Reductions in Payments to Medicare Advantage Plans

Country: USA
Partner Institute: Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management
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Health Policy Issues: Role Private Sector, Political Context, Funding / Pooling, Benefit Basket, Access, Remuneration / Payment

Current Process Stages

| Idea | Pilot | Policy Paper | Legislation | Implementation | Evaluation | Change |

Featured in half-yearly report: Health Policy Developments 13

1. Abstract

The 2003 Medicare Modernization Act increased payments to private health plans participating in the Medicare program. Between 2004-2008, extra payments to private plans amounted to $33 billion. The recent health reform bill, The 2010 Patient Protection and Affordable Care Act (H.R. 4872), includes provisions that will reduce these payments to plans.

2. Recent developments

Private managed care plans have been a part of the Medicare program for decades. Under the current system, Medicare beneficiaries are allowed to enroll in either the traditional fee-for-service Medicare program, or they may choose to enroll in a private Medicare managed care plan (referred to as a "Medicare Advantage (MA) plan"). An estimated 23 percent of all Medicare beneficiaries were enrolled in Medicare Advantage plans in 2009.

The Medicare Modernization Act of 2003 (MMA) increased payments to private plans and between 2004 and 2010 these plans were paid more per enrollee than average costs per beneficiary in the traditional fee-for-service program. The increased payments were intended to incentivize private health insurance plans to offer Medicare Advantage plans throughout the United States and to increase enrollment in these plans. In 2009 payments per enrollee to Medicare Advantage plans exceeded average costs in the traditional fee-for-service program by an estimated 14 percent or over $11 billion.

Until 2008, Medicare Advantage plan payments were set based on four distinct policies: (1) A county-level benchmark set by the Centers for Medicare and Medicaid Services (CMS); (2) A "budget-neutral" risk adjustment mechanism that ensured that payments to private plans would not decrease despite the implementation of a new risk adjustment system; (3) The inclusion of payments for Indirect Medical Education (IME) in the county benchmark rate, despite the fact that IME was also paid directly to teaching hospitals; and (4) A bidding system under which plans submit bids representing the cost of providing Medicare Parts A and B benefits to their enrollees. If a plan bids less than the county benchmark, Medicare keeps 25 percent of the difference, and the plan is required to use the remaining 75 percent to offer increased benefits or reduced premiums to enrollees.

Policies enacted in 2005 and 2008 reduced these payments slightly. The Deficit Reduction Act of 2005 (DRA) mandated that CMS phase out the budget neutral risk adjustment policy between 2006-2010 and The Medicare
Improvements for Patients and Providers Act of 2008 (MIPPA) phased out the duplicative payments to plans for Indirect Medical Education by 2010, and made additional changes to Private fee-for-service (PFFS) MA plans.

The Patient Protection and Affordable Care Act (passed by the Senate on December 24, 2009 and by the House of Representatives on March 21, 2010 and signed into law by President Obama on March 23, 2010) includes provisions that will further reduce payments to MA plans. A number of key changes will be made to the MA program as a result of the Patient Protection and Affordable Care Act. (1) This legislation will restructure payments to MA plans over four years, using the average MA plan bids in each county to guide the payment changes. Payments will be reduced, but in certain counties, where plan bids are less than 75 percent of traditional fee-for-service Medicare, extra benefits will be grandfathered in. (2) From 2011 to 2013 the Secretary of Health and Human Services will be required to adjust risk scores for differences in coding patterns between private plans and traditional fee-for-service Medicare. This provision is also expected to lead to reduced payments to plans. (3) Beginning in 2012, bonus payments will be awarded to plans based on quality of care. (4) The legislation will also prohibit MA plans from imposing cost sharing requirements for certain services that are higher than those under the traditional Medicare program. (5) Finally, in 2014 MA plans will not be allowed to have Medical Loss Ratios (payout ratios) lower than 85 percent.

3. Characteristics of this policy

<table>
<thead>
<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
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<tbody>
<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
</tr>
<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
</tr>
<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
</tr>
<tr>
<td>Transferability</td>
<td>strongly system-dependent</td>
<td>system-neutral</td>
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</table>

The role of private plans in Medicare has long been a source of controversy, and will likely continue to be debated in the future. These policy changes are an attempt to "level the playing field" between private plans and traditional fee-for-service Medicare by reversing some of the payment increases legislated in the MMA under the Bush Administration. The current consensus is that there is no sufficient reason to support higher payments to private insurers.

4. Purpose and process analysis

Initiators of idea/main actors

- **Government:** The Obama Administration strongly supports the reduction in extra payments to MA plans. CMS historically opposed reductions in MA payments under the Bush Administration, yet has remained relatively silent during this recent debate.

- **Providers:** Physician organizations have supported reduced payments to MA plans in the past, particularly in order to prevent scheduled cuts in Medicare payments to physicians.
• Payers: Health insurance companies are strongly opposed to this change and have argued that reductions in payments will lead to reduced benefits to enrollees and decreased MA plan offerings across the nation.

• Political Parties: Democrats who hold a majority in Congress in general strongly support cutting payments to MA plans, particularly in order to finance other aspects of health reform. Republicans are largely strongly opposed to the payment cuts.

Stakeholder positions
Republicans were instrumental to the passage of the Medicare Modernization Act of 2003 which increased payments to MA plans. Since then, they have historically opposed all forms of payment cuts in Medicare Advantage.

Democrats have not supported these payments in the past and have continued to argue that these funds would be better spent in other ways.

The election of President Obama, whose administration has voiced strong opposition to the extra payments MA plans receive, together with a Democratic majority in the House and Senate, have been key factors in moving these policy changes forward.

Actors and positions
Description of actors and their positions

Government
Obama Administration very supportive strongly opposed
Centers for Medicare and Medicaid Services (CMS) very supportive strongly opposed

Providers
Physician organizations very supportive strongly opposed

Payers
Health insurance companies very supportive strongly opposed

Political Parties
Democratic Party very supportive strongly opposed
Republican Party very supportive strongly opposed

Influences in policy making and legislation
With the strong support of the Obama Administration and Democrats in the House and Senate, these changes were included in the Patient Protection and Affordable Care Act, which was signed into law by President Obama on March 23, 2010. Ultimately, the Act was passed with only the support of Democrats.

Legislative outcome
Enactment

Actors and influence
Description of actors and their influence

Government
Obama Administration very strong none
Adoption and implementation

The Department of Health and Human Services and the Centers for Medicare and Medicaid Services will be responsible for implementing the provisions included in the Patient Protection and Affordable Care Act. Most of these provisions will be implemented from 2011 through 2014.

Monitoring and evaluation

The Patient Protection and Affordable Care Act does not include provisions for the monitoring and evaluation of the MA payment and programmatic changes included in the legislation.
5. Expected outcome

The majority of this legislation will not be implemented until 2011 and the effects of the policy changes may not be fully realized for a few years after that. However, it is expected that Medicare spending will decrease. It is also possible that some plans will leave the market when payments are decreased, however it is generally thought that plans operating efficiently will be able to continue operating despite the payment changes.

<table>
<thead>
<tr>
<th>Quality of Health Care Services</th>
<th>marginal</th>
<th>fundamental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Equity</td>
<td>system less equitable</td>
<td>system more equitable</td>
</tr>
<tr>
<td>Cost Efficiency</td>
<td>very low</td>
<td>very high</td>
</tr>
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</table>

The MA provisions included in the Patient Protection and Affordable Care Act will reduce Medicare spending and may impact private plan availability and enrollment in future years.

6. References

Sources of Information

• Berenson RA and Dowd BE. Medicare Advantage Plans at a Crossroads - Yet Again. Health Affairs Web Exclusive November 2008; w29-w40.


Reform formerly reported in

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