KAISER FAMILY FOUNDATION
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THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE BRIEF

FIRM PERSPECTIVES ON THE MEDICARE ADVANTAGE MARKET

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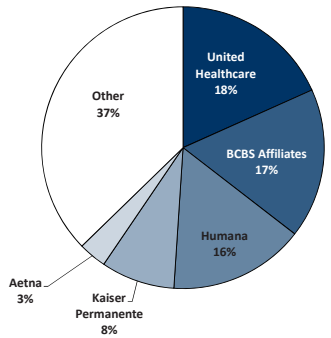
Overview

In general, Medicare Advantage firms expect their offerings to be relatively stable in 2012, the first year of the phase-in of controversial payment cuts to Medicare Advantage plans included in the Patient Protection and Affordable Care Act (ACA) of 2010. Firms are optimistic that new quality-based bonus payments will significantly offset payment reductions in the near term. Many say they are expanding care management efforts, an area where they perceive health plans can make a unique contribution. The decline in Medicare Advantage firm participation between 2009 and 2011, spurred by legislative restrictions on private fee-for-service (PFFS) plans, appears to have gone more smoothly than many analysts expected, with Medicare Advantage remaining a strong presence in the market and many beneficiaries transitioning from PFFS to preferred provider organizations (PPOs). While fewer firms now participate in Medicare Advantage, the shake-out appears to have favored firms with a longer term commitment to the Medicare Advantage and senior market.[1] In general, firms with a strong presence in the Medicare Advantage market remain cautiously optimistic about the future of Medicare Advantage, although they expect the market to consolidate further. Many firms are offering an increasingly diverse set of Medicare products with which to attract beneficiaries with different needs and preferences.

These findings and others are based on confidential, hour-long interviews with senior executives who have major responsibility for Medicare Advantage in 14 large, diverse firms participating in Medicare Advantage (see methods box in **Appendix**). The interviews covered a wide range of topics but generally focused on how firms viewed the Medicare Advantage market going forward and how they thought they might be affected by other changes included in the ACA of 2010. Most interviews were conducted after preliminary, but not final, 2012 payment rates were announced by the Centers for Medicare and Medicaid Services (CMS). Because Medicare Advantage enrollment is relatively concentrated among plans offered by a relatively small number of firms (**Exhibit 1**), these interviews provide insight into general market trends, although they do not necessarily indicate what will happen in individual markets.

EXHIBIT 1

Medicare Advantage Enrollment, by Firm or Affiliate, 2011



Total Medicare Advantage Enrollment = 11.9 million

NOTE: Other includes firms with less than 3% of total enrollment. BCBS affiliates are Blue Cross/Blue Shield affiliates, which include Wellpoint BCBS plans that comprise 4% of total enrollment in Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Enrollment files, 2011.

Relatively Stable Offerings Anticipated in 2012

Firms generally reported that they expected no major changes in 2012.[2] Firms that historically had offered PFFS plans had replaced the plans with other Medicare Advantage products, added provider networks to their design, or reduced their service areas, consistent with new requirements under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, which required PFFS plans in most counties to have provider networks by 2011.[3]

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Firms were analyzing the specific implications of the 2012 payment cuts in each county they served for the plans they offered, but most do not expect dramatic changes.[4] They anticipated accommodating 2012 payment cuts through a combination of what they characterized as "benefit tweaks" and "efficiency enhancements." A few, who were more specific, said that benefit stability was important to their enrollees so they hoped to limit change, probably favoring cuts in certain benefits if needed to keep premiums low. Firms anticipate bonus payments will offset some of the payment cuts, thus reducing the extent of change in plan design.

Specific strategies for 2012 are likely to differ by firm and market, depending upon where they seek to position their products.

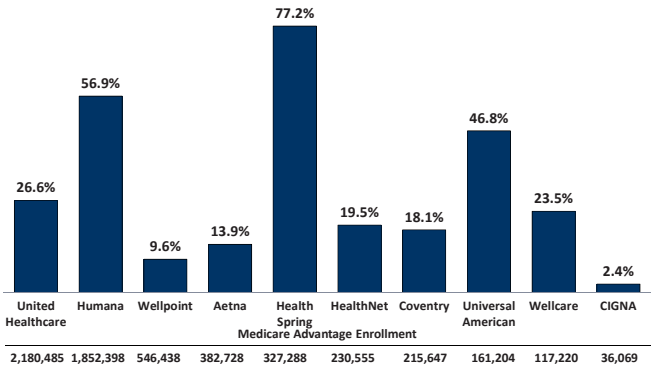
"Senior Market" is Important for the Long Term

Medicare Advantage firms say that Medicare is very important to their long term future. Those firms in which Medicare dominates their offerings say that without Medicare, obviously, they would have to go out of business. Most firms, however, are diversified across payers and also offer a range of Medicare products that include many versions of Medicare Advantage plans, Medigap options, stand-alone Part D drug plans, and selected other services that complement these offerings or help providers manage them.

Medicare is important to firms for several reasons. First, its contribution to firm revenue is disproportionate to its enrollment because Medicare beneficiaries use a lot more care on average. For example, one firm said it might be 20 percent of a firm's business but one-third of its revenue, although these figures will differ across firms. Medicare Advantage generates particularly large amounts of revenue relative to Medigap or Part D because it includes all benefits, not just a subset (**Exhibit 2**).

EXHIBIT 2

Medicare as a Share of Estimated Revenue Among Publicly Traded Firms, by Size of Enrollment, 2011



NOTE: Wellpoint's enrollment includes Wellpoint BlueCross BlueShield plans as well as other plans.
SOURCE: Analysis by Citi Investment Research and Analysis of Company data as reported in C. McDonald "It's Better to Learn Wisdom Late than Never at All" (Figure 9), April 17, 2011. Medicare Advantage enrollment from MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2011.

Second, firms see the individual and small group markets becoming increasingly less profitable with market changes and new restrictions on medical loss ratios. They also see erosion in group-based insurance, particularly for retirees. Public insurance, both through Medicare and Medicaid, are sectors where future growth is most likely given changes in demographics and public policy.[5]

Third, firms remaining in the Medicare Advantage market say they have already had their commitment tested. Many firms say that they experienced the cutbacks in Medicare+Choice in the 1990s. They remained in the market then and expect to remain in it now. Due to consolidation and the departure of many firms based almost exclusively on PFFS product offerings, the Medicare Advantage market also may be stronger now than it was several years ago. MIPPA forced firms to decide if they were willing to invest in network development and work with local providers. While Medicare Advantage firms say the shakeout is not over, many of those remaining appear to have a relatively long term commitment to the market. Fourth, firms have diversified their product line in ways that give them greater flexibility to remain engaged in the Medicare market. As one firm explained, "We offer pretty much anything" a senior might be interested in, including a full range of Medicare Advantage plans, a stand-alone Part D drug plan, and Medigap plans. Those firms we spoke with thought they could be successful in Medicare Advantage under current policy and felt Medicare Advantage provided them with more opportunities than other Medicare products. They expected Medicare Advantage to remain important to them, but had alternatives because they did not want to walk away from Medicare Advantage and could not imagine walking away from Medicare.

Bonus Payments Key to Firms' Strategies Going Forward

Firms viewed the potential of bonus payments, based on CMS quality ratings, as critical to the strategy of their firm going forward because they would partially or even substantially offset payment cuts. The firms noted, however, that because payment reductions would phase-in over time, the cumulative impact of the cuts was expected to be substantial. They said that 2012 was the second year in a row that payments would increase far less than inflation. Additional uncertainties loom around the actual payment rates (which depend on traditional program cost experience) and how the 2012 elections might influence payments in the future.

Firms expressed strong support for the CMS demonstration to expand and accelerate bonus payments to Medicare Advantage plans.[6] As one executive commented "unless some executive is asleep at the switchboard, I think everyone is paying attention to quality ratings and bonus payments." Bonus payments based on quality are viewed as "good policy" where organizational and government interests align. Most firms expected to benefit from the bonus payments, although few realistically thought they might reach "5 stars," the maximum. They also thought bonuses could potentially lead to more concentrated markets because bonus payments would be highly concentrated, resulting in some competitors having much more money to spend on extra benefits for enrollees than others in the same market.

With bonus payments strategically important, we heard concerns over the details of the bonus payment policy and specific metrics to be employed. Firms were pleased the bonus payments would ramp up quickly but expressed concern over the quality of metrics. In general, they said they preferred measures based on clinical outcomes and expressed concerns over relying heavily on measures from patient reports where, they thought, recall or plan attribution could be an issue. Firms also expressed support for holding Medicare Advantage and traditional fee-for-service Medicare to the same quality standards.

Firms also are concerned with how the benchmark for performance will be constructed and with how different metrics will be weighted.[7] For example, some expressed concern that national benchmarks favored high performing over low performing regions at baseline and that equal weighting of each metric might not give enough priority to outcome measures as opposed to patient reports, process measures, or plan administration, which also are considered in establishing performance. They also were concerned about uncertainty, suggesting that star ratings were a bit like a "moving target" and that many of the specifics driving bonuses were still unknown.

Special Needs Plans (SNPs). Firms with a strong presence in the SNP market that we interviewed expressed concerns that the metrics of the general Medicare Advantage bonus program do not work well for their populations. As they view it, SNPs have too few enrollees (because of specialization) to support some metrics and these enrollees also are less likely to respond to telephone surveys. They note that quality metrics used in Medicare Advantage also are not well tailored to patients in SNPs who have less common care needs and for whom performance on specialized services may be critical to beneficiaries' assessment of plan performance. For example, a relevant metric for SNPs, one firm noted, might assess the SNP's ability to maintain the beneficiary in the community and avoid unnecessary hospital admissions or readmissions. In addition, some general care guidelines may not apply for subsets of patients in SNPs because of competing medical considerations. For example, colonoscopy to screen for colorectal cancer might be contraindicated for some patients with ESRD. Additionally, because plan performance is assessed at the contract level, SNPs offered under a contract that includes regular Medicare Advantage plans also create unique measurement issues for CMS.[8] Such mixed contracts are not unusual. Where they occur, SNP enrollment typically is a small share of the overall contract enrollment so contract based performance metrics do not capture experience specific to those in the SNP.

"SGR Fix" is of Significant Concern

Firms view it as very important that Congress address the problems created by the Sustainable Growth Rate (SGR) formula used to determine physician payment in traditional fee-for-service Medicare.[9] A "permanent solution" to this problem is important to Medicare Advantage plans for several reasons. First, delays and temporary adjustments to the formula mean that plan bids (and thus payments), which are prospective, are based on outdated assumptions that always lag behind current policy. Second, many of the firms with whom we talked base their payments on Medicare fee-for-service payment rates.[10] As a consequence, the adoption of short-term, last minute fixes to the SGR formula not only causes payment uncertainty among plans and providers, but also forces plans to find savings elsewhere to offset any increase in physician fees that occur during the calendar year. The plans also have to retroactively adjust their payments to providers, a practice that they say "physicians hate," thus complicating an already complex relationship with providers. Third, some firms perceive that in some markets access to care for Medicare beneficiaries in Medicare Advantage and traditional Medicare may be adversely affected because physicians are less willing to take Medicare fee-for-service payments. Firms that capitate all or some of their provider groups are better protected from uncertainty in provider payments because at least some of the risk is shared with providers.

ACOs: "Watchful Waiting" with Some Skepticism

Most firms said that activity to create Medicare Accountable Care Organizations (ACOs) within the traditional Medicare program was still very early in development, with considerable market variation and ACOs several years from operational status. (Interviews preceded release of the draft CMS regulations for ACOs.) Firms were waiting to see what was motivating ACO formation, with concern about the focus on provider consolidation. They see ACOs as potentially relevant to them even though the policy applies to the traditional Medicare fee-for-service program. Firms also anticipated that ACOs would develop quite differently across geographic locales.

Some firms say that the concept behind ACOs reflects what they have been doing for a long time as part of their managed care efforts.[11] Those in advanced managed care markets with high Medicare Advantage penetration rates and large physician groups, like in California or Minnesota, felt they already had systems that functioned like ACOs. Medicare Advantage firms also described ACO-type efforts that they are developing in the commercial market with their provider groups. One firm commented that "most good ideas already have been explored," noting that their company had a history back to the 1990s of helping affiliated physician entities take on risk.

Prior experience working with provider groups left some skeptical over the potential of ACOs. One firm described problems in the past working with providers to take on some financial risk. Another firm cited the poor track record that hospitals generally had with changing provider behavior. Another firm wondered if ACOs would be more than a current version of old solutions like "disease management."

Some Medicare Advantage firms see ACOs as a potential new fee-for-service market that could benefit from their expertise with functions like insurance and sales, management of financial risk, and care management. However, Medicare Advantage firms said it was not clear that providers wanted their help or recognized the value in the functions they performed. Some providers, they said, perceive insurer margin as "just profit." For the most part, Medicare Advantage firms were deferring any decisions until ACO regulations were issued and could be assessed. Medicare Advantage firms generally appear to see benefits to providers integrating to enhance their ability to manage care and financial risk, but also potential threats if providers feel they no longer need the support of insurers.

More broadly, firms tended to be supportive of delivery reform and believed they were already engaged in many of the changes called for in the ACA. Several described medical home initiatives, efforts to reduce hospital readmissions, or care systems that they said were based on a care management model. Some noted that because Medicare Advantage firms are paid on a capitated basis, they already have a financial incentive and flexibility to manage care and incentivize providers.

CMS: Continuing to Shape the Market

Firms view CMS to be an increasingly important force in the development of the Medicare Advantage market. While Medicare Advantage firms may appreciate the rationale behind new requirements, they expressed concern about the cumulative burden of compliance with what they perceive to be an increasing number of regulations, required data submissions, and external audits. Beyond the burden, they saw the requirements as limiting firms' flexibility to offer what they believe will be an attractive line up of plans in the marketplace, with the government substituting its vision of what beneficiaries want for the plans' experience and the market.

In terms of specifics, the two biggest concerns raised relate to CMS's policy with respect to approval of plans as part of the bid negotiations, and CMS's risk adjustment data validation (RADV) audits. In contrast, the ACA requirements for medical loss ratios were typically not regarded as an issue, and firms were willing to live with restrictions on tiered provider copayments even though they might like the flexibility.

Meaningfully Different Plans and Bid Negotiations. In an effort to make choices simpler for beneficiaries and enhance plan value to beneficiaries, CMS, as part of its call for plans and bid negotiations, has been seeking to limit the number plans of similar type (e.g., HMOs, PPOs) that firms offer in a market by eliminating low enrollment plans, discouraging multiple plan submissions in the same area unless the plans were significantly different from one another, and limiting significant increases in annual cost sharing or decreases in benefits.[12] Some firms we interviewed said these policies had required them to make changes to their preferred plan line up in 2011. At least two firms described situations where the rules made it difficult for them to offer plans within the same contract that had similar benefits but different networks or care management features. Some also were concerned that the calculation of meaningful difference in out of pocket costs excluded premiums, thus biasing the comparison.

Some also were concerned that actions they might take to address one CMS policy that is part of bid negotiations (e.g., differentiating benefit packages) might leave them in conflict with another (e.g., avoiding significant changes in cost sharing and benefit design from year to year), describing this as like "navigating a river with big logs." For 2012 bids, CMS will keep the same policies but try to make them more consistent, transparent and predictable to sponsors by releasing in advance the model they use to assess meaningful differences.[13]

Because of new legislative requirements in the ACA that limit firms' discretion to modify Medicare's cost sharing for certain services, and CMS's policies on the review of annual plan offerings, firms thought that Medicare Advantage benefits were likely to be more similar across plans than in the past and less a factor in competition going forward. Some expressed concern this could complicate their ability to distinguish themselves from others in the market.

Risk Adjustment Data Validation (RADV) Audits. Medicare Advantage firms submit diagnostic data to support CMS's risk adjustment of plan payments. (These data have been necessary because Medicare Advantage plans have not historically been required to submit encounter data; they will be required to do so in 2012.) In recent years, CMS has elected to audit risk adjustment data for a subset of plans to validate data used for risk adjustment with the actual diagnoses recorded in medical records.[14]

Firms that had been selected for such an audit expressed frustration with the burden of such audits and the potentially large though unknown financial obligations they might face in the future. One firm described an audit that had been conducted in 2010 for services rendered in 2006 and paid in 2007, with findings still not released. That firm said the length of the look-back period complicated their ability to locate records from providers who may have died, moved out of state, or switched to electronic records.

Firms perceive the huge investment they have made in coding as legitimate and worry that they could be financially liable for incomplete documentation of diagnoses in providers' records. There is no analogous

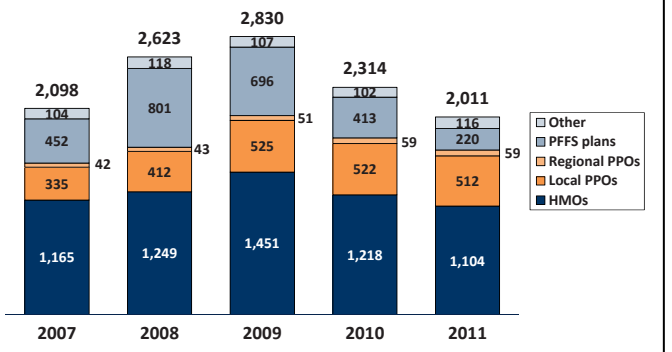
process for review of coding accuracy, they said, in traditional Medicare. Such policy disagreements may be hard to avoid, though, given the financial stakes associated with Medicare Advantage.

PPOs: A Growing Presence in the Medicare Advantage Market

Over time, PPOs have become more common in Medicare Advantage and enrollment in them has grown **(Exhibits 3 and 4)**. In general, firms see network-based Medicare Advantage products as the future. They see PPOs as particularly flexible and attractive to newly eligible Medicare beneficiaries, based on their coming to them with experience with employers that tend to favor such products. They thought HMO enrollment would continue to be strong, with HMOs particularly attractive to new beneficiaries who were enrolled in such plans prior to becoming eligible for Medicare, and attractive to beneficiaries without long standing relationships with specific providers. One Blue Cross Blue Shield affiliate explained that its PPO enrollment now eclipsed its HMO enrollment in Medicare Advantage, even though both plan types continue to grow.

EXHIBIT 3

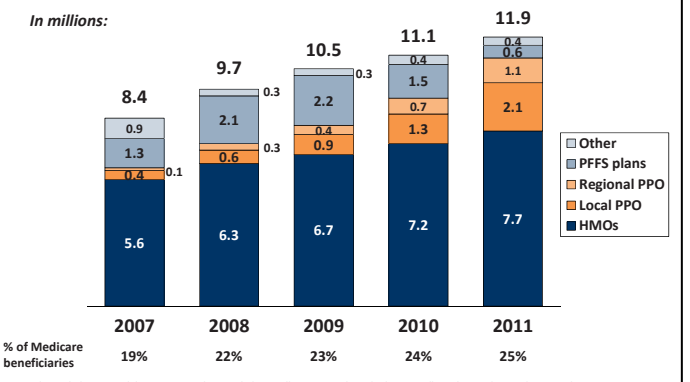
Distribution of Medicare Advantage Plans by Plan Type, 2007-2011



NOTE: Other includes cost and demonstration plans. Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). HMOs include Point of Service (POS) plans.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2007 - 2011.

EXHIBIT 4

Total Medicare Advantage Plan Enrollment, 2007-2011



NOTE: Other includes cost and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2011, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 2007; enrollment numbers from March of the respective year.

Attracting people who are becoming eligible for Medicare is increasingly important to Medicare Advantage firms as the baby boomers face retirement. Several firms said they were developing new products to attract retirees under 65, with the goal of keeping these enrollees when they become Medicare eligible. With employer-sponsored retiree coverage diminishing, firms expect more retirees to be looking at products available in the individual market and see a growing market for Medicare Advantage products as retirees consider their alternatives. To attract baby boomers, some firms were diversifying their marketing strategy, perceiving that new Medicare eligibles were more likely to use the internet and be more sophisticated consumers preferring their own research to relying on brokers to support their decisions on plan choice.

Most of the firms with whom we spoke that had previously offered PFFS plans had decided to try to migrate enrollees to a PPO product, rather than take advantage of auto assignment by offering a network-based PFFS plan. In some cases, they said the major client for the new product was a group account they were able to convince to transition, making it easier to retain enrollees without having to market directly to individuals. Other firms said they thought the PFFS "brand" was diminished or they had never really "liked" PFFS, but were responding to the competition. Firms with a heavy base in a market tended to find the transition to PPOs easier. Others were forced to reduce their Medicare Advantage footprint in order to make networks and care management more feasible, with network-based PFFS plans viewed as an important part of their long-term plan for transitioning enrollees to PPOs.

SNP Interest is Limited and Mainly Focused on the Dual Eligibles

The three firms we interviewed that focused on SNPs (and two others with a large enrollment in SNPs) believed strongly in the value of their plans, perceiving – each in different ways – that through specialization they were offering products of special value to those beneficiaries who qualified for the plan. Specifically, firms saw their value added as being able to better manage highly complex chronic conditions, meet social service needs that if addressed might allow beneficiaries to avoid unnecessary hospitalizations and institutionalization. For example, some provided home visits to keep patients out of the hospital, employed strategies designed to get patients to physicians and encourage medication compliance, and managed discharges to avoid rehospitalization. SNPs cited their solid knowledge of Medicaid and the way its benefits were designed to help beneficiaries better navigate the two systems. SNP authority also might allow them to cover benefits in a way that would not be financially feasible if offered to all Medicare Advantage enrollees (e.g., putting all cardiac medications in the first tier and allowing direct access to cardiologists in a congestive heart failure SNP).

Some of the firms felt that they now were more restricted and less able to innovate as a result of changes in CMS leadership and the new requirements for SNPs as a result of MIPPA. For example, they might be precluded from offering a specific benefit they previously had been allowed to offer under demonstration authority (like selected home care services). The firms also were concerned that risk adjustment, while valuable, still overpays for the healthiest and underpays for the highest cost patients. While this might work for a plan, they said, with an average mix of enrollees, it does not work for their plans, which disproportionately draw from the higher risk categories.

Among firms with relatively low or no SNP enrollment, some had considered the market previously or even offered SNPs, but were discouraged by the challenges of coordinating with Medicaid for dual eligibles. Several large commercial firms said that the kind of specialized model needed to support SNP success was operationally difficult to sustain in their environment. If they were "not on top of the game" with geriatric care management, they might decide to forgo the SNP option and focus on products that built more closely on their perceived relative strengths. Other firms said their care management systems for all Medicare Advantage enrollees worked well for dual enrollees and thus they saw little reason to add SNPs and be subject to additional requirements that were costly and administratively burdensome.

Challenges of coordinating with state Medicaid agencies were the most frequently mentioned barrier to development of SNPs. Several firms reported being discouraged historically by states with little interest in contracting for dual SNPs. Most firms also had limited prior Medicaid experience so the dual eligibles were not a "natural" market. However, integrating Medicare and Medicaid benefits was an issue even for a Medicaid dominant firm that was active in the market for dual eligibles because the Medicare and Medicaid benefits were separate units of the firm.

Some provisions of the 2010 health reform law may also be making some firms consider whether to reassess their interest in dual eligibles. Several firms mentioned that their state was now more interested in integration or involved in CMS's 15 state demonstration to improve Medicare and Medicaid services for dually eligible beneficiaries. Some firms that previously had expressed reluctance to become involved in dual SNPs said they might reconsider their strategies in the future depending on how state initiatives evolve and they remain conflicted about the complexity of coordinating policies of Medicare and Medicaid. With health reform, the Medicaid market also is likely to get larger, a potentially attractive market firms are tracking, although usually through units separate from those running the Medicare Advantage programs.

Summary and Implications for the Medicare Advantage Program

It is too soon to judge the ultimate effects of the changes made by the ACA on the Medicare Advantage market, but the immediate reactions by senior plan executives suggest few detrimental effects in the short term. Enrollment continues to grow in 2011 and firms anticipate relative stability in 2012. CMS's decision to pursue the bonus demonstration appears to be an important factor stabilizing the market and creating incentives for improved quality performance. However, there remain many technical issues to address in implementing measurement to drive payment. The considerable enthusiasm of industry for bonuses may be mitigated if the firms cannot successfully capture them. One can already anticipate that firms that do not receive the bonuses they hope to receive will likely point to problems with the metrics rather than their own performance.

The Medicare Advantage market appears to be making the transition away from PFFS, the dominant source of growth in plans and enrollment after the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, far more than most analysts would have predicted when MIPPA was enacted.[15] Beneficiaries continue to have many plan choices and Medicare Advantage enrollment has continued to grow as enrollment shifts to favor coordinated and network-based care plans. From a policy perspective, it also is encouraging to hear from firms that they are putting more emphasis on efforts to create a footprint in the market that strengthens their ability to manage care, improve their performance, and make them more efficient so that they can better succeed in an increasingly stringent financial environment.

Finally, firm interviews point out the potential artificiality of looking at Medicare Advantage and traditional Medicare as two entirely distinct markets. Many of the firms we talked with offer products for all Medicare beneficiaries, not just those in Medicare Advantage. Further, their Medicare Advantage contracts involve many providers who also treat beneficiaries in the traditional Medicare program. As firm discussions of ACO evolution reveal, they have insights into the challenges providers are facing through their experience working with them both in Medicare and in the commercial market. The issue is how best to leverage the firms' experience gained through Medicare Advantage to support and strengthen the broader initiatives of health care delivery and payment reform.

Data Sources and Methods

This analysis is based on structured interviews conducted from late March to early May 2011 with 14 large and diverse firms participating in Medicare Advantage. They included four large national firms, four Blue Cross and Blue Shield affiliated firms, three firms active in local markets, and three firms with a focus on SNPs.

Firms were provided a list of topics to be discussed and told that the interviews would be confidential and comments not attributed to particular firms. Interviews lasted about 45-60 minutes and involved the firms' self-designated senior executive responsible for the Medicare Advantage product and sometimes additional managers from that firm responsible for particular topics to be discussed. A few large national firms that are publicly traded declined to speak with us; we reviewed public disclosures to investors and selected Wall Street analysts' reports for these and other Medicare Advantage firms and found that their expectations are generally consistent with what was reported by the interviewed firms.

References

[1] M. Gold, G. Jacobson, A. Damico, and T. Neuman. "Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums," Washington DC: Kaiser Family Foundation, October 2010.
[2] Analysts following publicly traded Wall Street firms seem to have reached similar conclusions, see Oppenheimer "Medicare Advantage Outlook Stable as Bid Deadline Approaches," June 2, 20111.
[3] M. Gold, G. Jacobson, A. Damico, and T. Neuman. "Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums," Washington DC: Kaiser Family Foundation, October 2010.
[4] Medicare Advantage firms must submit bids to CMS by June 6, 2011, detailing the specific MA, MA-PD, PDP, cost based plans with a Part D benefit, and "800 series" employer plans they propose to offer for 2012 with detailed information to support CMS's review and approval of their bids and offerings.
[5] Interviewees generally managed the Medicare markets in their respective firms and did not speak to their firm's business strategy with respect to health insurance exchanges.
[6] Under its demonstration authority, CMS is implementing a Quality Bonus Payment Demonstration from 2012-2014 that will supersede the bonus authorized under the ACA. Bonus payments will be made to plans in contracts that have a star rating of 3 or more and range from 3 to 5 percent for those with 3 versus 5 stars, respectively. In 2014, 5 percent bonus payments will also be paid to plans rated four stars. Also, in 2012, plans rated five stars will have a special enrollment period, in final policy announced April 4, 2011. For more information, see http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Announcement2012final.pdf.
[7] G. Jacobson, A. Damico, J. Huang and T. Neuman. "Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011" Washington DC: Kaiser Family Foundation, February 2011.
[8] In 2011, the CAHPS required an oversample of enrollees in SNP benefit packages and the agency continues to work with Medicare Advantage firms to better capture performance of SNPs in terms that are relevant to their population.
[9] For details, see Medicare Payment Advisory Commission "Physician Services Payment System" Washington DC, revised October 2010; and Henry J. Aaron. "The SGR for Physician Payment: An Indispensable Abomination," N Engl J Med 2010; 363:403-405, July 29, 2010.
[10] Of those interviewed, five explicitly said they paid Medicare rates and another two said they used such rates but could negotiate it up or down in contracting with physicians. Two others based their rates either on percentage of Medicare or on a specific rate in some ways tied to Medicare. (A few plans used capitation exclusively.)
[11] For a review of some of this history, see M.Gold "Accountable Care Organizations: Will They Deliver," Washington DC: Mathematica Policy Research, January 2010.
[12] These expectations were formalized in the April 2010 revision to the Part C rules and further discussed in the April 15, 2011 revision. 42 CFR Parts 417, 422, and 423 "Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and other Changes; Final Report," Federal Register vol. 76, 73, April 15, 2010.
[13] Links provided in the Final 2012 Call Letter to MA/PDP plans at http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Announcement2012final.pdf
[14] Medicare Advantage Risk Adjustment Data Validation (RADV), December 20, 2010, at www.cms.gov/HealthPlansGenInfo/
[15] M. Gold "Medicare's Private Plans: A Report Card on Medicare Advantage," Health Affairs, 2009; 28:1w41-w54.

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