

Payment reform will impact Medicare Advantage



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In March 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA), which will change many aspects of the health insurance industry. In particular, the Medicare Advantage (MA) program will be significantly affected.

WHAT IS MEDICARE ADVANTAGE?

Medicare Advantage is a federal program in which health insurance organizations provide medical benefits to Medicare eligibles. In exchange for providing their enrollees with at least traditional Medicare benefits, the MA organization receives revenue from the Centers for Medicare and Medicaid Services (CMS). In addition, some organizations may require an enrollee premium (in addition to Medicare's Part B premium) if the CMS revenue is not projected to be sufficient to cover the cost of the plan's benefits and administration plus profit. The plans typically offer benefit enhancements in the form of reduced cost sharing or coverage of benefits that traditional Medicare does not cover. As of September 2010, about 25% of the Medicare population was enrolled in a Medicare Advantage plan.

HOW DOES MEDICARE ADVANTAGE WORK? WHAT DO SOME OF ITS KEY TERMS MEAN?

MA organizations submit a *bid* indicating how much revenue the organization would need to receive from CMS to provide traditional Medicare benefits (including administrative costs and profit). CMS publishes county-specific *benchmark payment rates* that are the maximums CMS will pay to organizations providing traditional Medicare benefits to Medicare eligibles. The benchmark payment rates vary by county and are loosely based on traditional Medicare fee-for-service (FFS) costs in each county; the relationship between FFS cost and benchmark revenue, however, varies widely among counties nationwide.

The bid process, which takes place in the spring of each year, compares an MA organization's bid to the weighted average benchmark revenue in the organization's service area, with the bid usually being less than the benchmark revenue amount. When this is the case, the difference is called the *savings*. MA organizations currently retain 75% of the savings, or the rebate, which they must use to provide additional benefits, reduce member cost sharing, or reduce member premiums.

Because the health status of Medicare eligibles varies widely, CMS risk-adjusts revenue to account for plans that enroll a healthier or sicker-than-average population.

KEY IMPACTS OF THE PPACA ON MEDICARE ADVANTAGE Benchmark payment rates will decrease relative to FFS costs under PPACA.

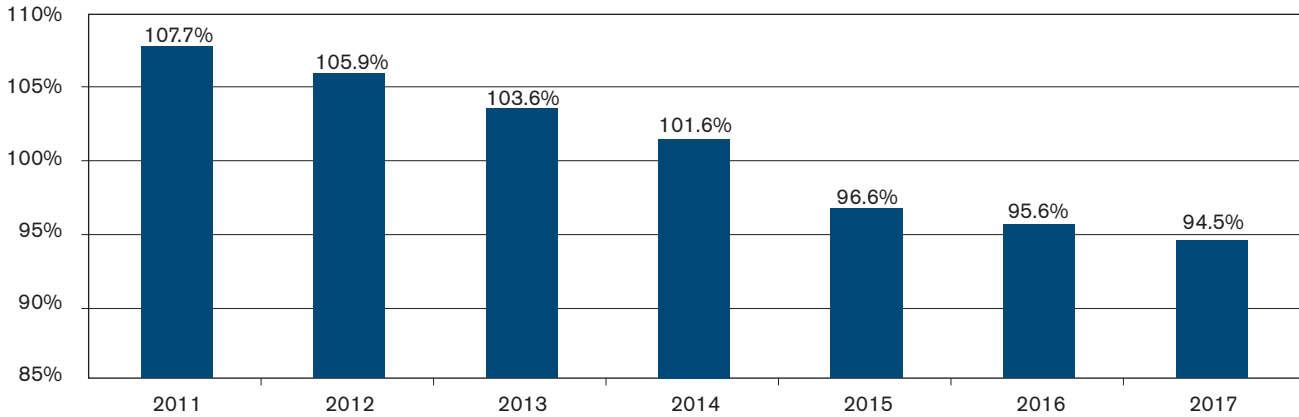
Starting in 2012, all counties will be ranked from highest to lowest based on the estimate by CMS of FFS costs in each county. The first quartile (the 25% of counties that have the highest FFS costs) will receive a benchmark payment equal to 95% of the estimated FFS cost for each respective county. The second, third, and fourth quartiles will receive 100%, 107.5%, and 115%, respectively, of the estimated county-specific FFS cost.

The new benchmark payment rate methodology will begin in 2012 and will be phased in over a two-, four-, or six-year period, depending on how much the new payment rate differs from the prior rate in each county (where largest differences earn the six-year phase-in period). During the phase-in period, the new payment rates will be blended with payment rates developed using the current methodology.

The benchmark payment rate relationships discussed above apply to estimated FFS costs developed by CMS each spring, assuming that the current law, which requires significant Medicare physician payment cuts in future years, will be enforced. However, later in the year, Congress historically overturns the law to avoid the scheduled cuts. Thus, if Congress and CMS continue historical patterns, CMS will develop FFS cost estimates in the spring, reflecting the physician payment cuts in current law. These estimates are understated compared to similar FFS cost projections later in the year, reflecting the elimination of the scheduled physician payment cuts. Unfortunately, this results in benchmark payment rates published in the spring that are understated compared to ultimate FFS costs.

Unless Congress makes physician payment fixes prior to April each year, or CMS accounts for these likely physician payment cut fixes when CMS makes its spring projections, the new components of benchmark payments rates, which are not reset with late physician

FIGURE 1: ESTIMATED NATIONWIDE AVERAGE BENCHMARK PAYMENT RATES AS A PERCENT OF ESTIMATED FEE-FOR-SERVICE COST, 2011-2017 (ASSUMES 3.0 STAR RATING FOR ALL PLANS AND USING NOVEMBER 2010 MA ENROLLMENT BY COUNTY)



payment fixes, will effectively be well less than the 95%, 100%, 107.5%, or 115% of FFS cost estimates that many expect.

Because Congress repeatedly overturned the physician cuts in the past, we assume it will continue to do so. Therefore, the values in Figure 1 assume that the physician payment cuts that would be implemented under current law will not be implemented during 2012-2017.

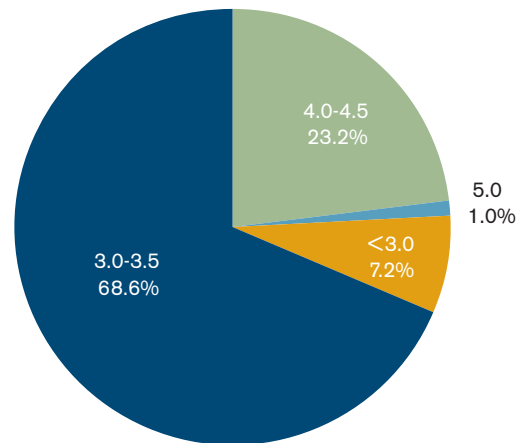
The graph in Figure 1 illustrates our estimate for these new MA benchmark payment levels, assuming a star rating of 3.0, compared to estimated traditional Medicare FFS costs from 2011 through 2017, when MA payment reform is fully implemented.

If physician payment fixes are in place prior to CMS developing the FFS cost estimates in spring for 2017, we estimate that the 2017 benchmark payment rates would average about 101% as a percent of 2017 FFS cost.

More than ever, high-quality measures can pay off for an MA organization. Prior to PPACA, the CMS star quality rankings of MA plans were used by high-quality MA organizations to help market their plans. Beginning in 2012, an MA organization can increase its CMS revenue by demonstrating quality to earn a benchmark revenue bonus. CMS will use each MA organization's star rating to award these bonuses to eligible organizations. The star rating system uses a scale from 0 to 5, with ratings of 5 representing the highest quality as measured by CMS. All organizations with a star rating of 3.0 or higher will receive a revenue bonus in 2012. The bonuses can be significant, as 3.0-, 4.0-, and 5.0-rated plans in 2012 will earn 3.0%, 4.0%, and 5.0% bonuses, respectively, on the portion of the benchmark revenue based on the new payment methodology. Unless the MA organization is one of just three MA organizations that earned a 5.0 rating, no MA organization will receive a bonus for the portion of benchmark revenue based on the current methodology.

Figure 2 summarizes the distribution of 2011 star ratings, by enrollment, which will be used for 2012 payment purposes.

FIGURE 2: DISTRIBUTION OF 2011 MEDICARE ADVANTAGE ENROLLMENT BY STAR RATING



The details of the bonus payment methodology were revised in mid-November 2010. The revisions allow more plans to qualify for a bonus in 2012-2014 and increase the bonus amounts. This expansion of the bonus program will result in about 91% of all contracts (and about 93% of enrollment) receiving a bonus.

The star rating is based on measures in five categories:

1. Preventive care
2. Managing chronic conditions
3. Plan responsiveness and care
4. Member complaints and appeals
5. Customer service

A limited number of counties qualify for double bonus. Based on certain criteria outlined by the PPACA, approximately 6% of counties are eligible for an additional bonus. If an MA organization operates in such counties, the star-rating bonus earned by the MA organization for those counties will be doubled.

Note that CMS revenue payments under the new methodology (including bonus) cannot exceed the payment under the existing methodology. This is true for all MA organizations except those with a star rating of 5.0, which are not subject to the existing methodology limitation.

Rebate amounts will be reduced starting in 2012. The rebate amount (historically 75% of the difference between the bid and the benchmark revenue) will decrease beginning in 2012. A deeper rebate reduction will occur for MA organizations with lower star ratings. Once fully phased in for 2014, the rebate amounts will be 50%-70%, depending on an organization's star rating. Rebate changes will be phased in over three years starting in 2012.

The minimum loss ratio requirement for MA plans takes effect in 2014. Beginning in 2014, MA organizations will be required to meet or exceed an 85% loss ratio. Organizations that close the year with a loss ratio below 85% must return the excess revenue to CMS. Failing to meet the loss ratio requirement for multiple years can result in enrollment sanctions or plan termination.

MA organizations bid in early June for the following calendar year's MA plans. As part of that bid, they must estimate medical costs and revenue. Favorable deviation from the medical costs and/or revenue projected in the bid could cause MA organizations to fall short of the minimum loss ratio. Thus, once the minimum medical loss ratio applies to MA organizations, we believe they will more diligently measure their revenue and medical cost experience.

In particular, they may try to more precisely measure medical costs and revenue, determine the additional revenue that risk score improvements can bring, and estimate the cost reductions that any management efforts (e.g., medical management, provider reimbursement reductions, or fraud and abuse activities) can realize in order to frequently update their MA projections for the current calendar year.

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Depending on the final MA minimum loss ratio regulations, these more timely monitoring and projection efforts may occasionally result in some MA organizations halting some or all efforts to improve risk scores or reduce medical costs for some or part of a calendar year in order to avoid falling short of the minimum loss ratio and save administrative costs that, absent the minimum loss ratio requirement, would normally provide a return on investment.

WHAT'S THE END GAME HERE?

Each MA organization will need to evaluate its star rating and MA payment reform in its service area to determine the impact these changes will have on its future revenue. Some MA organizations will face increased competition from Medicare Supplement products that were largely untouched by healthcare reform. In fact, we expect that some MA organizations may consider offering Medicare Supplement products to widen their Medicare product portfolio in an effort to retain enrollment.

Whether the impact of the PPACA causes MA organizations to improve their operational efficiency, focus more on quality, or develop an MA plan exit strategy, the PPACA will bring change to the MA market. Because the PPACA's payment reform impact varies significantly by area, MA organizations have different star ratings and abilities to improve them, and other MA plan circumstances differ widely by organization, each organization will need to identify the most appropriate strategy for each of its service areas and products.

As we move forward, we should watch for any changes in this federal program and how the concepts Congress used in the MA program may be incorporated in other federal legislation.

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