Critical Considerations for New Entrants in the Medicare Advantage Market

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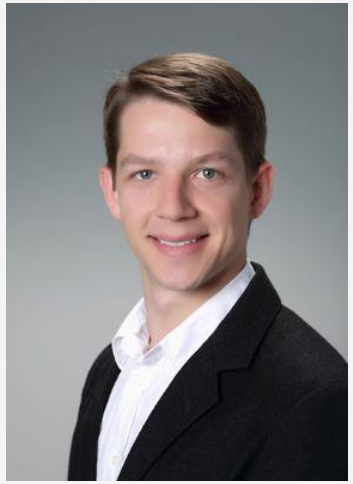
Presenters



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Setting Yourself Up for Success: 6 Topics to Consider

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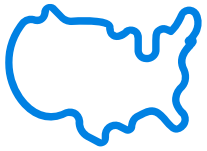
6 topics to consider



Service area size

Competition

Penetration rate

Star rating

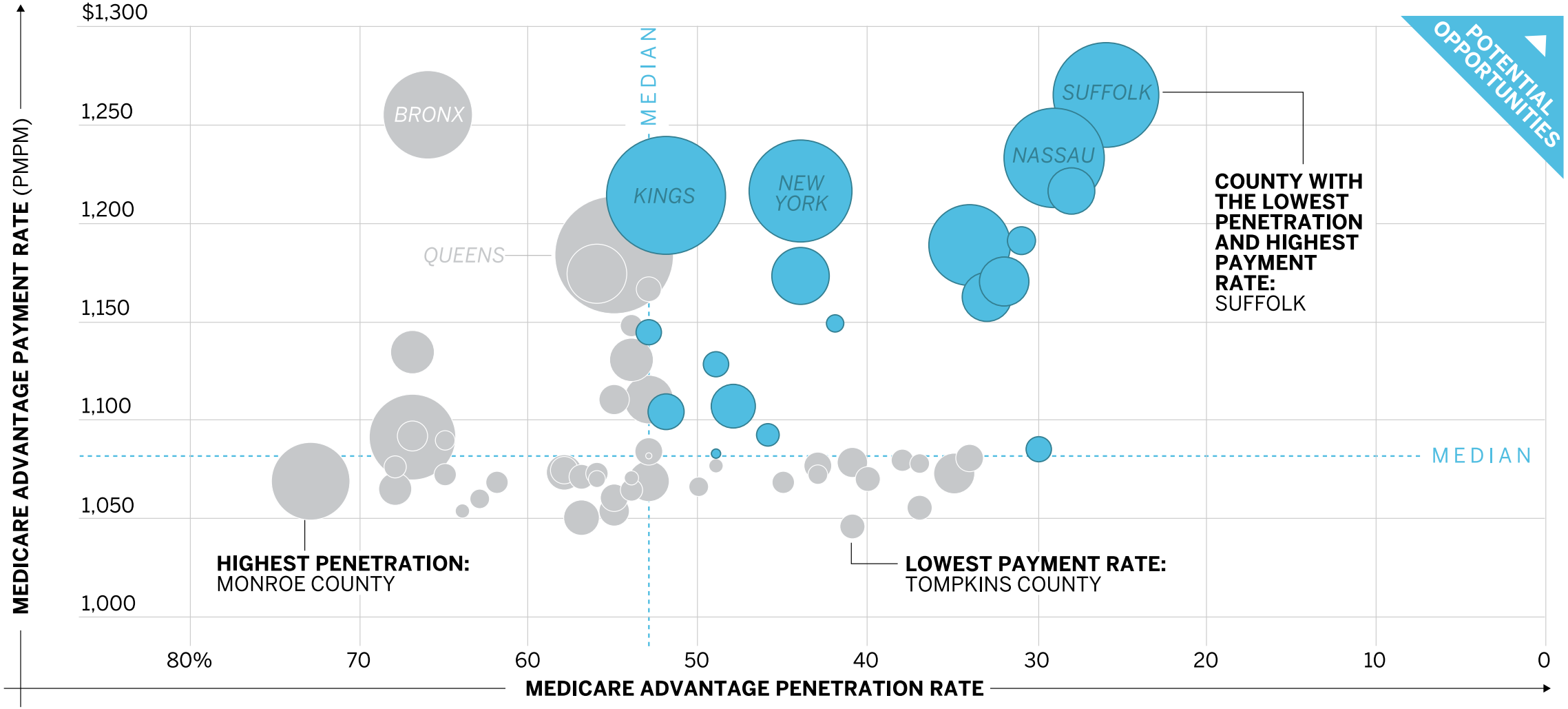
Payment rate

Risk scores

Service area

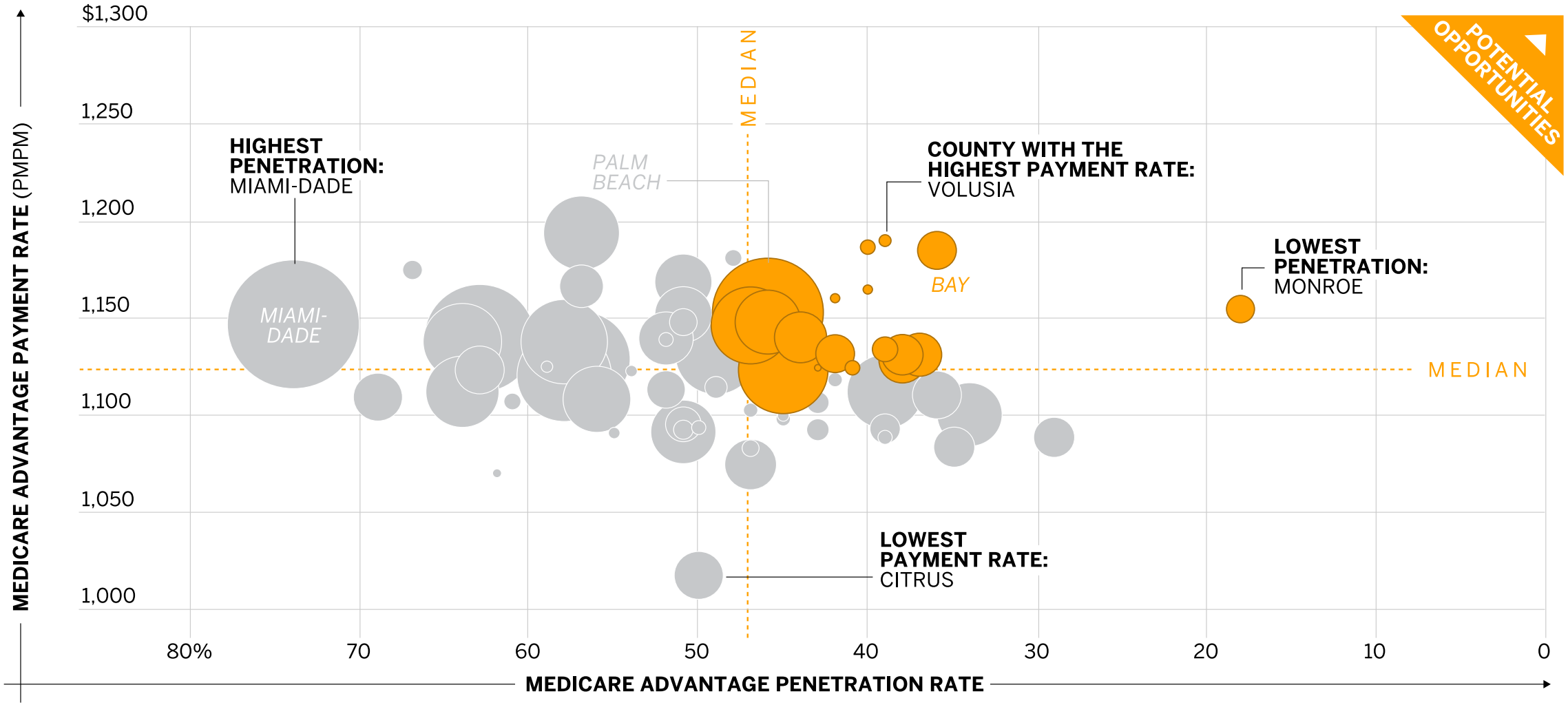
- What is a service area?
- How does an insurer choose a service area?
- Let’s consider New York and Florida

New York



SOURCES: CMS MEDICARE ADVANTAGE/PART D CONTRACT AND ENROLLMENT DATA: MA STATE/COUNTY PENETRATION, JUNE 2022; 2023 MEDICARE ADVANTAGE RATEBOOK AND PRESCRIPTION DRUG RATE INFORMATION: 3.5% BONUS

Florida



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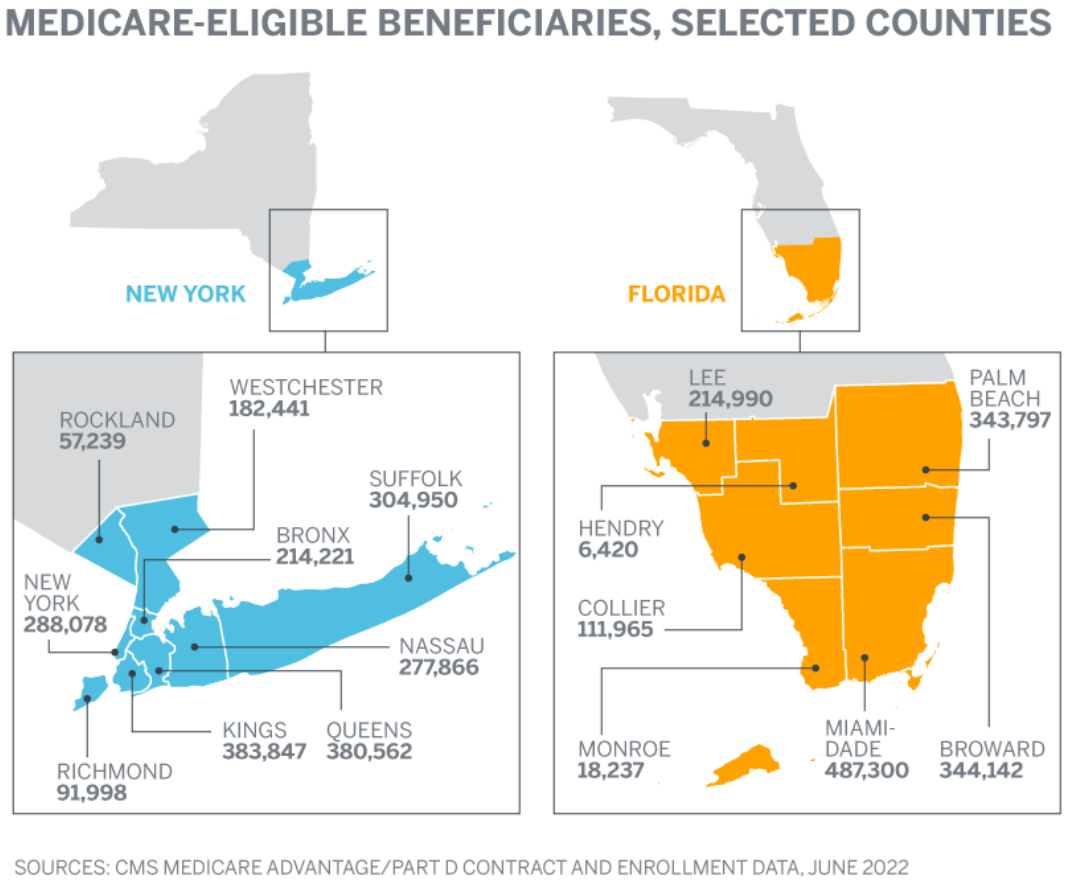
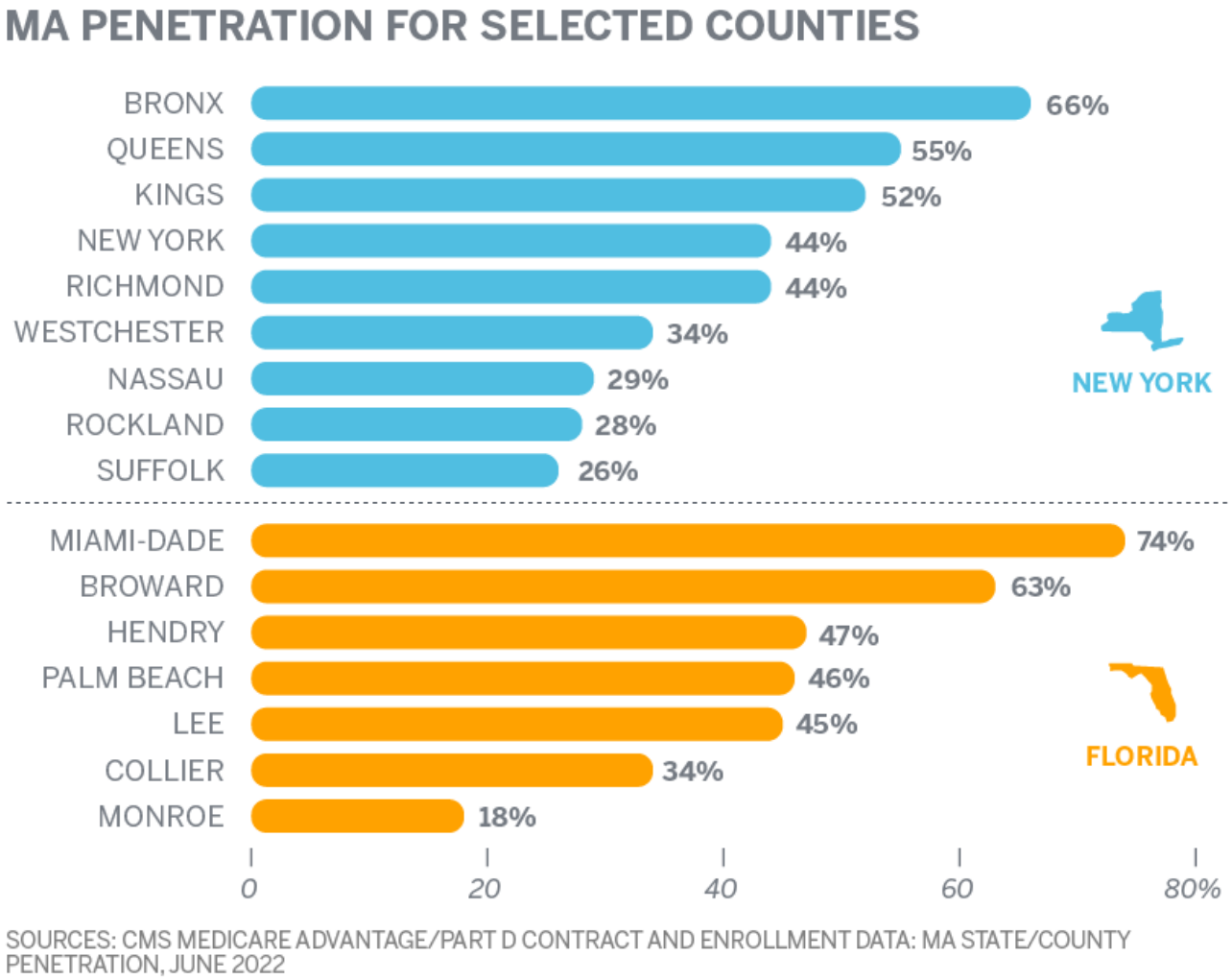
Service area size

- How many Medicare-eligible beneficiaries are in the area?
- How many beneficiaries do we need/want?
- How do the financials change if counties are grouped into one service area?



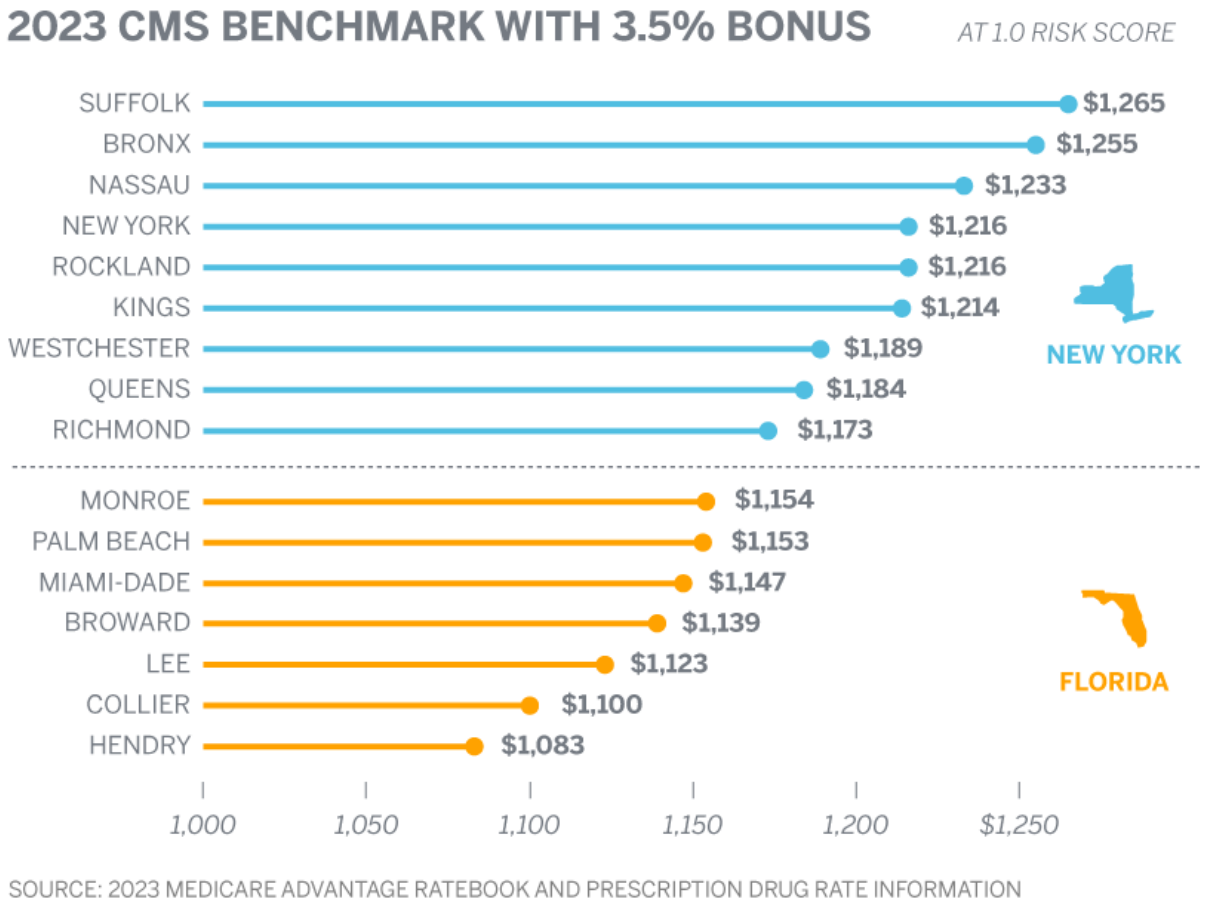
Penetration rate

- How popular is MA in the service area?
- What reasons may there be for MA to have a lower penetration rate in a given county?



Payment rate

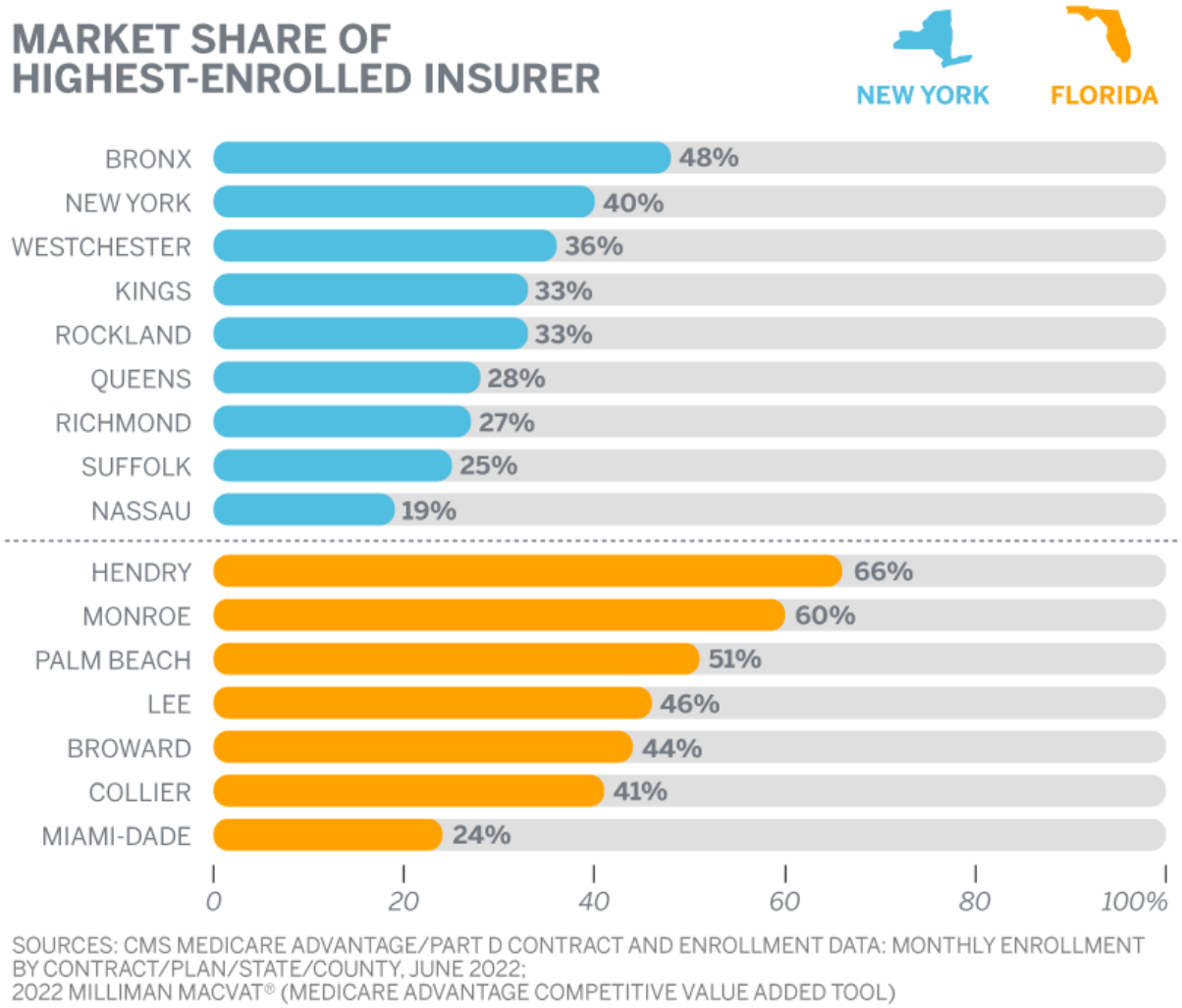
- How much will CMS pay to offer Medicare benefits?
- Is that amount sufficient to cover expected costs?
- Is that amount sufficient to allow for any profit?
- If not, how would an insurer charging beneficiaries a premium compare to those already in the market?



SOURCE: 2023 MEDICARE ADVANTAGE RATEBOOK AND PRESCRIPTION DRUG RATE INFORMATION

Competition

- Is there already a dominant player or two in the market?
- If so, why are the competitor's plans so popular with beneficiaries?
- How does a new insurer distinguish its plan(s) from those already offered?



Star rating

- How will the star rating impact revenue?
- What is the average star rating of the highest-enrolled insurer in the service area?
- How prevalent are 4.0-star rated insurers in the service area?
- What does it take to achieve 4.0 stars and does insurer have plans/capabilities to operationally achieve it?

STAR RATINGS BY COUNTY

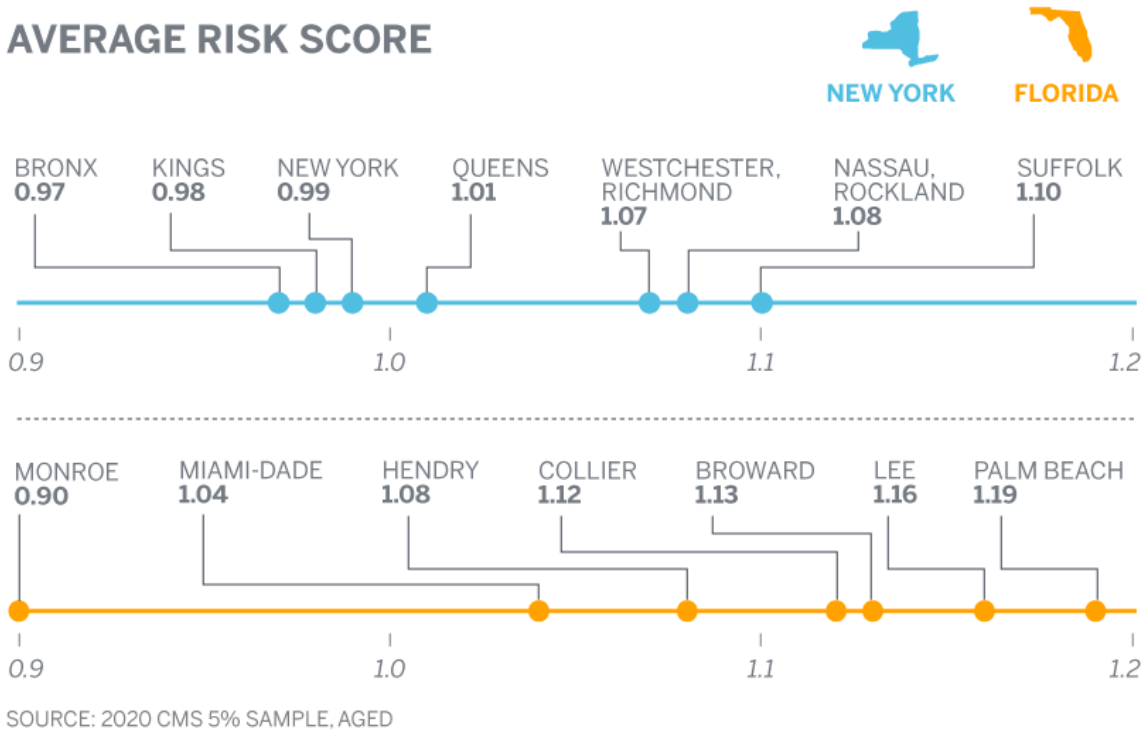
NEW YORK FLORIDA

COUNTY	AVG. FOR HIGHEST-ENROLLED INSURER	PERCENT ENROLLED IN PLAN WITH 4.0 OR ABOVE
BRONX	4.00	53%
QUEENS	3.81	40%
KINGS	4.00	39%
RICHMOND	3.96	38%
NEW YORK	4.00	37%
NASSAU	4.34	30%
SUFFOLK	4.32	27%
ROCKLAND	3.92	24%
WESTCHESTER	3.98	24%
BROWARD	4.56	74%
MIAMI-DADE	4.73	74%
PALM BEACH	4.49	54%
HENDRY	4.06	54%
LEE	4.23	52%
COLLIER	4.11	38%
MONROE	4.00	17%

SOURCES: CMS PART C AND D PERFORMANCE DATA: 2022 STAR RATINGS DATA TABLE (OCT. 6, 2021)

Risk scores

- Is the insurer prepared to properly capture beneficiary diagnosis codes through risk score coding initiatives?
- Does the insurer have the capabilities to properly address the disease burden of the incoming population?



MA Bid Development Process: What should I be asking my actuary?

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Workflow Timeline

Pre-pricing Process

- Data Request
- Follow CMS Advance Notice and Potential Changes
- Feasibility Analyses / Strategy Discussions
- Experience Monitoring (For Established Plans)

Preliminary Pricing

- Bid Development Begins
- Assist with Application and Client Questions
- Analysis and Summaries of Historical Data
- Register to HPMS for Actuarial Certification
- Payment Rate Announced (first Monday in April)
- Weekly CMS Actuarial User Conferences
- Formulary Analysis

Finalize Pricing

- Finish Bid Development Based on Client Feedback of Initial Projections
- Prepare Bid Supporting Documentation
- Submit MA and PD Bid Pricing Tools (BPTs)

Post-Submission Period

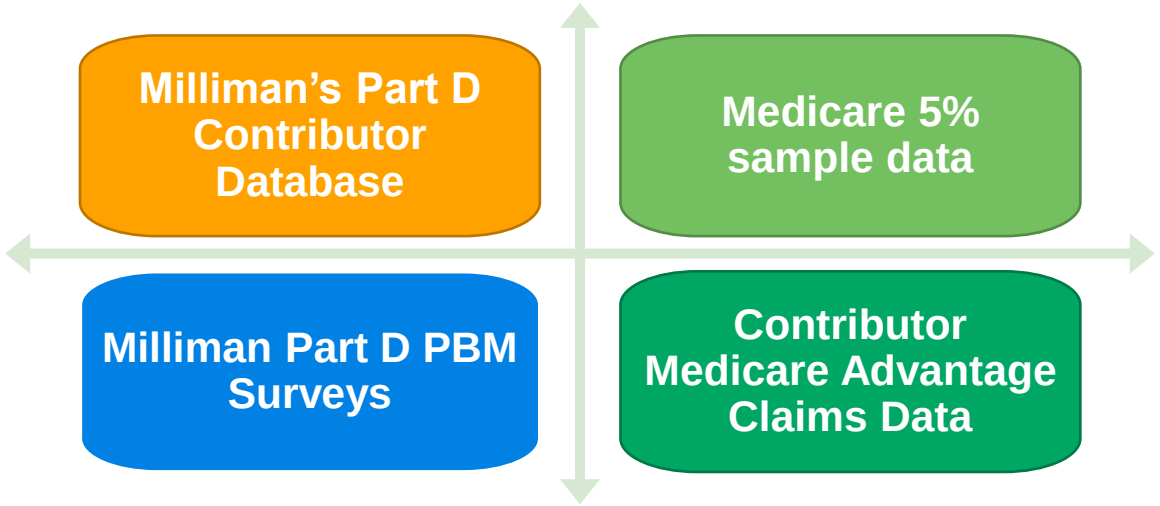
- Assist with Desk Review Questions
- Resubmit Bids Based on Revised Part D Low Income Benchmarks and National Average Bid Amounts

Data Request

- Proposed Part C and Part D Benefit Design
  - Needs to match the Plan Benefit Package (PBP) submitted later
- Part C Contracting rates for the major service categories (Inpatient Facility, SNF, home health, OP Facility, professional, etc…)
- Part D PBM Contracting Terms
  - Discounts & Dispensing Fees
  - Manufacturer DIR
  - Pharmacy DIR
- Formulary
- Membership Projections by County and Risk Score Coding Expectations
- Administrative Cost Projections
- Gain / loss targets
- Plan Narrative
- MA Business Plan

What does manual rating/data mean? How can I get it?

- Without any plan-specific data, new organizations need a way to estimate the costs for their new plan.
- Milliman has access to a variety of different data sources and research that help us price new plans



- Using these data sources as a starting point, adjustments can be made during the pricing to reflect the specifications

Setting expectations for new plans through initial pricing exercises

- For organizations new to Medicare, it is very difficult to achieve a positive profit margin in the first few years due to the following:
  - Plan design and benefits need to be aggressive to compete with the current market
  - Unfavorable provider and PBM contracting (lack of leverage)
  - Large administrative and staffing costs
  - Low membership
  - Star rating for new plans leads to lower revenue
  - Comprehensive formulary decisions to attract new members
  - Risk scores don’t reflect coding improvement
- Any plan with a negative profit margin will likely be asked to submit a business plan to CMS and demonstrate how they think they will be able to turn a profit in the near future

Most important levers to change during pricing

- Which areas and counties to enroll in
  - Benchmarks vs. Projected Costs
- Changes in benefit design
- What kind of Supplemental benefits to offer
- How much of the Part C and Part D premium is bought down by the plan

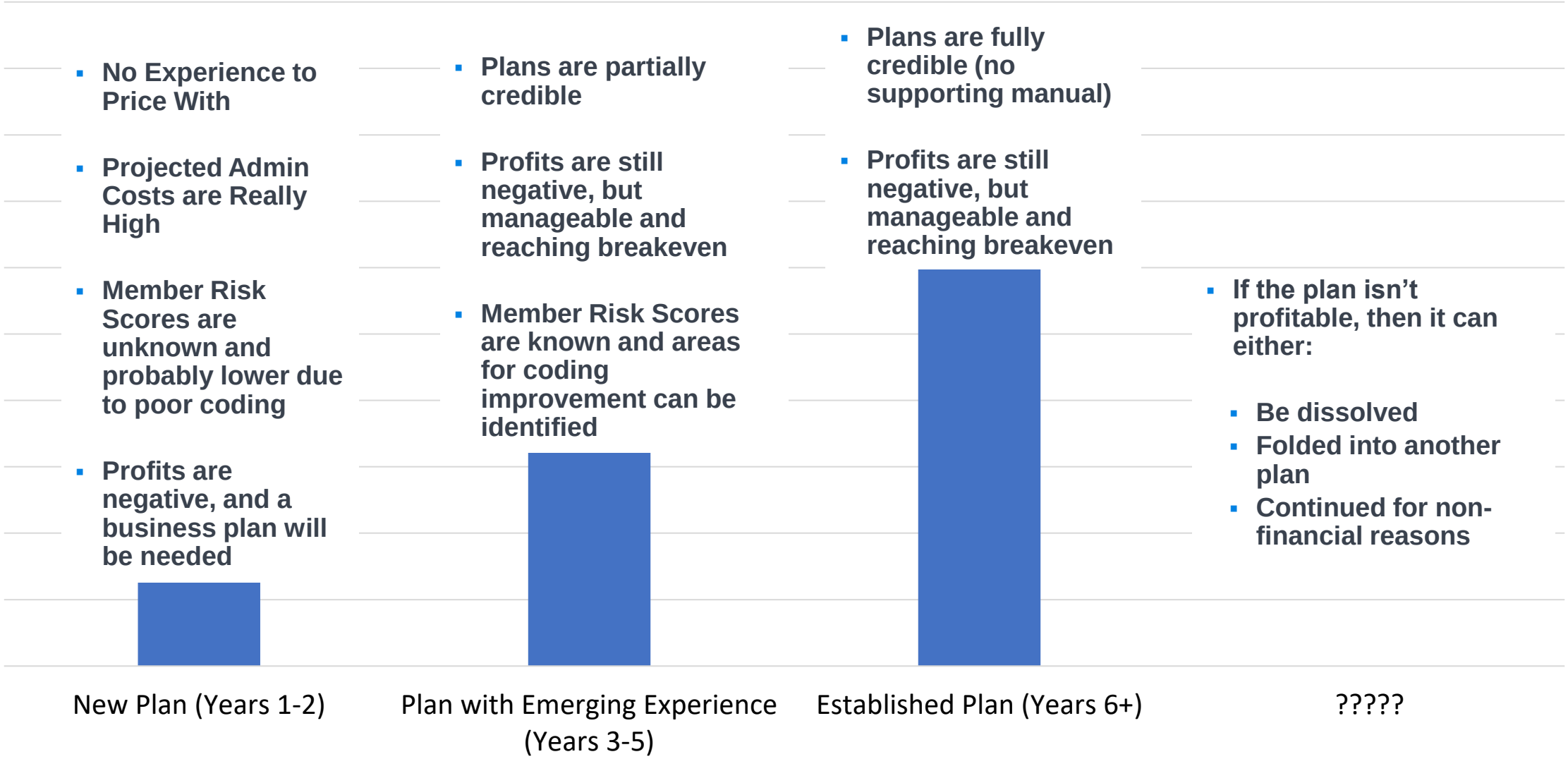
Things to Consider when creating a Part D Formulary

- Formulary Requirements:
  - There are 146 different therapeutic categories of drugs
  - Formularies must include at least two drugs in each therapeutic category of Part D drugs
  - They must include substantially all drugs in the following classes: antidepressants, anticonvulsants, antipsychotics, anti-cancer, immunosuppressants, and HIV/AIDS medications
  - If a generic is available for a drug, it must be included on the formulary
- ***Covering or giving preferred cost sharing status to certain types of drugs can attract different types of patients that may not be profitable to the plan.***
- ***Important to consider the interaction between Part D and Part B drugs***

Common themes to desk review questions

- Making sure all the numbers in the BPTs align with those in supporting documentation
- Description of which specific drug changes are causing the biggest impact to projected costs
- Detailed support of projected administrative costs
- Summary of how the data used for key inputs matches the final output
- For plans with experience, making sure that past experience aligns with the projection
  - Comparing prior projected amounts to actual

Pricing life cycle of a plan



Market Entry Challenges and Keys to Success

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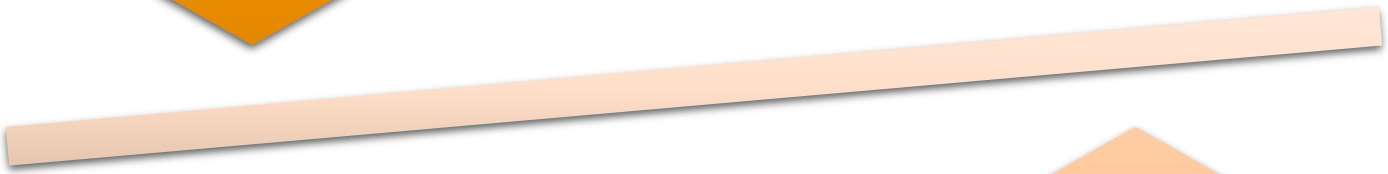
Keys to success

COMMITTED + COMPLIANT AT ALL TIMES +

Maximize revenue

- Strive for 5 Star Quality Rating
- Optimize Risk Scores
- Achieve enrollment targets



Minimize cost

- Manage utilization and medical costs
- Align provider contracts with goals
- Operate efficiently to improve Medical Loss Ratios (MLR)

New MA-PD start-up BIGGEST Challenges

Application

- PBM contract executed
- Other admin contracts in place
- Contracted network meeting CMS minimum standards
- Compliance program in place
- State licensure
- Model of Care (MOC) completed for SNP (if applicable)

Readiness

- CMS enrollment processes
- Claims configuration
- Marketing strategy to attract and retain members
- Marketing materials
- Operational Policies and Procedures

Operative

- Sales / enrollment
- Revenue management
- Cost management
- Compliance

Provider network contracting

Application

- Must have CMS-compliant contracts in place
  - Must include CMS required contract language
  - Agree to have all provider contracts and/or agreements available upon CMS request.
  - Contracts to the level of the organization or provider actually rendering the service or with those having signature authority for those entities (FDRs)
  - Medicare participating providers
  - Medicare ‘approved’ facilities (e.g., Transplants)
- Health Service Delivery (HSD) Tables submitted with Application
  - Include all contracted provider / facility names, addresses, specialties
- Must meet CMS minimum Network Adequacy Requirements

Provider network contracting

Application

- Strategically designed networks help plans to:
  - Attract and retain members
  - Provide a superior member experience of care
  - Optimize health outcomes
  - Support financial viability through cost of care and risk adjustment optimization
- Strong plan / provider relationships can support positive outcomes
  - Joint operating committee model for aligned goals, issue identification, and strategic planning
  - Data and information sharing to support cost of care, quality, and risk adjustment
  - Cohesive member / patient education and communication
  - Program innovation

Medicare Advantage enrollment and marketing

Readiness

Criteria

- Can first market October 1 of the year prior to the plan year
- Can only enroll individual beneficiaries who reside within the plan's designated service area
- Can only enroll beneficiaries during CMS designated election periods

Enrollment

- Annual Election Period (AEP): Oct 15th – Dec 7th
- Medicare Advantage Open Enrollment Period: Jan 1 – Mar 31
  - Allows enrollees to drop their MA plan and switch to another MA plan or Original Medicare
  - Individuals can also select a PDP if switching back to Original Medicare
- Mid-year enrollment changes
  - Newly-eligible (i.e., age-ins)
  - Member relocation out of current plan's service area

Special Considerations

Year-Round Marketing – with some frequency limitations

- Dual SNP (D-SNP): Dual eligible (Medicare/ Medicaid)
- Chronic Care SNP (C-SNP) Documented qualifying disease
- Institutional SNP (I-SNP) Require long term care

5-star plans

- Enrollee can switch to a 5-star plan at any time during the year

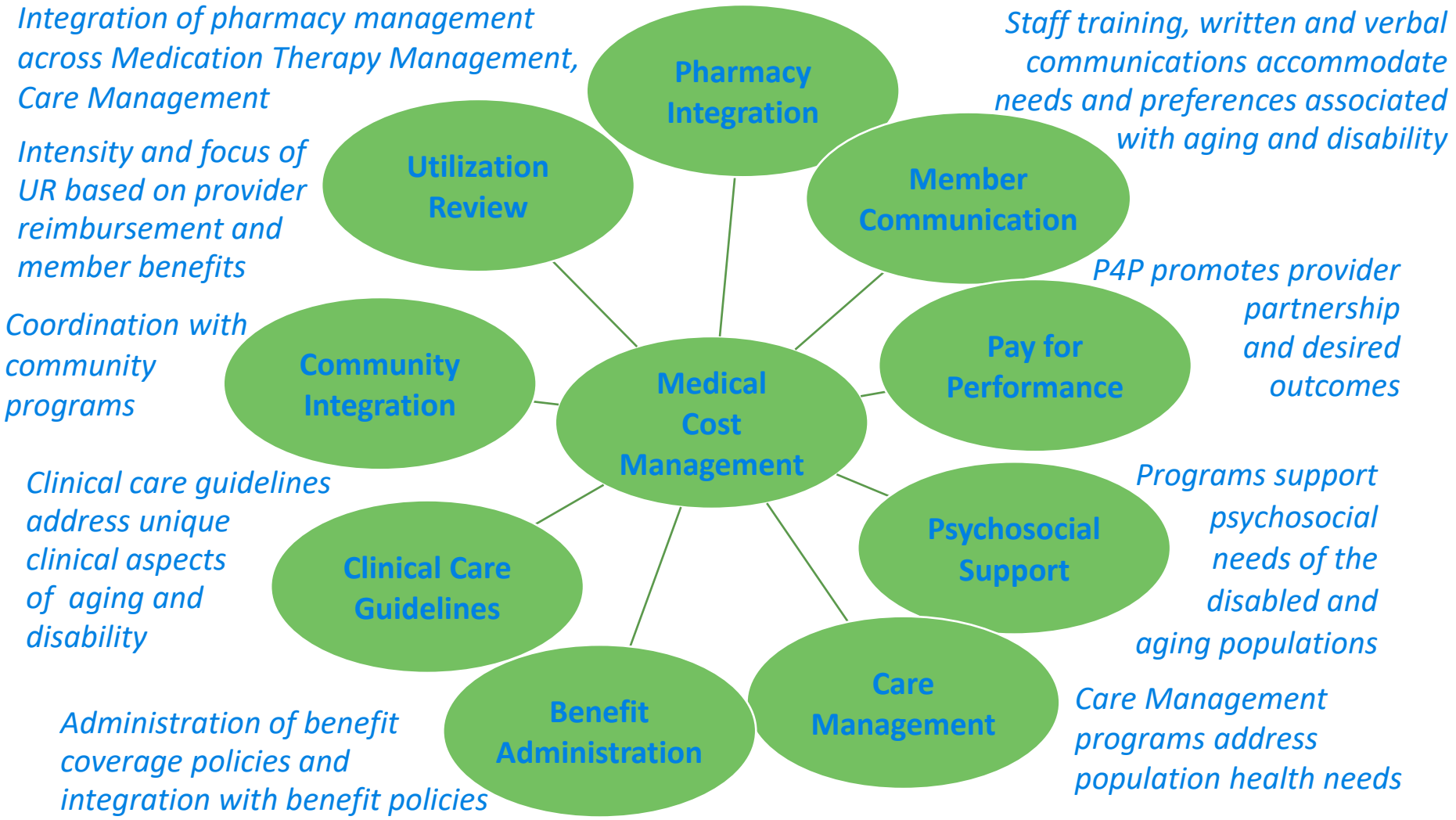
Below 3-star plans

- CMS may send February Notice to enrollees in plans with fewer than 3.0 stars (Part C or Part D) for three or more consecutive years, and give enrollees the option to change plans

Medicare health care management

Areas that differ in a Medicare product & population

Operative



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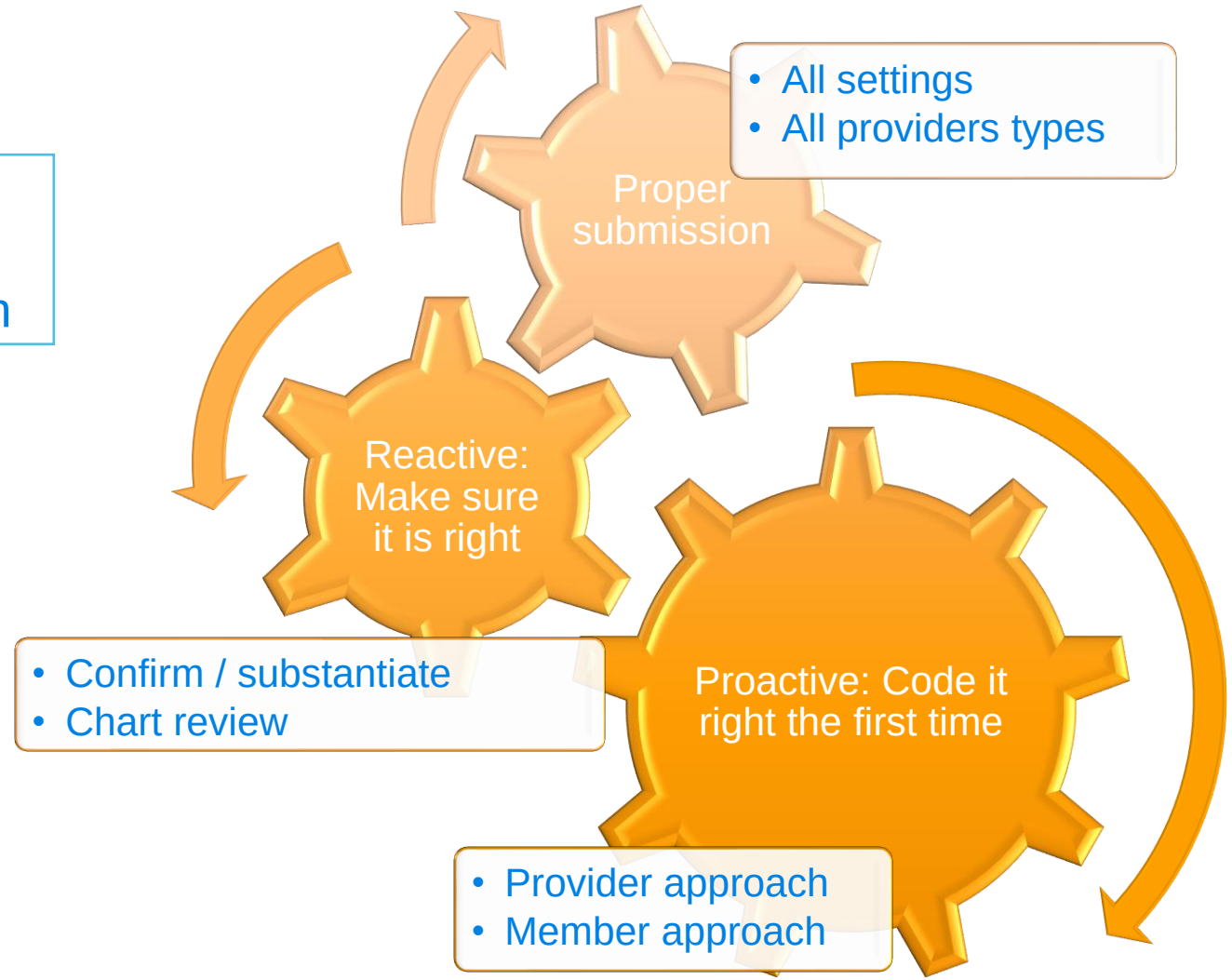
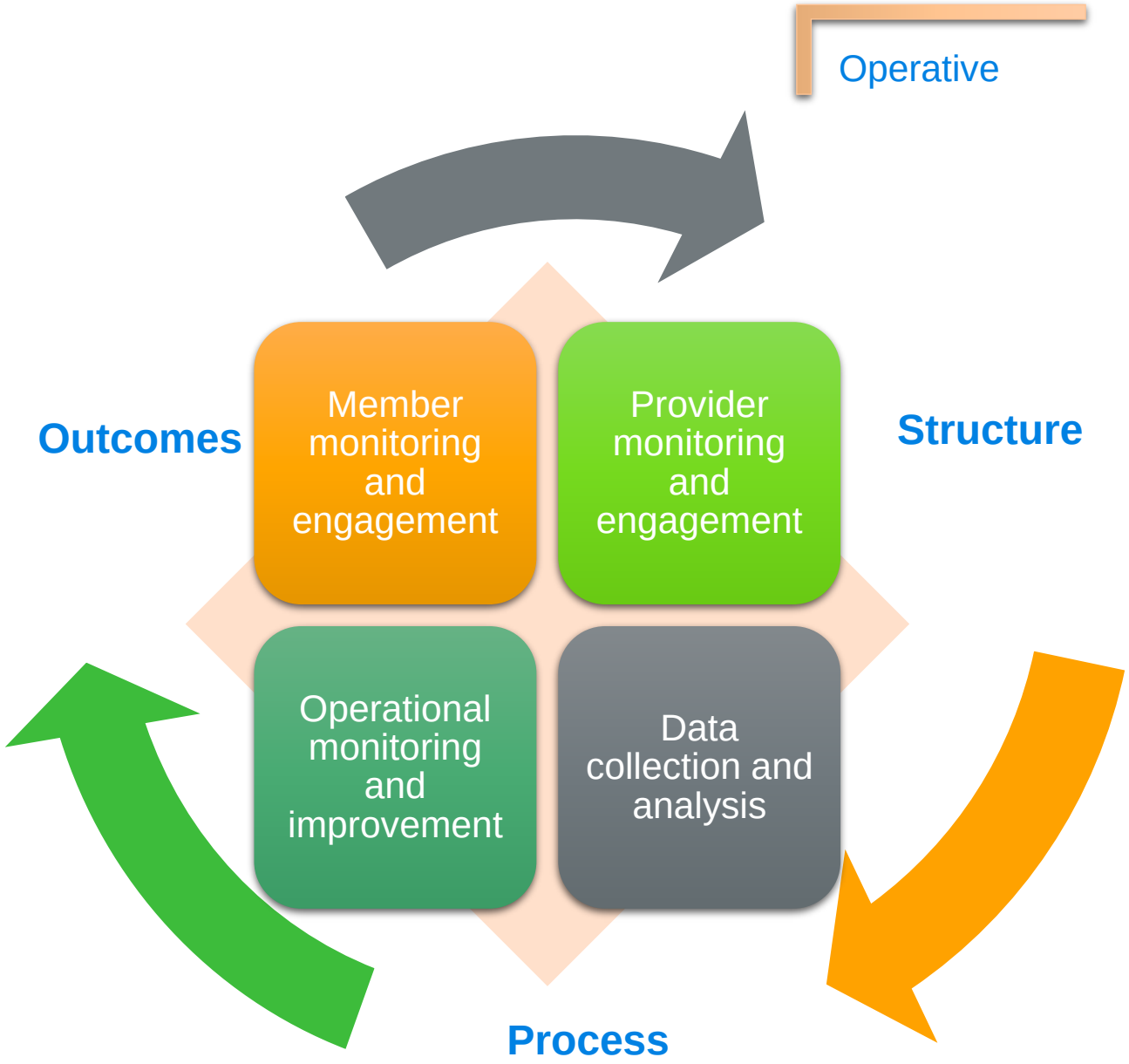
Risk score improvement

Doing Nothing or Only a Little is a Losing Proposition



Star management

- Implement strategy and work plan prior to start-up
- Understand what drives each measure
- Evaluate how management, processes, staff, technology and tools affect each measure
- Determine what improvements should be made
- Develop actions which take into consideration trade-offs between improved star rating against efforts for each measure
- CMS changes the measures and other aspects from year to year



Is MA a good opportunity?

- With dedication and patience, it can be
  - Requires commitment to the following items
    - Compliance
    - Medical management
    - Risk score improvement
    - Star ratings
    - Provider / pharmaceutical contracting
    - Sales and marketing
  - Given the relatively high revenue PMPM, many carriers that achieve a profit margin of only a few percent are successful
    - Annual profits not always predictable
      - Actual medical costs, pharmacy costs, administrative costs, and risk scores often vary from projected amounts
    - Often takes until year 4 or 5 to see first annual profit

MA-PD / SNP Application Timeline for Contract Year 2024

SNP Application Milestone	Date *
Notice of Intent to Apply (NOIA) online release	Mid October 2022
NOIA deadline to ensure HPMS access (new MA plans)	Mid November 2022
Release of Contract Year 2024 Applications	Early January 2023
NOIA submission deadline	Late January 2023
Applications Submission Deadline	Mid-February 2023
Applications Deficiency Notices	March 2023
Applications Notices of Intent to Deny	Mid - April 2023
Applications Conditional Approval/ Denial Notices	Late May 2023
D-SNP SMAC** Submission Deadline	Beginning of July 2023
Contract Execution/renewal	September 2023

* *Dates are approximate, based on prior years' CMS timelines and are subject to change*

** *State Medicaid Agency Contract*

2024 Operational Go-Live

Plan Creation, Plan Benefit Package (PBP) software released	April	2023
Formulary Submission Due	Mid-End May	2023
CMS' model marketing materials /Marketing Guidelines available	May	2023
Bids due	June 5	2023
Begin submitting marketing materials to CMS	June	2023
Finish submitting marketing materials to CMS *(CMS suggested)*	June 30	2023
CMS executes contracts with organizations	September	2023
Complete product implementation and associated testing	September	2023
Annual Election Period	**Oct 15-Dec 7**	**2023**
Marketing materials approved by CMS and complete	October 1	2023
Web site operational	October 1	2023
Customer Service Call Center in place	October 1	2023
MAPD Product Effective & Operational	**January 1**	**2024**

"CMS may verify an Applicant's readiness and compliance with Medicare requirements through on-site visits at the Applicant's facilities."

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Questions?

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