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Key considerations in product design for actuaries for the 2021 MA pricing season

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Newly available product design options will require actuaries to develop new tools and processes in order to assist Medicare Advantage organizations (MAOs) in bid development.

This paper provides general guidance and key considerations in utilizing the latest benefit customization opportunities. Early planning and coordination with other key players internal and external to the MAO will be critical for plans to take advantage of these new opportunities to improve healthcare outcomes and increase beneficiary satisfaction.

Recent changes in federal regulations and Centers for Medicare and Medicaid Services (CMS) guidance now allow MAOs to vary benefit designs based on health status and/or social determinants of health (SDoH). In addition, MAOs may also now expand covered services beyond traditional health-related benefits. We will summarize four of the channels available to provide supplemental benefits:

1. Supplemental benefits as defined in the Medicare Managed Care Manual (MMCM)[1]
2. Value-based insurance design (VBID) models[2]
3. CMS redefinition of "Primarily Health Related" and Uniformity Flexibility (UF)
4. Special Supplemental Benefits for the Chronically Ill (SSBCI)

General considerations

The bid development process for Medicare Advantage (MA) plans requires health actuaries to complete the product design and pricing in a very condensed timeline. While preparatory work is essential, MAOs do not have a full picture of the actual projected revenue until mid-April. That allows MAOs and actuaries about 50 days to complete product design, financial projections, and required documentation. As shown in the table in Figure 1, the VBID program requires another application process within the bid submission timeframe and some of the other options are still subject to CMS updated guidance. Please note that CMS proposed to codify benefit flexibilities in the proposed regulations for 2021, so the dates below would likely vary in the future.

FIGURE 1: BID TIMELINE

DATE	BID PROCESS	VBID PROCESS	UF BENEFITS/ SSBCI
Early February	Advance notice		
Late-February		Hospice capitation rate methodology	
Late April		VBID application deadline	
Early April	Rate announcement		
Mid-April		VBID hospice payment rates and CMS feedback for bid inclusion	
Mid/Late April			Additional CMS guidance
Early May		VBID hospice participation deadline	
First Monday of June	Bid submission deadline		
June/July	Desk review process	Desk review process	CMS review/feedback

Within that limited period, MAOs must make critical strategic decisions. The product design process must balance the competitive pressure of the specific market conditions and the MAO's financial situation. In addition, MAOs should review clinical and medical management opportunities, which are necessary to reduce cost, enhance care, and improve quality ratings and therefore lead to the ability to expand supplemental benefits.

Actuaries can prepare initial scenarios to provide MAOs with guidance on the available budget for supplemental benefits. Initial pricing estimates, including expected utilization and cost estimates, could also be prepared for each intended benefit. In general, it is beneficial to have preliminary pricing for multiple levels of each benefit early in April (i.e., different maximums), as well as benefits that may not eventually be offered, to assist in the benefit configurations once budgets are established.

[1] Medicare Managed Care Manual (April 22, 2016). Chapter 4: Benefits and Beneficiary Protections, Section 30: Supplemental Benefits. Retrieved February 25, 2020, from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

[2] CMS. Medicare Advantage Value-Based Insurance Design Model. Retrieved February 25, 2020, from https://innovation.cms.gov/initiatives/vbid.

As discussed below in more detail, the additional benefit flexibility requires a new level of detailed analysis. Actuaries and product development will need to coordinate more closely with the MAO's clinical team to properly identify target populations, develop utilization and pricing assumptions, and in some cases estimate savings from specific initiatives. Utilization assumptions should reflect higher utilization patterns, especially for very specialized or attractive benefit offerings. Actuaries will also need to estimate projected costs of such services, many of which are new to the MA program and will not yet have experience data readily available.

Actuaries will also need to coordinate closely with the MAO's marketing and communication team to properly define proposed benefits and ensure consistency with descriptions and pricing strategy. Finally, network and configuration teams will need to be involved to determine the process of contracting with new categories of providers and how such payments and contracts will be included in future base period experience.

Standard supplemental benefits

Supplemental benefits will continue to be a core value proposition that attracts beneficiaries to the Medicare Advantage program. Regional and plan-specific conditions dictate the extent to which MAOs provide enhanced coverage for members, including cost-sharing reductions, Part B and/or Part D premium buydown, and additional supplemental benefits. Additional considerations apply to special needs plans (SNPs), such as dual-eligible SNPs (D-SNPs), which must coordinate with state-level Medicaid requirements, and chronic condition SNPs (C-SNPs), which must comply with specific model of care requirements.

Most beneficiaries have access to plans that offer different supplemental benefit packages, but the most common benefits include dental, vision, and hearing. Changes to the Medicare Plan Finder for 2020 have also increased the focus on certain supplemental benefits, as coverage is now more prominently displayed for vision, dental, hearing, transportation, and fitness benefits.[3] Additional benefits are also displayed, but require additional interactions with the website, including over-the-counter (OTC) drugs, worldwide emergency, telehealth, in-home support, home safety devices and modifications, and emergency response devices, as well as meals and annual physical exams.[4]

FIGURE 2: STANDARD SUPPLEMENTAL BENEFITS

All members of a plan receive the same traditional supplemental benefit offerings. This allows the MAO to streamline the enrollment process, simplify the marketing and communication strategy, and minimize beneficiary confusion, grievances, and/or complaints. In addition, traditional supplemental benefits are often easy for members to understand, allowing MAOs to aggressively market them, especially if those benefits are more generous than competitor options.

The cost of offering multiple supplemental benefits to all members within a product may not be feasible, however. The ability to target the benefits to a subset of the population would allow the plan to expand the benefit offering at a lower overall cost, in particular for benefits that can generate savings by improving health outcomes in the targeted population. MAOs may also offer a "basket of benefits," which provides several supplemental benefits and allows the member to choose from a subset of the options up to a specified dollar limit of services. For example, a member may have the option of choosing either an OTC benefit or a preventive dental benefit, but not both. Plans could also evaluate having a combined annual limits for a subset of supplemental benefits, an approach sometimes applied specifically to dental, vision, and hearing in the MA market. This approach not only helps tailor the benefits to meet the specific needs of the members, but also helps distribute the overall cost because not all of the members are receiving all the benefits.

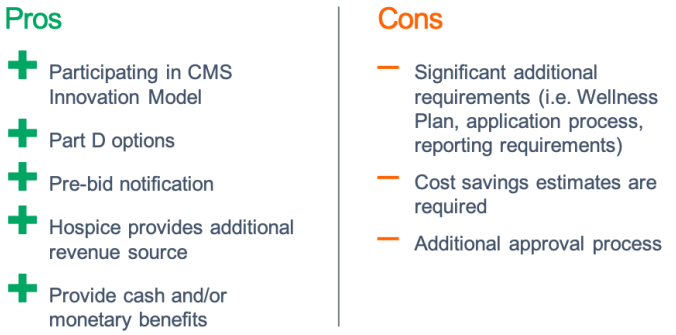
[3] Klein, M. & Kranovich, M. (October 15, 2019). Changes to 2020 Medicare Plan Finder. Milliman White Paper. Retrieved February 25, 2020, from https://www.milliman.com/insight/Changes-to-2020-Medicare-Plan-Finder.

[4] See the Medicare Plan Finder at https://www.medicare.gov/plan-compare/#/?lang=en.

Value-based insurance design (VBID) model

Beginning with the 2017 plan year, CMS created a voluntary VBID model to test the impact of providing MAOs with benefit design flexibility for enrollees with certain chronic conditions or differing SDoH. Under this model, MAOs may offer enhanced benefits such as reduced cost sharing or additional supplemental benefits for eligible members, expanded incentives and reward programs, and other interventions. Participating plans are granted a waiver of the uniformity requirement in order to vary the benefit design for these enrollees.[5] The VBID model was limited to seven states and seven eligible conditions for 2017, but has since expanded to be available nationwide, including all territories. The scope of covered conditions and flexibility has also expanded over time, and will include a separate VBID hospice model test for coverage of this benefit for the first time in 2021.

FIGURE 3: VALUE-BASED INSURANCE DESIGN



For calendar year (CY) 2021, MAOs participating in the VBID model are eligible to test one or more of the following interventions.

- **Value-based insurance design by condition, socioeconomic status, or both:** Participating MAOs can provide reduced cost sharing or additional supplemental benefits for enrollees based on condition and/or SDoH. MAOs may also propose reduced cost sharing for Part D drugs. Beginning in 2021, this may include new and existing technologies, or FDA-approved medical devices.
- **Medicare Advantage and Part D rewards and incentives programs:** Participating MAOs can implement broader MA and Part D rewards and incentive (RI) programs than were previously permissible.
- **Wellness and healthcare planning:** All participating MAOs must adopt this component, which includes coordinated approaches to wellness and healthcare planning (including advance care planning).
- **Hospice:** In return for a monthly capitation payment, participating MAOs have the option of retaining financial responsibility for members electing hospice status for the first time in CY 2021, as part of its own VBID model test.
- **Cash or monetary rebates:** Beginning in 2021, plans may now share plan rebates directly with members via cash rebates or other monetary benefits. Unlike the other VBID benefits, this must be uniformly offered to all plan members as a mandatory supplemental benefit, and not just those targeted for intervention.

Participating in the VBID model is currently the only way an MAO may vary Part D benefits within a plan, as participants may vary the Part C or D benefits of a VBID plan based on a member's chronic condition or SDoH. The VBID model is also the only way to provide direct cash or monetary payments to members. MAOs may also choose to incorporate other aspects of the VBID model, including RI programs and hospice. As noted above, all participants must offer a wellness and healthcare planning program.

Flexibility is still somewhat limited, in that participating MAOs must demonstrate that the proposed VBID intervention will result in net savings. For example, the cost of a reduction to insulin copays for diabetic members must be offset by avoided hospitalizations or emergency visits, or a new RI program that results in healthier behaviors is expected to reduce overall claim costs. Plans may not simply enhance benefits for members without consideration of the increased benefit cost.

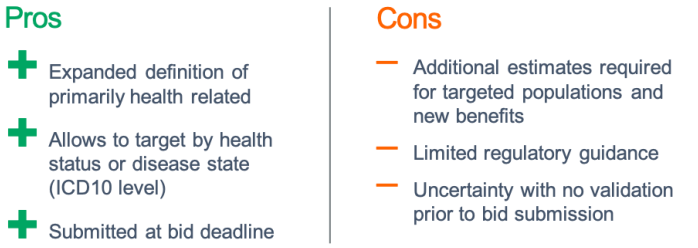
In order to offer a VBID benefit, MAOs must submit an application to CMS. The deadline for CY 2021 applications for both VBID model tests is April 24, 2020, so interested plans should begin preparing their applications well in advance of the regular bid process in order to complete their submission before the deadline. As part of the application, MAOs must submit revised bids from the prior year (i.e., CY 2020 Bid Pricing Tools) that show the impact of the proposed intervention(s) on utilization and claim costs. As such, MAOs must identify VBID members eligible in their experience.

[5] Medicare Advantage Value-Based Insurance Design Model, op cit.

2019 reinterpretation of "Primarily Health Related" and Uniformity Flexibility

In Part II of the 2019 Advance Notice,[6] CMS announced its intention to redefine its interpretation of the "primarily health related" supplemental benefit definition. Beginning in CY 2019, CMS expanded its definition to consider an item or service as primarily health-related if it is used to diagnose, compensates for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization. A supplemental benefit is not primarily health-related under the previous or new definition if it is an item or service that is solely or primarily used for cosmetic, comfort, general use, or social determinant purposes.[7] Please refer to our recent Milliman research paper on Medicare Advantage Uniformity Flexibility (UF) benefit offerings for a summary of plan offerings in 2019 related to this opportunity.[8]

FIGURE 4: 2019 REINTERPRETATION OF "PRIMARILY HEALTH RELATED" AND UF



Also in the 2019 Advance Notice, CMS allowed plans to target specific populations with the UF reinterpretation. CMS determined that providing access to benefits or services "that is tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly is consistent with the uniformity requirement in the MA regulations."[9] This new guidance allows MAOs to provide additional benefits (i.e., lower cost sharing or additional supplemental benefits) to members with specific medical conditions, so long as all members with the conditions receive the same benefits and cost-sharing levels. Any additional benefits must also be directly related to the conditions targeted by the MAO. For example, a plan may be able to offer reduced pulmonologist copays or smoking cessation classes for members with chronic obstructive pulmonary disease (COPD), but not a new vision hardware benefit as it would be unrelated to the underlying medical condition. The benefit is also required to focus on the enrollee's healthcare need and to be recommended or provided by a medical professional.

CMS requires the targeted population to be formally defined based on the International Statistical Classification of Diseases and Related Health Problems, also known as ICD-10 codes, and to briefly describe such criteria (without using the codes) to beneficiaries.[10]

These targeted benefits carry some elevated risk of beneficiary confusion, as members could unintentionally enroll in a plan based on a supplemental benefit for which they are not actually eligible. MAOs must clearly indicate the benefit eligibility in their marketing material to mitigate this risk.

Special Supplemental Benefits for Chronically Ill (SSBCI)

The Balanced Budget Act of 2018 (BBA) created the opportunity for what CMS refers to as Special Supplemental Benefits for the Chronically Ill or SSBCI. The BBA waived the uniformity requirement with respect to SSBCI starting in CY 2020, allowing MAOs to offer supplemental benefits non-uniformly to eligible chronically ill enrollees. SSBCI can include reduced cost sharing for Medicare covered or supplemental benefits. In addition, SSBCI can include benefits that are primarily health-related and/or non-primarily-health-related. As indicated, CMS believes the intended purpose of the new category of supplemental benefits is "to enable MA plans to better tailor benefit offerings, address gaps in care, and improve health outcomes for the chronically ill population." Finally, SSBCI allow the use of social determinants of health (SDoH) to be used as a factor, but not the sole basis, to determine eligibility.[11] The proposed CY 2021 rule is consistent with initial guidance and includes additional documentation requirements regarding written policies and to make such information and documentation of eligibility available to CMS upon request.

[6] CMS (February 1, 2018). Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter. Retrieved February 25, 2020, from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part2.pdf.

[7] CMS (April 2018). HPMS Memo. Retrieved February 25, 2020, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27.

[8] Friedman, J. (March 2019). Medicare Advantage Uniformity Flexibility Benefit Offerings. Milliman White Paper. Retrieved February 25, 2020, from https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2019/medicare-advantage-uniformity-flexibility-offerings.ashx.

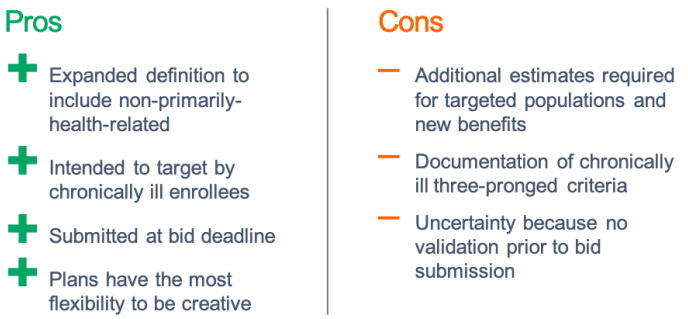
[9] CMS, Advance Notice, op cit.

[10] CMS, HPMS Memo, op cit.

[11] CMS (April 24, 2019). Implementing Supplemental Benefits for Chronically Ill Enrollees. Retrieved February 25, 2020, from https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

MAOs will be able to offer non-primarily-health-related benefits, as long as there is a "reasonable expectation that the services will help people with chronic conditions improve or maintain their health or overall function." The term *"reasonable expectation"* in the context above has not been defined by CMS. It is up to the MAO to decide which items or services to offer at bid submission. However, CMS may later determine that an item or service does not qualify as SSBCI.

FIGURE 5: SPECIAL SUPPLEMENTAL BENEFITS FOR CHRONICALLY ILL



MAOs must develop a process to identify eligible chronically ill enrollees, which must satisfy the following three criteria:

1. Has one or more comorbid and medically complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee.
2. Has a high risk of hospitalization or other adverse health outcomes.
3. Requires intensive care coordination.

Although MAOs do not need to submit their processes to CMS, they should document how they determined an enrollee's eligibility, as CMS is allowed to request this detail. Because there is potential for an increase in complaints and appeals from enrollees who do not qualify for SSBCI, MAOs should use objective measures to determine eligibility. CMS also provides a list of 15 chronic conditions that meet the first eligibility criteria.

They are consistent with the conditions identified for special needs plans (SNPs) but also allow plans the flexibility to consider additional conditions that are life-threatening or significantly limit the overall health or function of the enrollee. These 15 chronic conditions[12] are shown in Figure 6.

FIGURE 6: CHRONIC CONDITIONS THAT MEET ELIGIBILITY CRITERIA

Chronic Conditions	Chronic Conditions with Defined Limitations
▪ Chronic alcohol and other drug dependence	▪ Autoimmune disorders
▪ Chronic heart failure	▪ Cancer, excluding pre-cancer conditions or in situ status
▪ Dementia	▪ Cardiovascular disorders
▪ Diabetes mellitus	▪ Severe hematologic disorders
▪ End-stage liver disease	▪ Chronic lung disorders
▪ End-stage renal disease (ESRD) requiring dialysis	▪ Chronic and disabling mental health conditions
▪ HIV/AIDS	▪ Neurologic disorders
▪ Stroke	

As with non-uniform benefits, MAOs will need to be cautious in marketing SSBCI. Marketing material must be clear that the benefit does not apply to all enrollees. Another challenge for the MAOs is determining the cost for potential items and services they may want to offer. Because no prior experience exists, it may be difficult to find data to support pricing assumptions. In addition, MAOs may need to contract with new categories of providers.

Sample supplemental benefits

The table in Figure 7 lists some of the benefits available in the different supplemental definitions. These lists are based on published CMS guidance and are not intended to be exhaustive. Additional requirements apply to each benefit, so a careful review of applicable regulations is critical for successful product design.

For example, MAOs can provide nonemergency transportation as a standard supplemental benefit directly related to an enrollee's healthcare for Part A and B services (i.e., doctor visits). Additional options are provided under the benefit flexibility by either expanding on the definition of primarily health-related to allow for coverage of transportation related to other supplemental benefits (not just Part A or Part B services) and for a health aide to assist the enrollee; or the benefit can be offered only to targeted populations based on health status or disease state under the reinterpretation of uniformity requirements.[13] Finally, under the SSBCI options, MAOs can offer coverage for transportation to obtain nonmedical items, such as grocery shopping and banking, for those beneficiaries who qualify for chronically ill status.[14]

[12] See Chapter 16b of the MMCM, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf.

[13] CMS, HPMS Memo, op cit.

[14] CMS, Implementing Supplemental Benefits for Chronically Ill Enrollees, op cit.

FIGURE 7: STANDARD, BENEFIT FLEXIBILITY, AND CHRONICALLY ILL SAMPLE SUPPLEMENTAL BENEFITS

Standard	Benefit Flexibility	Special Supplemental Benefits for the Chronically Ill
Dental	Adult Day Care Services	Adult Day Care Services
Vision	Home-Based Palliative Care	Home-Based Palliative Care
Hearing	In-Home Support Services	In-Home Support Services
Nonemergency Tranportation	Support for Caregivers of Enrollees	Support for Caregivers of Enrollees
Fitness Benefit	Medically Approved Non-Opioid Pain Management	Medically Approved Non-Opioid Pain Management
Worldwide Emergency	Stand-alone Memory Fitness Benefit	Stand-alone Memory Fitness Benefit
Routine Chiropractic Services	Home and Bathroom Safety Devices and Modifications	Home and Bathroom Safety Devices and Modifications
In-home Support	Nonemergency Transportation	Nonemergency Transportation
Home Safety Devices and Modifications		
Emergency Response Devices		
Meals		
Annual Physical Exam		

Conclusion

CMS is continuing to implement and provide new opportunities to expand benefit offerings to support and enhance care for Medicare beneficiaries. MAOs will need to incorporate these changes into their strategies, product design, contracting, pricing, network design, and other aspects of their business. A rigorous financial analysis, along with a deep strategic and product review, are key in unlocking the benefit of these alternatives.

Each of the options summarized above has important advantages, as well as challenges to implement. A well thought out product design would look to maximize the value of the benefits offered to its beneficiaries by integrating aspects of two or more of the channels provided by CMS, making the appropriate adjustments for local market conditions and plan-specific populations.

As described above, given the short timeframes and multiple deadlines, MAOs should invest time in the fall to evaluate the proposed product design for the next bid cycle. It will not be feasible to wait to start in February. Many of the initiatives and product designs require careful consideration of targeted populations, evaluation of multiple clinical conditions, and in many cases pricing variables that are not well defined. An early start will allow actuaries to provide multiple alternatives for the product design process needed during the critical bid development period.

Caveats, Limitations and Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Luis Maldonado, Sylvia Hagin, and Brian Regan are consulting actuaries for Milliman and members of the American Academy of Actuaries. Each individually meets the qualification standards to render the information contained herein. To the best of their knowledge and belief, the information is complete and accurate.

This paper is intended to summarize key aspects of various CMS regulations and programs that allow MAOs to provide additional supplemental benefits to beneficiaries as of CY 2021.

The list of considerations discussed are not exhaustive and they do not reflect the full extent of opportunities available for MAOs. This information is not appropriate, and should not be used, for other purposes.

The authors relied on information provided in CMS regulatory documents. We accepted the information as stated, but note that results will change with any changes or additional guidance published by CMS. Our interpretations should not be relied on as legal interpretations. Benefit flexibility rules are complex, and readers should retain their own qualified professionals for advice appropriate to their specific needs.

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