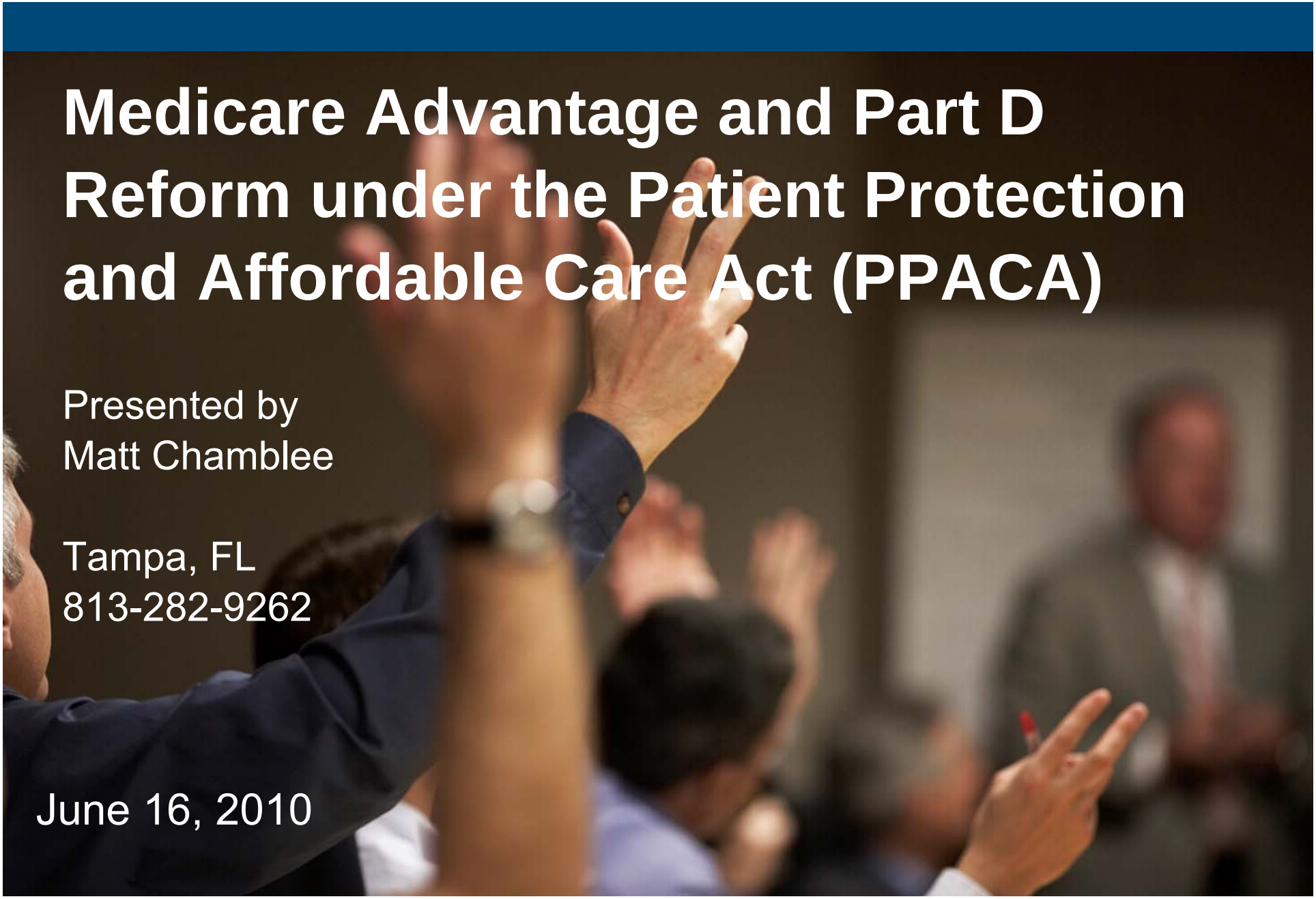

# Medicare Advantage and Part D Reform under the Patient Protection and Affordable Care Act (PPACA)

Presented by
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June 16, 2010

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# Scope of Presentation

- Medicare Advantage marketplace as of today.
  - Penetration, payments relative to FFS, and general landscape
- Changes to Part D in 2010+
  - Part D “rebate” to members in CY 2010 who qualify
  - Closing of the Part D “doughnut hole” starting in CY 2011 with some generic coverage in the gap
  - Brand discounts directly to members in the gap starting in CY 2011
- Changes to Part C in 2010+
  - Part C benchmarks frozen from CY 2010 Phasing in of new Part C benchmarks over several years
  - Payments tied to quality of care
  - Retrospective loss ratio requirements
  - ACO’s allowed to enter market



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# Scope of Presentation (cont.)

- Some uncertainty involved
  - Some provisions are not clear, or are subject to interpretation.
  - As regulations are issued by CMS, some provisions may change
  - We continue to study the issues
- Caveats
  - Intended to provide an overview -- limited to key provisions affecting the Medicare Advantage market
  - Not exhaustive and not a substitute for the language in the bills
  - Does not constitute legal advice



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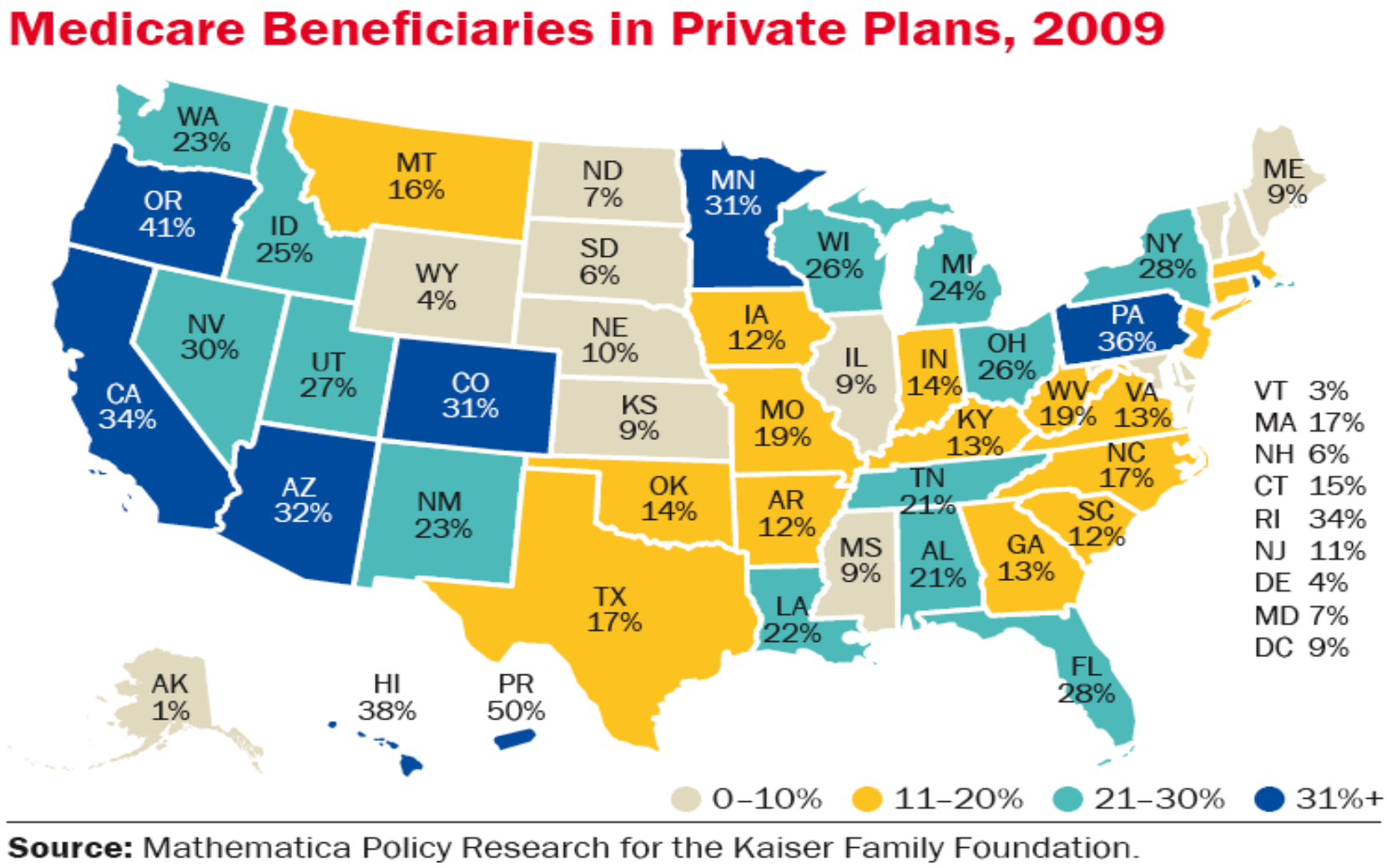
# Medicare Advantage marketplace as of today - Penetration



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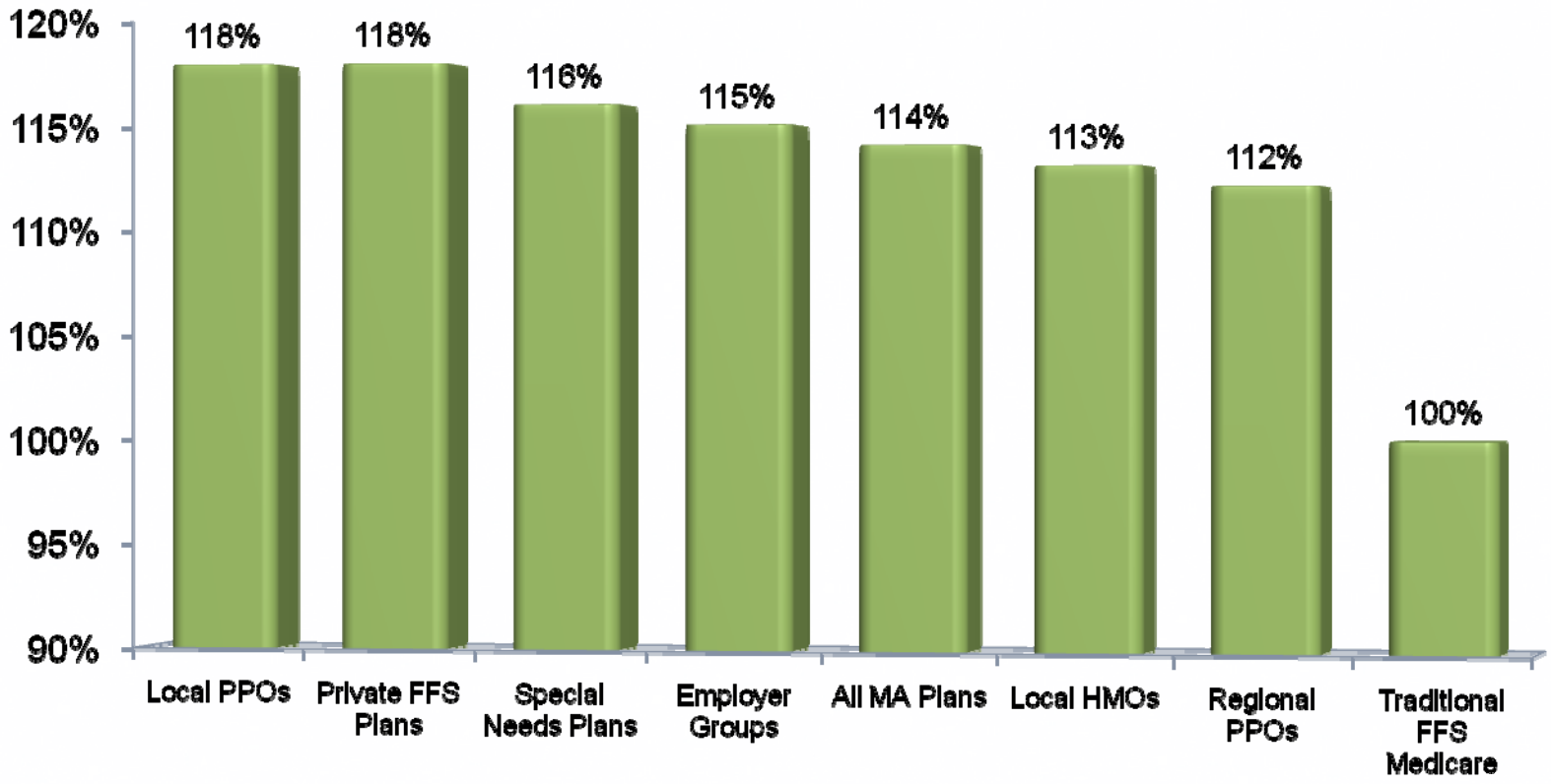
# Medicare Advantage marketplace as of today - Payments



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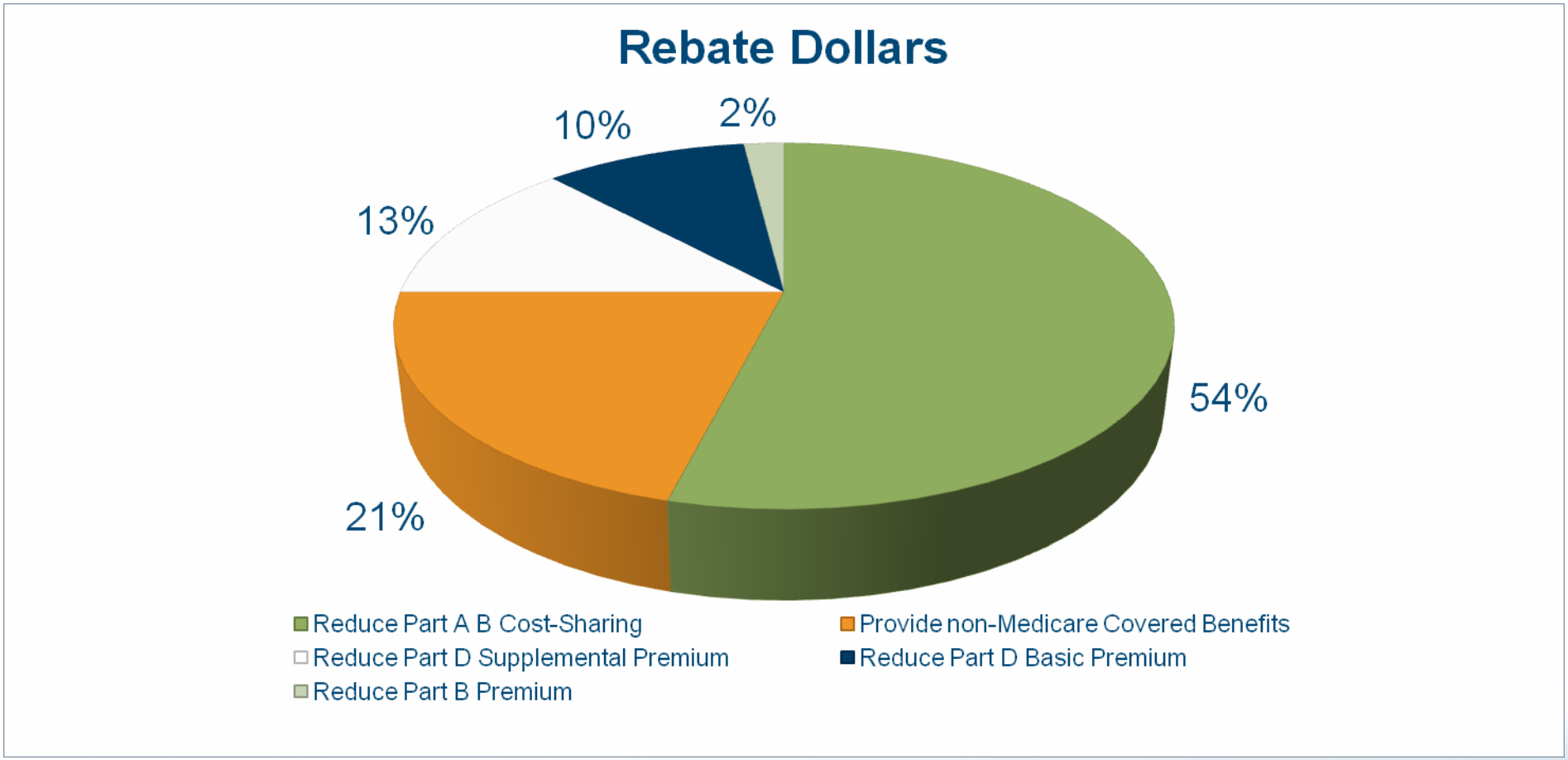
# Medicare Advantage marketplace as of today – what is all the extra money spent on?



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# Changes to Part D in 2010+

- $250 rebate paid by government to beneficiaries that exceed Initial Coverage Limit in 2010
  - Check sent from CMS to member (of course the plan will have to answer questions from members, “where is my money…”)
- Beginning in 2011
  - Generic coinsurance will be decreased by 7% annually – “plan liability”
  - Pharmaceutical companies to cover 50% of usual brand cost by paying that amount to reduce member cost share through coverage gap – administered by plan at point of sale but not a “plan liability”



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# Changes to Part D in 2010+ (cont.)

- Starting in 2013 Brand coinsurance decreases according to a schedule but always reduced by Pharma's 50%
- These amounts do not change TrOOP accrual (level at which catastrophic coverage begins)
- TrOOP will reduce gradually starting in 2014 (phased in until 2019)



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# Changes to Part D in 2010+ (cont.)

| Year | Member Generic Coinsurance | Nominal Brand Coinsurance | Pharma Coinsurance Contribution | Net Member Brand Coinsurance |
|---|---|---|---|---|
| 2011 | 93% | 100% | 50% | 50% |
| 2012 | 86% | 100% | 50% | 50% |
| 2013 | 79% | 97.5% | 50% | 47.5% |
| 2014 | 72% | 97.5% | 50% | 47.5% |
| 2015 | 65% | 95% | 50% | 45% |
| 2016 | 58% | 95% | 50% | 45% |
| 2017 | 51% | 90% | 50% | 40% |
| 2018 | 44% | 85% | 50% | 35% |
| 2019 | 37% | 80% | 50% | 30% |
| 2020 | 25% | 75% | 50% | 25% |



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# Issues for Part D Going Forward

- Actuarial equivalence for mandated gap coverage
- Brand coverage in the gap in addition to the mandated coverage
- Employer plans and the brand discount
- OOPC and meaningful differences between plans
- New Part D risk-model implemented in 2011
- Means testing Part D government subsidies



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# Changes to Part C in 2011, or lack thereof

- Benchmarks in 2011 are frozen – same as 2010.
  - No reductions for IME
- Rebates are treated the same as in 2010 – 75% of the difference between bid and benchmark.
- Benefits that can be bought with rebate dollars are the same as in 2010
  - For example, Part B premiums can be bought down, no additional restrictions on supplemental benefits



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# Changes to Part C in 2011, some things did change

- PFFS plans without a network were restricted to certain rural service areas
- Preventative Benefits were encouraged to have no cost share
- Cost sharing limits for certain Medicare covered benefits
- OOP maximum – establishment of MOOP and VOOP for certain plan types – interaction with the OOP and cost sharing for specific benefits\
- New enrollee risk scores for C-SNP's have been increased
- **Increased accountability of the certifying actuary!**
- New Med-Supp plans to compete against MA plans



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# Changes to Part C in 2011, so what gives

- Traditional PFFS phased out – replaced by Network PFFS, PPO, and HMO plans where possible
- Consolidation of plans within a service area for a sponsor
  - OOPC calculation  to determine meaningful differences
- What do plans give up
  - Same benchmarks as last year (without any doctor fix included)
  - Another year of trends though
  - So decrease margins, or benefits, increase cost share or premiums



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# Changes to Part C in 2012+

- Election Periods:
  - Annual Coordinated Election Period will be October 15 to December 7 starting 2012 contract year
  - Annual election period (option to return to traditional Medicare) will be 45 days



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# Changes to Part C in 2012+ - multiple proposals

- Originally, two proposed approaches to benchmark rate reduction
  - H.R. 3200: America's Affordable Health Choices Act of 2009
    - Phase down of benchmarks to FFS cost levels
    - Bonus payments based on quality
  - Senate Bill
    - Competitive bidding
    - Bonus payments based on quality
- PPACA
  - Phase down of benchmarks to quartile-determined multipliers of FFS cost levels



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# Changes to Part C in 2012+ - it could have been the Senate bill

- Reduction in Medicare Advantage growth percentage of 3% for 2011
- Phases in payments based on enrollment-weighted average plan bid by 2015
- Beginning in 2014, would have had bonus payments for quality of care
- Changes could have been drastic
  - Chance the blended benchmark would be less than 100% of FFS costs
  - Some Medicare Advantage plans may become uncompetitive with other options (e.g., Medicare  Supplement)



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# Changes to Part C in 2012+ - Benchmarks under PPACA

- Counties Stratified Based on FFS Costs (quartiles exclude territories)
- Divided into Quartiles
  - Highest-cost quartile → 95% of FFS Costs
  - Second-highest cost quartile → 100% of FFS Costs
  - Third-highest cost quartile → 107.5% of FFS Costs
  - Lowest-cost quartile → 115% of FFS Costs

- Can Not Exceed Benchmark Under Current Methodology



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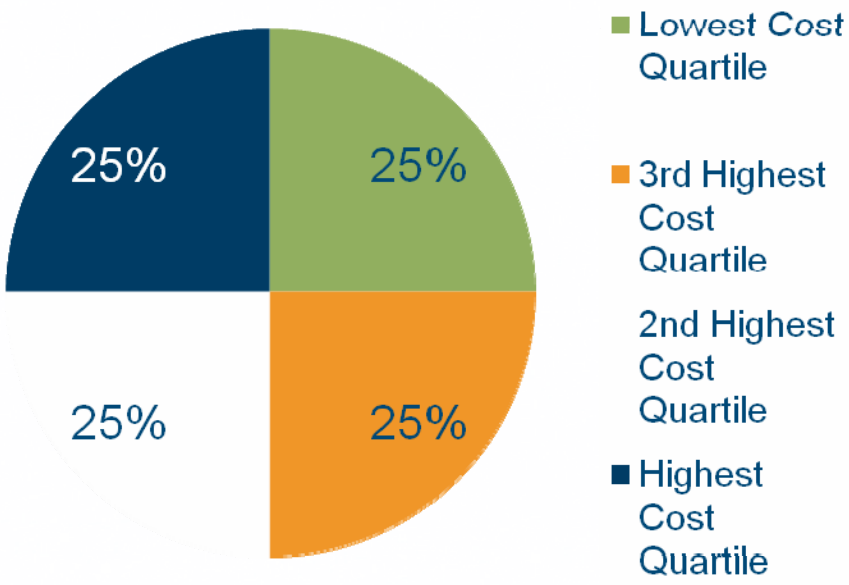
# Changes to Part C in 2012+ - Benchmarks under PPACA

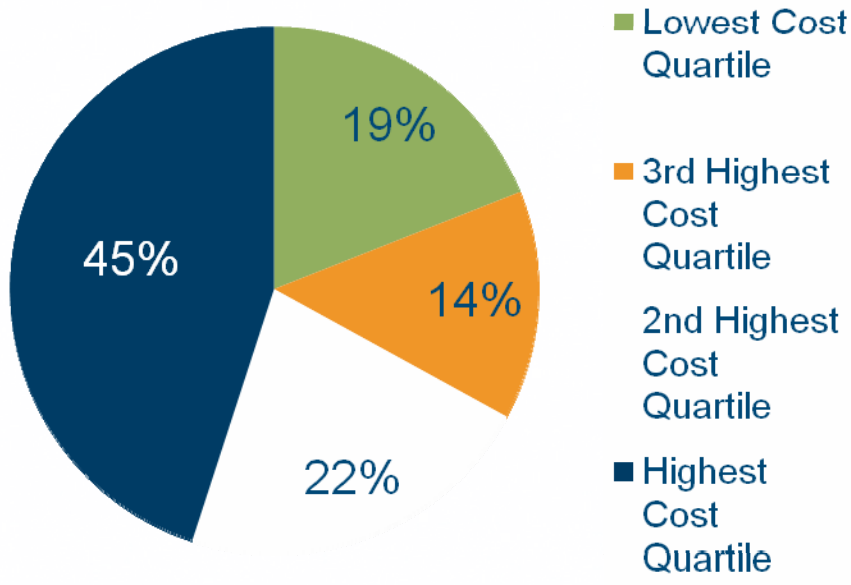
- Re-ranked Annually
  - Counties that change quartiles are transitioned for 1 year
  - Straight average of previous year multiplier and current year multiplier
- At least once every three years, Base Payment Amounts will be "rebased,"
  - This means that new FFS rates are developed – and new quartiles

# Changes to Part C in 2012+ - where are the MA members

## Counties Ranked by FFS Costs




## MA Enrollees in Each Quartile



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# Changes to Part C in 2012+ - there is a transition right?

- There is a transition….

$$D = \left[\left(\begin{matrix}2010\\ Benchmark\end{matrix}\right) - \left(\begin{matrix}2010\\ PBA\end{matrix}\right)\right]$$

- where,

$$\left(\begin{matrix}2010\\ PBA\end{matrix}\right) = \left[\left(\begin{matrix}FFS\ \%\ from\\ above\ table\end{matrix}\right) + \left(\begin{matrix}1.5\%\ for\ most\ counties, or\\ 3.0\%\ for\ "Qualifying\ Counties"\end{matrix}\right)\right] \cdot \left(\begin{matrix}County\\ FFS\ Rate\end{matrix}\right)$$

- Value of D determines phase-in, either 2,4 or 6 years.



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# Changes to Part C in 2012+ - Bonus Payments for Quality

- 2 Types of Bonus Payments Starting in 2012
  - STAR Bonus Payments
    - Dependent on Quality Measure of Plan
      - Must be 4.0+ STAR Rated Plan
  - Bonus Payment Doubles – Qualified County
    - Meet the above and:
      - MA Penetration > 25% as of December 2009
      - 2004 Rates Established at $525, Affiliated with MSA with > 250,000 Population (i.e., legacy urban floor)
      - FFS Costs < National Average FFS Costs



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# Changes to Part C in 2012+ - STAR Bonus Payments

| Quality Incentives for Qualified Plans (expressed as a percent of "base" MA plan payments) | | | | |
|---|---|---|---|---|
| Calendar Year | Existing Plans In Non-qualified Counties (1) | Existing Plans in Qualified Counties (1) | New Plans In Non-qualified Counties (2) | New Plans In Qualified Counties (2) |
| 2012 | 1.5% | 3.0% | 1.5% | 3.0% |
| 2013 | 3.0% | 6.0% | 2.5% | 5.0% |
| 2014 | 5.0% | 10.0% | 3.5% | 7.0% |

(1) Low-enrollment plans are Qualified Plans in 2012; CMS is tasked to determine how to treat low-enrollment plans in 2013 and later.

(2) A "New Plan" is a plan from an MA organization that had no MA contract in the preceding three years.



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# Changes to Part C in 2012+ - Rebates are linked to Quality as Well

| Rebate Percentages by Plan Quality Rating (QR) | | | |
|---|---|---|---|
| Calendar Year | Quality Rating / New and Low-enrollment Plans | | |
| | QR< 3.5 Stars | 3.5 Stars <=QR> 4.5 Stars and New Plans | QR>=4.5 Stars and Low-enrollment Plans |
| 2011 | 75% | 75% | 75% |
| 2012 | 66 2/3% | 71 2/3% | 73 1/3% |
| 2013 | 58 1/3% | 68 1/3% | 71 2/3% |
| 2014 + | 50% | 65% | 70% |



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# Changes to Part C in 2012+ - Other Changes

- How are rebates to be applied in 2012+
  - First, to “use the most significant share to meaningfully” reduce cost sharing under Parts A, B, and D.
  - Second, to “use the next most significant share to meaningfully” add coverage of preventive and wellness benefits not covered by Original Medicare, such as smoking cessation, a free flu shot, and/or an annual physical.
  - Third, “to use the remaining share” to add other services, such as eye exams and dental coverage.
  - Cannot buy-down Part B premiums after 2011

# Changes to Part C in 2012+ - Other Changes

- Coding Intensity Adjustments
  - In 2011 the adjustment to reflect MA coding pattern differences was the same as in 2010 – 3.41%
  - PPACA states that by 2019 the difference has to be at least 5.7% unless the risk based adjustments for MA plans are based upon MA diagnostic, cost and use data
  - Probably will get coding adjustments /normalization factors based upon MA data before 2019



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# Changes to Part C in 2012+ - Other Changes

- Minimum Loss Ratios starting in 2014
  - Retrospective Loss Ratios cannot be lower than 85%
  - Must payback difference in all years that you exceed 15% retention
  - If the test fails for three consecutive years, the plan will not be allowed to enroll new members
  - If the test fails for five consecutive years, the plan will be terminated



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# Changes to Part C in 2012+ - ACO's

- **Accountable care organizations (ACO's) -** New type of entity that may enter into a gain-sharing arrangement with CMS. The ACO essentially cuts out the health plan "middle man" by allowing provider groups to contract directly with CMS.
- The program is effective January 1, 2012, and has the following goals, identified in the law:
  - To promote accountability for a patient population
  - To coordinate items and services under Parts A and B
  - To encourage investment in infrastructure and redesigned care processes for high-quality and efficient service delivery

# Changes to Part C in 2012+ - ACO's (cont.)

- An ACO must be willing to be responsible for the quality, cost, and overall care of the 5,000 or more fee-for-service Medicare beneficiaries that are assigned to it for at least a three-year period.
- ACOs that meet CMS quality standards and produce financial savings for its beneficiaries are eligible to share in those savings.
  - CMS takes 100% of the savings in the initial risk corridor to be established, and 50% of the balance.
  - The ACO receives 50% of any savings beyond the initial risk corridor, but a portion of this is withheld by CMS against the possibility of future losses.



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# Changes to Part C in 2012+ - ACO's (cont.)

- Benchmarks for the ACO are based on three years of historical experience for the beneficiaries assigned to the ACO by CMS.
- The benchmarks are to be adjusted for "beneficiary characteristics and such other factors" deemed appropriate by CMS.
- Annual increases in benchmarks are set equal to the growth in national average expenditures under Medicare Parts A and B



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# References

- Link to text of the Act:
  - http://rules.house.gov/bills_details.aspx?NewsID=4606
    - Senate Bill as passed:  H.R. 3590
    - Text of the Amendment (Reconciliation Act of 2010)
    - Text of the Amendment to the Amendment

# *Discussion / Questions?*

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