retention.

If a segmented plan 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 crosswalked through the traditional Health Plan Management System (HPMS) crosswalk process and can be achieved using the Medicare Advantage and Prescription Drug system (MARx) crosswalk.<sup>3</sup> The HPMS crosswalk process will make membership actively choose to enroll in a new plan, which can be a detriment to member retention. On the other hand, the MARx crosswalk moves a member between segments within the plan based on the county of residence when the service area is redefined, without requiring any decisions by the member.

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

<sup>2</sup> CMS (April 1, 2019). Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Retrieved August 1, 2019, from <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf>.

<sup>3</sup> CMS CY 2020 Bid Pricing Tools (BPT) and Instructions. Retrieved August 1, 2019, from <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BPT2020.html>.

### 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) in the high-MLR counties.

Therefore, it may make sense to segment the underperforming/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 members 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 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 member 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 between segments than between plans without segments. The crosswalking efficiency of segmenting likely makes it preferable to applying to CMS for a formal crosswalk 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.

While the above outlines a number of examples of reasons why it may be appropriate to consider segmenting plans, there are considerations one must make when implementing segmenting, which are addressed below. Some of these could be considered disadvantages of segmentation (e.g., the need for Part D benefits to be identical between segments), and creating segmented plans could 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. This could be viewed as a disadvantage of segmentation if it is desirable to alter Part D benefits by particular segmented service areas. 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 the Part D bid 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 crosswalking those members.

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 crosswalk (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 that, if a segmented plan is created, then it needs to include at least two segments (e.g., 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.<sup>4</sup>

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

This is a reminder that all other bid requirements other than those outlined above in the “Advantages 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 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.<sup>5</sup> 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).
- Segments in different plans that are of the same plan type and are in the same service area could be combined for gain/loss margin testing (e.g., profit pairing). For example, segment 001 in PBP 001 could be paired with PBP 002 without a segment for gain/loss margin testing as long as they are both coordinated care plans with identical service areas.
- Generally, MAOs are not allowed to increase premiums or reduce benefits for a plan for more than the limit set out in the annual rate announcement<sup>6</sup> (approximately \$36 for CY 2020). 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 that are formally crosswalked 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 2020 bid instructions state “base period data for one or more CY 2018 contract number-plan ID-segment ID must be reported on Worksheet 1 of the bid into which the members are cross-walked...when the proportion of members 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.”<sup>7</sup> 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 crosswalked membership. If crosswalked membership is not 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 crosswalked 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 2016 through 2020 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®.

4 CMS (February 10, 2017). Medicare Managed Care Manual: Chapter 1, General Provisions. Retrieved August 1, 2019, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c01.pdf>.

5 CMS, CY 2020 Bid Pricing Tools (BPT) and Instructions, op cit.

6 CMS (April 1, 2019), 2020 Medicare Advantage Capitation Rates, op cit.

7 CMS, CY 2020 Bid Pricing Tools (BPT) and Instructions, op cit.

## 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 who receives this work product. Any third-party recipient of this report who 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 and experience working with Medicare Advantage clients. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. The opinions included here are mine alone and not necessarily those of Milliman.

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