

In the Spotlight: Health Care Reform and Medicare Advantage

The Affordable Care Act (ACA) made several sweeping changes to Medicare Advantage (or Part C). (For changes made to the Medicare Part D prescription drug plans, refer to [In the Spotlight: Health Care Reform and Medicare Part D](#).) Medicare Advantage gives Medicare beneficiaries the option to purchase Medicare coverage through a private insurer, usually offering more benefits than standard Medicare fee-for-service, while the insurer is reimbursed a set monthly set rate by the Centers for Medicare and Medicaid Services (CMS). In a March 2010 [Report to Congress](#), the Medicare Payment Advisory Commission found that the Medicare program spent about \$14 billion more for those beneficiaries enrolled in Medicare Advantage than those enrolled in original Medicare. Because of this difference in payment levels, many of ACA's changes center on payment restructuring for Medicare Advantage, including a general reduction in reimbursement rates, a shift toward paying more for insurers with higher quality ratings, rebate reductions, and requirements for medical loss ratios (MLR). Additionally, there will be changes to the enrollment periods for Medicare Advantage.

Reimbursement Rates

ACA is largely funded by cuts to the Medicare Advantage program. Beginning in 2011, Medicare Advantage will be frozen at 2010 reimbursement levels. From 2010 until 2020, Medicare Advantage funding will be cut \$131 billion directly, in addition to cuts in fee-for-service Medicare. In order to bring Medicare Advantage costs more in line with standard Medicare, a new reimbursement rate will be used, setting Medicare Advantage reimbursement on parity with original Medicare costs. All counties in America have been allocated to quartiles based on the costs for original Medicare per person in each county. The Medicare Advantage benchmark reimbursement amount will be adjusted based on the quartile of the country being served. For counties in the highest cost quartile, benchmarks will equal 95% of original Medicare spending and for counties in the lowest cost areas, benchmarks will equal 115% of original Medicare spending. This new payment model will be phased in over a 6-year period. Most Medicare Advantage insurers will see their reimbursement rates reduced to meet the new standard over a 3-year period. However, if the difference between 2010 payment levels and the new benchmark rate is more than \$30, the new payments will be phased in over 4 years; if the difference is more than \$50, the phase in will occur over 3-to-6 years.

Star Ratings

Currently, CMS ranks Medicare Advantage plans on a 5-star scale to inform beneficiaries of the high quality plans. The quality plan ratings will be posted on CMS' website this fall, [according to CMS officials](#). The rating system will also be slightly different – plans will be rated in half-star increments, based on the average of all 37 Part C and 18 Part D individual measures. Beginning in 2011, CMS will add a warning symbol to plans that have had fewer than 3 stars for 3 or more years.

Quality Bonuses

ACA created a bonus structure based on this 5-star scale which will offset the decreased reimbursement rates and reward and promote high-quality Medicare Advantage plans. In 2012, Medicare Advantage plans with 4 or more stars will receive a bonus payment of 1.5%. In 2013, these highly rated plans will receive a 3% bonus payment. Starting in 2014, bonus payments will reach 5% for plans with 4 or more stars. Plans in certain counties who receive 4 or more stars could double their bonus payments. These bonus payments will offset part of the reduction in reimbursement rates.

Rebate Reductions

Medicare Advantage plans whose bids are below the benchmarks set by CMS currently retain 75% of the difference between the benchmark and the bid. Beginning in 2012, rebates will be reduced overall and calculated based on quality ratings. Medicare Advantage plans with quality ratings of 4.5-5 stars will be allowed to retain 70% of the difference between the benchmarks and bid; plans with 3.5 but less than 4.5 stars will retain 65% of the difference, and plans with less than 3.5 stars will be permitted to retain 50% of the difference. These rebate changes will be phased in between 2012-2014, resulting in overall reduction of payments to Medicare Advantage plans.

Benefit Design Requirements

For plan years beginning 2012, ACA limits how plans may use the beneficiary rebates and bonuses. Plans are required to use most of the funds to reduce the cost-sharing for any of the benefits also offered in fee-for-service Medicare parts A and B (and not to reduce or eliminate the Part B premium). Any reduction in out-of-pocket spending limits would be required to apply to all Part A and B benefits.

MLR

In addition to reducing payment levels and shifting payments toward plans with the highest quality ratings, the ACA also sets new medical loss ratio (MLR) requirements for Medicare Advantage plans. (For information on MLR as it relates to all plans, please refer to [In the Spotlight: Health Care Reform and Medical Loss Ratio](#).) Beginning in 2014, all Medicare Advantage plans will be required to maintain an MLR of at least 85%. Plans that do not maintain at least an 85% MLR will be required to refund to CMS the difference between the actual MLR and 85%. Plans that continue to fall short of the MLR requirement for 3 or more consecutive years will no longer be permitted to accept new enrollees. If the plans continue not to meet MLR requirements for 5 consecutive years, their Medicare Advantage contract will be terminated.

Enrollment Periods

Starting in 2011, the law eliminates the previous open enrollment period, January 1 – March 31, for Medicare Advantage plans. The OEP is being replaced with a new 45-day period called the Annual Disenrollment Period January 1 – February 15, allowing beneficiaries to disenroll from a Medicare Advantage plan and return to Original Medicare and elect a Part D plan. Starting with the plans that begin in 2012, the annual enrollment period for Medicare Advantage and Part D plans will be October 15 through December 7, 2011.

Fraud and Abuse

ACA expands the types of conduct for which HHS may use civil monetary penalties, including knowingly making, using or causing to be made false statements or material misrepresentations on bids and claims for payment on items and services furnished under a Federal health care program. Civil monetary penalties may also be used if information is not made available in a timely fashion during an audit or a request by the Office of Inspector General. Additionally, ACA requires that overpayments received by a provider, Medicaid managed care organization, or Medicare Advantage organization must be reported and returned within 60 days after it was discovered. ACA also extends and strengthens the Recovery Audit Contractor responsibilities, subjecting Medicare Advantage and Part D plans to RAC audits and audits of the Plans' anti-fraud programs.

What to expect long-term

The reduced reimbursement rates and increased restrictions on Medicare Advantage will increase financial strain on insurers. In some cases, like [Harvard Pilgrim](#) in Massachusetts, insurers have deemed the increased financial burden too great, and have pulled out of the Medicare Advantage market, citing concerns about the long-term viability of the Medicare Advantage market. AHIP [released a statement](#) in September 2010 that confirmed insurers commitment to the 11 million seniors enrolled in Medicare Advantage but raised concerns about rising costs, fewer choices, and reduced benefits that may result from ACA requirements. Historical data suggests that Medicare Advantage plans need to be

financially viable in order to continue offering this service to seniors. For example, when the Balanced Budget Act was passed in 1997, reducing reimbursement rates below medical cost trends, many insurers eventually had to withdraw from the Medicare Advantage market, affecting nearly 2.4 million beneficiaries. The [Congressional Budget Office](#) also predicts a strain in the market, estimating a 35% decline in enrollment in 2019 based on their current projections and a 50% reduction in benefits. In April, [CMS estimated](#) up to a 50% reduction in enrollment of Medicare Advantage by 2017 as a result of ACA.

BCBSNC Views

BCBSNC believes that the Medicare Advantage program provides an important choice for seniors and wants to see it continue as a viable option. We support improvements to the Medicare Advantage program that help to meet the needs of Medicare beneficiaries. One such improvement of particular value is the quality bonus payments provision. We see this as a step in the right direction to amend a system that has long rewarded amount of care over the quality of care.

For More Information

Medicare: Medicare.gov

Federal Health Care Reform and Medicare site: www.healthcare.gov/law/provisions/rebate/index.html

AHIP Statement on Reform: <http://www.ahip.org/content/pressrelease.aspx?docid=31571>

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