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
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
Medicare Advantage marketplace as of today - Penetration

Medicare Beneficiaries in Private Plans, 2009

Source: Mathematica Policy Research for the Kaiser Family Foundation.
Medicare Advantage marketplace as of today - Payments

- Local PPOs: 118%
- Private FFS Plans: 118%
- Special Needs Plans: 116%
- Employer Groups: 115%
- All MA Plans: 114%
- Local HMOs: 113%
- Regional PPOs: 112%
- Traditional FFS Medicare: 100%
Medicare Advantage marketplace as of today – what is all the extra money spent on?

Rebate Dollars

- Reduce Part A B Cost-Sharing: 21%
- Reduce Part D Supplemental Premium: 13%
- Reduce Part D Basic Premium: 10%
- Provide non-Medicare Covered Benefits: 2%
- Other: 54%
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”
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).
### Changes to Part D in 2010+ (cont.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Member Generic Coinsurance</th>
<th>Nominal Brand Coinsurance</th>
<th>Pharma Coinsurance Contribution</th>
<th>Net Member Brand Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>93%</td>
<td>100%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2012</td>
<td>86%</td>
<td>100%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2013</td>
<td>79%</td>
<td>97.5%</td>
<td>50%</td>
<td>47.5%</td>
</tr>
<tr>
<td>2014</td>
<td>72%</td>
<td>97.5%</td>
<td>50%</td>
<td>47.5%</td>
</tr>
<tr>
<td>2015</td>
<td>65%</td>
<td>95%</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>2016</td>
<td>58%</td>
<td>95%</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>2017</td>
<td>51%</td>
<td>90%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>2018</td>
<td>44%</td>
<td>85%</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>2019</td>
<td>37%</td>
<td>80%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>2020</td>
<td>25%</td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
</tr>
</tbody>
</table>
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
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
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
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
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
Changes to Part C in 2012+ - multiple proposals

- Originally, two proposed approaches to benchmark rate reduction
    - 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
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)
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
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
- 25% - Lowest Cost Quartile
- 25% - 3rd Highest Cost Quartile
- 25% - 2nd Highest Cost Quartile
- 25% - Highest Cost Quartile

MA Enrollees in Each Quartile
- 45% - Lowest Cost Quartile
- 19% - 3rd Highest Cost Quartile
- 14% - 2nd Highest Cost Quartile
- 22% - Highest Cost Quartile
Changes to Part C in 2012+ - there is a transition right?

- There is a transition.

\[ D = \left[ \frac{2010}{\text{Benchmark}} - \frac{2010}{\text{PBA}} \right] \]

- where,

\[ \frac{2010}{\text{PBA}} = \left[ \frac{\text{FFS % from above table}}{\text{FFS Rate}} + \left( 1.5\% \text{ for most counties, or } 3.0\% \text{ for "Qualifying Counties"} \right) \right] \]

- Value of D determines phase-in, either 2,4 or 6 years.
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
### Changes to Part C in 2012+ - STAR Bonus Payments

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Existing Plans in Non-qualified Counties (1)</th>
<th>Existing Plans in Qualified Counties (1)</th>
<th>New Plans in Non-qualified Counties (2)</th>
<th>New Plans in Qualified Counties (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1.5%</td>
<td>3.0%</td>
<td>1.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td>2013</td>
<td>3.0%</td>
<td>6.0%</td>
<td>2.5%</td>
<td>5.0%</td>
</tr>
<tr>
<td>2014</td>
<td>5.0%</td>
<td>10.0%</td>
<td>3.5%</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Quality Rating / New and Low-enrollment Plans</th>
<th>QR&gt;=4.5 Stars and Low-enrollment Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QR&lt; 3.5 Stars</td>
<td>3.5 Stars &lt;=QR&gt; 4.5 Stars and New Plans</td>
</tr>
<tr>
<td>2011</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>2012</td>
<td>66 2/3%</td>
<td>71 2/3%</td>
</tr>
<tr>
<td>2013</td>
<td>58 1/3%</td>
<td>68 1/3%</td>
</tr>
<tr>
<td>2014 +</td>
<td>50%</td>
<td>65%</td>
</tr>
</tbody>
</table>
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
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
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.
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.

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- 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.
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.
References

- Link to text of the Act:
    • Senate Bill as passed: H.R. 3590
    • Text of the Amendment (Reconciliation Act of 2010)
    • Text of the Amendment to the Amendment
Discussion / Questions?