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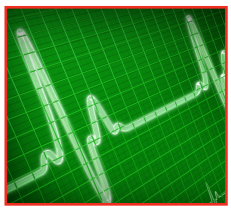


# Thirteen Things Medicare Advantage Plans Should Know about Health Reform

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Medicare Advantage plans were one of the hardest hit groups under the recently enacted health reform legislation. The provisions under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (together the "Act") indicate an intense effort to bring Medicare Advantage payments more in line with traditional fee-for-service Medicare, reward higher quality plans with bonuses and strengthen protections for beneficiaries. Here are some of the highlights.

**1 Medicare Advantage Payments Suffer Deep Cuts.** Payments to Medicare Advantage plans will be frozen in 2011 and cuts will begin in 2012. Medicare Advantage benchmarks in 2012 and later years will be based on a percent of the Fee-For-Service (FFS) rates in each county. The percentages applicable to each county will be based on the county's ranking relative to the FFS rates of all counties in the 50 states and Washington, D.C. According to the Congressional Budget Office (CBO), the changes to Medicare Advantage payment methodology are projected to reduce spending by $134.9 billion over the next ten years. Some high-cost areas will be paid 5 percent below traditional Medicare while some lower-cost areas will be paid 15 percent above Medicare. These cuts will have a significant impact on Medicare Advantage business models.

**2 Bonuses for Quality of Care.** To offset the Medicare Advantage payment cuts, the Act creates performance bonuses for care coordination, care management and quality rankings. Plans that receive four or five stars, based on the current CMS five-star rating system, will receive bonus payments of up to 5 percent over the next few years. Quality scores will also determine the portion of plan savings that may be returned as additional benefits to members in the form of rebates. Plans would be wise to improve their scores as payment becomes increasingly tied to quality. In the short term, that may mean paying more attention to customer service issues. Over the long term, plans should focus on outcomes, improving beneficiary experience, and disease management.

**3 New Medical Loss Ratio Requirements.** Beginning with effective plan year 2010, Medicare Advantage companies will have to report the amount they spend on medical services to the Secretary of HHS. Effective for contract year 2014, CMS will require plans to spend at least 85 percent of revenues on medical expenses, as opposed to administrative expenses. Plans will be required to return to CMS any amounts exceeding what may be retained based on these requirements. Insurers will need to find ways to reduce administrative costs through outsourcing, or reclassifying some costs as medical. The yet-to-be-issued HHS guidelines defining medical costs will significantly impact how burdensome this requirement will be on Medicare Advantage plans.

**4 Beware the Marketing Violations.** Effective January 1, 2010, the Act adds new types of marketing violations for which sanctions and penalties can be applied, including enrolling or transferring an individual between plans without his/her consent or transferring an individual solely for the purpose of earning a commission. Additional prohibited practices include denying or discouraging enrollment due to a medical condition indicating substantial future medical expenses and misrepresentation or falsification of information. The Act expands the prohibition to all

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employees, contractors, providers or suppliers that contract with the Medicare Advantage plan. Civil monetary penalties range from $25,000 to $100,000 per determination and the HHS Secretary is required to audit one-third of all Medicare Advantage Plans to look for marketing violations.

**5 Essential Services Must Be Covered.** In an attempt to strengthen protections and coverage for plan beneficiaries, beginning in 2011 Medicare Advantage plans will be prohibited from having higher copayment requirements than traditional fee-for-service Medicare for chemotherapy, renal dialysis, skilled nursing care, and other services the Secretary of HHS deems appropriate. Effective January 1, 2012, a Medicare Advantage plan's ability to offer reduced Part B premiums as a benefit is also eliminated.

**6 Special Needs Plans Accreditation.** Special Needs Plans will now be required to have National Committee for Quality Assurance (NCQA) approval for 2012 and later years. It is unclear whether plans with URAC accreditation will be required to obtain additional approval from NCQA. CMS is also making a number of changes in how risk scores are handled for Special Needs Plans populations.

**7 Open Enrollment Periods Change**. For plan years 2012 and beyond, the Act establishes the open enrollment period as October 15 through December 7 to help ensure enrollment processing by January. Beginning in 2011, Medicare Advantage enrollees will be permitted to disenroll and return to traditional Medicare any time between January 1 and March 15 of each year.

**8 CMS May Deny Bids.** The Act gives the Secretary the specific authority to reject Medicare Advantage plan bids if the plan proposes significant increases in cost-sharing or decreases in benefits offered under the plan. This applies to bids submitted for contract years on or after January 1, 2011.

**9 Beneficiary Complaints.** The Secretary will develop a system that will collect and maintain information on Medicare Advantage Prescription Drug beneficiary complaints. Effective January 1, 2012, each program sponsor must use a single, uniform exceptions and appeals process with respect to the determination of prescription drug coverage for an enrollee. A model complaint form will be developed by the Secretary, which will be prominently displayed on the Medicare.gov webpage. Additionally, plans' uniform exceptions and appeals processes must be accessible via telephone and the internet.

**10 Annual Fee on Health Insurance Providers**. The law imposes an annual fee on non-exempt health insurers beginning in 2014. This annual fee is applicable to Medicare Advantage sponsors. It is estimated that this fee will cost the insurance industry $60.1 billion over the six-year period from 2014 through 2019.

**11 RAC Audits for Medicare Advantage Plans.** The Act expands the federal Recovery Audit Contractor (RAC) program to Medicaid and Medicare Parts C and D. RACs are paid on a contingency fee basis for Parts A and B, which has been a source of concern for the industry, but it is unclear at this point if the Medicare Advantage plan RACs will also be paid on a contingency basis. Medicare Advantage companies should expect additional scrutiny of their anti-fraud plans and should take this opportunity to review and update the anti-fraud plans on a timely basis.

**12 Penalties for Inspection Delays or False Statements.** Civil monetary penalties will be expanded for making false statements or delaying inspections. Penalties are increased to $50,000 per violation and $15,000 per day of delay. The goal is to ensure that audits and inspections of Medicare Advantage plans will occur in a timely manner.

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**13 Establishment of the Independent Payment Advisory Board.** Finally, the law establishes the Independent Payment Advisory Board, which is charged with developing proposals to reduce Medicare cost growth and improving the quality of care provided to beneficiaries. The Board's authority includes making proposals that would reduce payment to Medicare Advantage, such as reductions in direct subsidy payments that are related to administrative expenses (including profits) for basic coverage and performance bonuses for Medicare Advantage plans.

The changes to the Medicare Advantage program are driven largely by concerns about the current payment system and its effect on Medicare spending. In order to remain viable under the new law, Medicare Advantage plans should carefully consider ways to reduce administrative costs, take advantage of financial savings through quality improvements, and implement regulatory compliance mechanisms.

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