FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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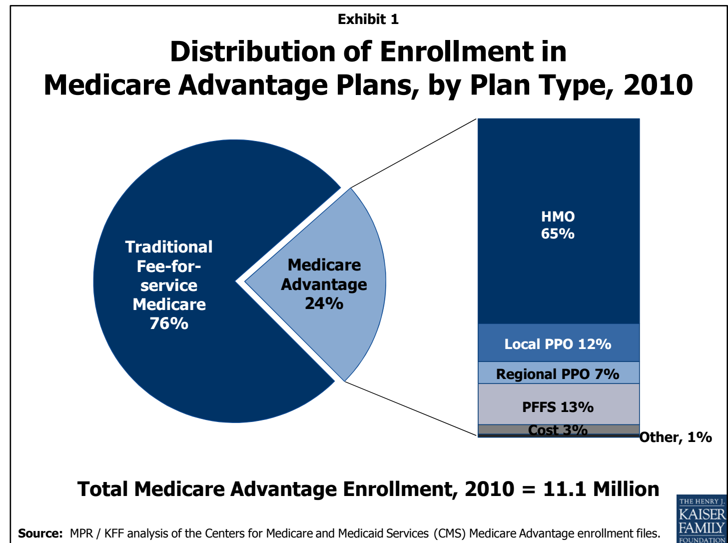
EXPLAINING HEALTH REFORM: Key Changes in the Medicare Advantage Program

The 2010 health reform law[1] makes several changes to the Medicare Advantage program that offers beneficiaries the option of enrolling in private health plans for Medicare benefits, as an alternative to the traditional fee-for-service Medicare program. Private plans, such as health maintenance organizations (HMOs), have been an option under Medicare since the 1970s. Today, Medicare contracts with HMOs, preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, provider-sponsored organizations (PSOs), high deductible plans linked to medical savings accounts (MSAs), and special needs plans (SNPs) for individuals dually eligible for Medicare and Medicaid, the institutionalized, or those with certain chronic conditions.



In 2010, 24 percent of all Medicare beneficiaries are enrolled in Medicare Advantage plans, the majority of whom are in Medicare HMOs **(Exhibit 1)**. On average, Medicare beneficiaries are able to choose from 33 different Medicare Advantage plans in 2010.[2]

The 2010 health reform law includes provisions to eliminate relatively high payments to Medicare Advantage plans, financially reward high-quality Medicare Advantage plans, and strengthen protections for consumers enrolled in Medicare Advantage plans.

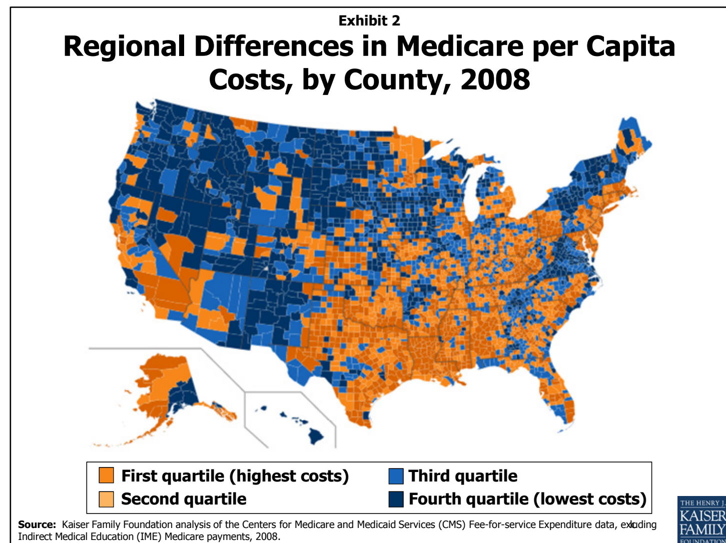
How are Medicare Advantage plans currently paid?

Medicare Advantage plans receive payments from Medicare to provide all Medicare-covered benefits to enrollees. Since 2006, the federal government has paid Medicare Advantage plans under a "bidding process"; plans submit bids to the government that estimate their costs per enrollee for Medicare-covered services. The bids are compared to benchmark amounts that are established in statute and vary by county. The benchmarks are the maximum amount Medicare will pay plans in a given county to provide Medicare Part A and B benefits. If a plan's bid is higher than the benchmark, enrollees pay the difference in the form of a monthly premium, in addition to the Medicare Part B premium. If the bid is lower than the benchmark, the plan receives 75 percent of the difference (Medicare keeps the other 25 percent), known as a "rebate," that plans must use to provide supplemental benefits such as lower premiums, lower cost sharing, or extra benefits; most rebates (54 percent) are used to lower cost sharing.[3] The Medicare Payment Advisory Commission (MedPAC) reports that Medicare payments to private health plans in 2010 are between 9 percent and 13 percent higher, on average, than local fee-for-service costs.[4]

How will the 2010 health reform law change payments to Medicare Advantage plans?

The 2010 health reform law gradually phases down Medicare payments to plans, to bring payments closer to the average costs of Medicare beneficiaries, by county. In 2011, benchmarks for Medicare Advantage plans will remain the same as they are in 2010.[5] Between 2012 and 2013, plan benchmarks will gradually be reduced to levels closer to the costs of enrollees in traditional Medicare in each county, with relatively lower benchmarks in counties with high fee-for-service Medicare costs, and relatively higher benchmarks in counties with lower fee-for-service costs. In determining Medicare Advantage payments, the calculation of Medicare fee-for-service costs for a county excludes Indirect Medical Education (IME) payments **(Exhibit 2)**.

- Benchmarks will be 95 percent of fee-for-service costs per enrollee for the counties in the top quartile of fee-for-service costs, such as Miami-Dade County (FL) and Orange County (CA).
- Benchmarks will be 115 percent of fee-for-service costs per enrollee for the counties in the bottom quartile of fee-for-service costs, such as Honolulu (HI) and Boise (ID).
- Benchmarks will be 107.5 percent and 100 percent of fee-for-service costs per enrollee for counties in the third highest and second highest quartile of fee-for-service costs, respectively.



For counties in which the phased-in change in payments is less than $30, the new benchmarks will be phased in over 2 years, beginning in 2012, as previously described. The new benchmarks will be phased in over 4 years in counties in which the phased-in change in payments is at least $30 but less than $50, and will be phased in over 6 years in counties in which the phased-in change in payments is $50 or more.

Risk adjustment. Medicare payments to private plans will be further reduced through changes in the method used to compensate plans for the health status of enrollees (risk adjustment). Recognizing a trend among Medicare Advantage plans to report information that increases enrollees' risk scores relative to similar beneficiaries in traditional fee-for-service Medicare, CMS first reduced risk scores for the 2010 plan year and will reduce the risk scores for 2011 by 3.41 percent. The health reform law extends the authority of CMS to continue to adjust the risk scores, and requires CMS to adjust risk scores, beginning in 2014, with a reduction of at least 5.7 percent in 2019 and future years.[6]

Quality-based payments. Plans that receive 4 or more out of 5 stars from the health plan quality rankings will receive bonus payments of 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 percent in 2014 and later years; high quality plans in certain counties will receive double bonuses.[7]

The majority of plans will be allowed to retain only 50 percent of the difference between the plan bid and the benchmark, but plans receiving 3.5 or 4 stars will retain 65 percent of the difference and plans receiving 4.5 or 5 stars will retain 70 percent of the difference. Total payments to plans, including bonuses, will be capped at current payment levels.

Special Needs Plans (SNPs). The health reform law extends for three additional years the amount of time SNPs can continue to be offered to beneficiaries (until 2014), and requires SNPs to be approved by the National Committee for Quality Assurance (NCQA), beginning 2012. SNPs for individuals dually eligible for Medicare and Medicaid will be permitted to operate without established contracts with state Medicaid programs until 2013. Payments to SNPs for individuals with chronic conditions will be risk adjusted based on the costs of enrollees with the same health conditions, beginning in 2011.[8]

Additional protections for Medicare Advantage enrollees. The 2010 health reform law includes provisions to strengthen protections and coverage for beneficiaries in plans.

- Medicare Advantage plans will be prohibited from having higher cost-sharing requirements than traditional fee-for-service Medicare for chemotherapy, renal dialysis, skilled nursing care, and other services the Secretary of HHS deems appropriate, beginning in 2011.
- Medicare Advantage plans will be required to maintain a medical loss ratio (i.e., the share of federal payments and beneficiary premiums spent on medical services) of at least 85 percent, limiting the amount spent on administrative expenses, including profits, beginning in 2014.
- Enrollees in Medicare Advantage Prescription Drug plans (MA-PDs) will be entitled to improved coverage in the Part D coverage gap.

Enrollment period changes. Currently, beneficiaries may elect to enroll in a Medicare Advantage plan between November 15 and December 31 of each year. Beneficiaries enrolled in a Medicare Advantage plan as of January 1 can switch Medicare Advantage plans or return to traditional Medicare for 90 days after the beginning of the calendar year. The annual election period will be changed to October 15 to December 7 of each year, beginning in 2011 for plan year 2012. Beneficiaries enrolled in a Medicare Advantage plan as of January 1 will be allowed only 46 days after the beginning of the calendar year to disenroll from the plan and return to traditional fee-for-service Medicare, beginning in 2011; they will not be allowed to switch from one Medicare Advantage plan to another during this time period.

What are the implications for the future of the Medicare Advantage program?

Historically, Congress has enacted a number of changes that affect the role of private plans under Medicare, including adding new types of plans to the program, both increasing and decreasing Medicare payments to plans (at different points in time), tightening the rules governing the marketing of the plans, and even changing the name of the program (from Medicare+Choice to Medicare Advantage). The health reform law of 2010 makes a number of additional changes to the Medicare Advantage program, driven largely by concerns about the current payment system and its effect on Medicare spending. The 2010 changes are intended to bring average payments to plans closer to the costs of traditional fee-for-service Medicare, reward higher quality plans with bonuses, and strengthen protections for beneficiaries enrolled in Medicare Advantage plans.

The effect of these payment reductions are likely to vary across firms, plans, and counties. Companies offering Medicare Advantage plans may respond to payment changes in several different ways, depending on the circumstances of the company, the location of their plans, their historical commitment to the Medicare market, and their ability to leverage efficiencies in the delivery of care to enrollees. For example, some companies may decide to raise beneficiaries' premiums and/or cost-sharing requirements, reduce their network of providers, reduce extra benefits, or make improvements to obtain quality-based payments. Some may choose to withdraw from the market entirely. Others may not make dramatic changes. Decisions made by these firms could have important implications for beneficiaries' decisions with respect to Medicare Advantage enrollment, out-of-pocket costs, and access to providers—effects that should be monitored over time.

[1] The health reform law refers to the "Patient Protection and Affordable Care Act" (P.L. 111-148) as enacted on March 23, 2010 and amended by the "Health Care and Education Reconciliation Act of 2010" (P.L. 111-152) as enacted on March 30, 2010.

[2] Gold M, Phelps D, Neuman T, and Jacobson G, "Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums," November 2009.

[3] Medicare Payment Advisory Commission, Report to Congress, March 2010.

[4] The difference between Medicare payments to private plans and Medicare fee-for-service costs varies depending upon whether the scheduled 21 percent cut in Medicare payments to physicians occurs. Medicare payments to plans would have averaged 113 percent of Medicare fee-for-services costs in 2010, if Congress had not acted to prevent the scheduled 21 percent reduction in physician fees under Medicare as of January 2010. If Congress enacts legislation to prevent the physician fee reduction for all of 2010, MedPAC estimates payments to plans would average 109 percent of Medicare fee-for-service costs in 2010.

[5] Prior to enactment of the health reform law, plan benchmarks were set to increase by 1.38 percent between 2010 and 2011. See Centers for Medicare and Medicaid Services (CMS), Office of Public Affairs, "CMS Issues Preliminary 2011 Payment Policies for Medicare Advantage and Prescription Drug Plans," February 19, 2010.

[6] Required risk adjustment will cease when the Secretary implements risk adjustment based on diagnostic, cost and use data.

[7] All small / low enrollment plans receive quality bonus payments in 2012. All new plans (i.e., those offered by organizations that did not have a Medicare Advantage contract in the previous 3 years) will receive quality bonus payments of 1.5 percent in 2012, 2.5 percent in 2013, and 3.5 percent in 2014. The Secretary is required to establish a method for computing quality ratings for small plans for 2013, and new plans for 2014, and subsequent years.

[8] The law grants the Secretary of HHS the authority to adjust payments to SNPs for individuals dually eligible for Medicare and Medicaid for enrollees' frailty, beginning in 2011, but this adjustment will not be made in 2011 due to lack of sufficient data to accurately determine frailty levels. CMS expects a larger sample size of dual SNPs in the Health Outcome Survey (HOS) in 2011, which would allow frailty levels to be calculated for CY2012. See CMS, "Announcement of Calendar Year (CY) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," April 5, 2010.

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