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Cora Drew, Esq., MPH - Senior Research Associate • Jessica Burt - Editor

# 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 tradition 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 staring 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 then 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]

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

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**Robert James Cimasi**, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Intuition of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: "*The U.S. Healthcare Certificate of Need Sourcebook*" [2005 - Beard Books], *"An Exciting Insight into the Healthcare Industry and Medical Practice Valuation"* [2002 – AICPA], and *"A Guide to Consulting Services for Emerging Healthcare Organizations"* [1999 John Wiley and Sons].

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows.

**Todd A. Zigrang**, MBA, MHA, ASA, FACHE, is the Senior Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia, and is a Fellow of the American College of Healthcare Executives. He has co-authored *"Research and Financial Benchmarking in the Healthcare Industry"* (STP Financial Management) and *"Healthcare Industry Research and its Application in Financial Consulting"* (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser's Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.

**Anne P. Sharamitaro**, Esq., is the Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC), where she focuses on the areas of Certificate of Need (CON); regulatory compliance, managed care, and antitrust consulting. Ms. Sharamitaro is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as an editor for the Journal of Health Law, published by the American Health Lawyers Association. She has presented healthcare industry related research papers before Physician Hospitals of America and the National Association of Certified Valuation Analysts and co-authored chapters in "*Healthcare Organizations: Financial Management Strategies*," published in 2008.

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