

Medicare Advantage Plans Squeezed in 2012 Under Healthcare Reform

Under Medicare Part C, Medicare Advantage, beneficiaries are allowed to receive Medicare benefits through private health insurance plans which are often attractive to Medicare beneficiaries, despite required copayments, since they generally include treatment not traditionally covered by Medicare Parts A and B, such as prescription drugs, dental, vision, and health club memberships.¹ Medicare Advantage plans have increased in popularity in recent years, as enrollment rose from 5.6 million in 2005 to 11.8 million in 2011.² Under the Patient Protection and Affordable Care Act (ACA), government subsidies for Medicare Advantage plans will be reduced leading to an uncertain future for this popular Medicare option.³

Medicare Advantage (MA) subsidies are calculated by taking the difference between the private insurance plan predicted cost of care demonstrated through a bid submitted to the Centers for Medicare and Medicaid Services (CMS) and the maximum Medicare Parts A and B payment for traditional Medicare benefits in a geographic area, referred to as the benchmark.⁴ If the bid is below the benchmark, which is generally the case, the private plan receives a rebate (savings) equal to 75 percent of the difference. This rebate must be used to provide additional benefits; reduce member cost sharing; or reduce member premiums.⁵ If the bid is above the benchmark, Medicare beneficiaries are charged a premium to cover the overage. To encourage plan participation, Congress has historically increased benchmark amounts, which currently range from 100 to 150 percent of actual fee-for-service (FFS) costs.⁶ As a result, it is estimated that CMS spends approximately 14 percent, or \$1000, more per enrollee on MA programs than traditional Medicare option.⁷

ACA provisions attempt to lower the additional costs MA plans create for the federal budget by freezing benchmark amounts starting in 2011 and reducing benchmarks over a two–six year phase in period beginning in 2010.⁸ Reductions in benchmark payments will be based on CMS ranking of FFS costs in each county. Once ranked, the highest quartile will have its benchmark amounts lowered to 95 percent of local FFS costs, the next quartile to 100 percent, then 107.5 percent, and finally the lowest quartile to 115 percent.⁹ Nationally, benchmark amounts in 2017 should average 101 percent of FFS costs as compared to 112 percent in

2010.¹⁰ Rebate percentage payments will also be reduced starting in 2012. Based on “*star quality*” ratings, some MA plans will receive even lower rebates, with all subsidies being lowered to 50-70 percent of current payment rates by 2014.¹¹

Critics have expressed concern with cuts to MA benchmarks, as the ACA provisions are based on the assumption that CMS cuts to Medicare physician payments will be enforced, which historically, Congress has averted. Insurance plans participating in MA programs place their bids to CMS in the spring, meaning that unless Congress averts cuts to physician payments before April or CMS preemptively accounts congressional action, the post-ACA rebate savings will be approximately 6.5 percent less than the 95 – 115 percent adjustment.¹²

Quality of care improvement is also emphasized by ACA changes to MA programs. In 2012 benchmarks will be adjusted based on quality measures with *qualifying* plans receiving bonus payments.¹³ Qualifying plans are defined as those that receive a four star (or higher) rating on a five star scale constructed on five measures: (1) preventative care; managing chronic conditions; plan responsiveness and care; member complaints and appeals; and, customer service. While this star rating system is already in effect, previously it was only used by plan discretion as a marketing tool.¹⁴ In November 2010 CMS announced that under the MA quality bonus payment demonstration project, bonus payments would be expanded to include plans that received three star quality ratings.¹⁵ Under this strategy, 80 percent of all MA plans would receive bonus payments in 2012. MedPAC has expressed criticism to CMS regarding the demonstration project incurring more costs than benefit, and sending the wrong message about the importance of quality.¹⁶

The Congressional Budget Office has projected that the ACA changes to federal subsidies will result in \$135 billion in savings between 2010 and 2019. In addition, MA plan enrollment is estimated to plummet by 35 percent over the same time period, to 9.1 million enrolled in 2019 compared to the pre-ACA estimate of 13.9 million. This effect will vary by geographic region, market competition, and plan quality.¹⁷ Some insurers offering MA plans will face increased competition from

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other Medicare options, but all plans will need to evaluate appropriate quality and efficiency strategies based on their respective market services areas and product mix.¹⁸

¹ "Payment Reform will Impact Medicare Advantage" By Patrick J. Dunks, et al., Milliman Healthcare reform Briefing Paper, February 2011.

² "Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums" By Marsha Gold, et al., The Henry J. Kaiser Family Foundation, October 2010, p.1; "Medicare Advantage 2010 Data Spotlight: Plan Enrollment Patterns and Trends" By Marsha Gold, et al., The Henry J. Kaiser Family Foundation, June 2010, p.1.

³ "Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums" By Marsha Gold, et al., The Henry J. Kaiser Family Foundation, October 2010, p. 2, 10.

⁴ "Payment Reform will Impact Medicare Advantage" By Patrick J. Dunks, et al., Milliman Healthcare reform Briefing Paper, February 2011.

⁵ "Payment Reform will Impact Medicare Advantage" By Patrick J. Dunks, et al., Milliman Healthcare reform Briefing Paper, February 2011.

⁶ "Medicare Provisions in PPACA (P.L. 111-148)" By Patricia A. Davis, et al., Report To Congress, Congressional Research Service, April 21, 2010.

⁷ "PPACA: Feds Hops to Squeeze Medicare Advantage" by Allison Bell, National Underwriter, August 2, 2010, <http://www.lifeandhealthinsurancenews.com/News/2010/8/Pages/PPACA-Feds-Hope-to-Squeeze-Medicare-Advantage.aspx> (Accessed 4/22/11).

⁸ "Patient Protection and Affordable Care Act" Pub. L. 111-148, Section 3201 (March 23, 2010), p.442.

⁹ "Payment Reform will Impact Medicare Advantage" By Patrick J. Dunks, et al., Milliman Healthcare reform Briefing Paper, February 2011.

¹⁰ "The Medicare Advantage Program: Status Report" By Scott Harrison, MedPac Presentation, November 4, 2010.

¹¹ "Payment Reform will Impact Medicare Advantage" By Patrick J. Dunks, et al., Milliman Healthcare reform Briefing Paper, February 2011.

¹² "Payment Reform will Impact Medicare Advantage" By Patrick J. Dunks, et al., Milliman Healthcare reform Briefing Paper, February 2011.

¹³ "Patient Protection and Affordable Care Act" Pub. L. 111-148, Section 3201(n) (March 23, 2010), p. 447.

¹⁴ "Payment Reform will Impact Medicare Advantage" By Patrick J. Dunks, et al., Milliman Healthcare reform Briefing Paper, February 2011.

¹⁵ "Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2011 and other Proposed Changes" 75 Fed. Reg. 71190-92 (November 22, 2010).

¹⁶ "Concerns with CMS Proposed Rules: File Code CMS-4144-P" By Glen M. Hackbarth MedPAC Chairman, To Donald Berwick, Administrator for Centers for Medicare and Medicaid Services, January 6, 2011.

¹⁷ "Medicare Provisions in PPACA (P.L. 111-148)" By Patricia A. Davis, et al., Report To Congress, Congressional Research Service, April 21, 2010.

¹⁸ "Payment Reform will Impact Medicare Advantage" By Patrick J. Dunks, et al., Milliman Healthcare reform Briefing Paper, February 2011.



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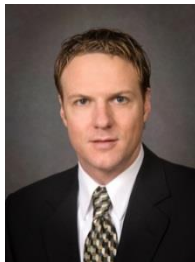
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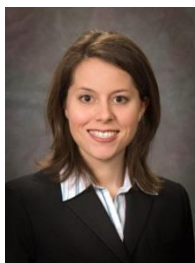
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