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To: Clients and Friends

From: John Gorman and Jean LeMasurier

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Re: Health Care Reform: Impact Provisions on Medicare Advantage and Part D

Two historic Health Care Reform bills were signed into law at the end of March 2010. First, P.L. 111-148, the *Patient Protection and Affordable Health Care Act* (PPACA) was enacted March 23. Next, P.L. 111-152, the *Health Care and Education Reconciliation Act of 2010*, was enacted March 30. Both new laws include provisions that will significantly impact the Medicare Advantage and Part D prescription drug programs.

Medicare Advantage

MA Payment – The Reconciliation Act repeals the competitive bidding provision included in the PPACA law. The benchmark payment for 2011 is maintained at the 2010 level.

For most counties, MA payment is reduced to a percentage of FFS levels over two years (2012-2013). Payment will vary according to where a county ranks on FFS costs with plans grouped into four quartiles. The reformed benchmark will equal 95%, 100%, 107.5% or 115% of FFS depending on quartile.

For example, the highest quartile with the highest FFS costs will be reduced to 95% of FFS. The lowest cost quartile will be paid at 115% of FFS.

Certain areas will have a longer transition. There is a four year phase-in for areas where the new benchmarks, if implemented in 2010, would be \$30-\$49 lower than the current benchmarks. There is a six year transition where the difference is at least \$50.

If rankings change from year to year, the new payment will be phased-in over two years.

Quality Bonus – Payment is increased for plans that achieve at least a four star quality rating as follows: 2012: 1.5%; 2013: 3%; and 2014 and subsequent years 5%.

These bonuses are doubled for high performing plans in qualifying counties (2004 payment at the urban floor rate for MSAs of more than 250,000; 25% MA penetration; and FFS costs lower than the national FFS per capita rate).

Plans that do not report data will be ranked at 3.5 stars and will not qualify for the bonuses.

Low enrollment plans will qualify for the bonus in 2012. The Secretary will develop a method in subsequent years to compute a quality rating for low enrollment plans.

New plans (MA organizations without a MA contract for the previous three years) will qualify for lower quality bonuses (2101: 1.5%; 2013: 2.5% and 2014 and subsequent years: 3.5%).

Coding Intensity Adjustment – The coding intensity adjustment is made permanent. The Secretary is required to annually conduct an analysis and make appropriate adjustments to the risk scores. The adjustment for 2014 must be no less than the factor for 2010 plus 1.3%.

For 2015-2018, the factor must be no less than the factor for the prior year plus 0.25%. For 2019 and beyond, the factor must be no less than 5.7%.

CMS is continuing the 2010 coding intensity adjustment of 3.41% into 2010. There is no announcement yet regarding 2012 and 2013.

Beneficiary Rebates – Effective January 1, 2012, a new beneficiary rebate is phased in (currently 75% of savings between the bid and the benchmark) over three years. The new beneficiary rebate is connected to the quality rating of a plan.

The rebate is 70 percent for plans with 4.5 stars; 65 percent for plans between 3.5 and 4.5 stars; and 50 percent for plans less than 3 stars. Low enrollment plans are treated as having 4.5 stars in 2012 and new plans are treated as having 3.5 stars.

Minimum Loss Ratio – Beginning in 2014, plans will have to refund to the Secretary any revenue that does not meet a minimum MLR of 85%. Plans that fail to meet the minimum MLR for 3 consecutive years will be closed for new enrollment during the second following year. Plans that fail to meet the minimum MLR for 5 consecutive years will be terminated. CMS has not published a definition of MLR. (Key unknowns: Will non-claim costs related to health care quality be counted as medical expenses? Will premium taxes be deducted from revenue?)+.

Benefits – Cost sharing cannot be higher than FFS for predictable and transparent benefits, e.g. chemotherapy, dialysis and SNF. Plan use of bonuses and supplemental benefits is standardized beginning in 2012 – first, Parts A, B and D cost sharing must be reduced; Part B premium reductions are prohibited; and out of pocket limits must apply to A and B benefits; second, plans can add prevention and wellness benefits; and third plans can add non-covered benefits.

Election Periods – Effective in 2011, the Annual Election Period is October 15 to December 7.

The Open Enrollment Period is eliminated (January-March) for MA plans in 2011 and replaced with an Annual Disenrollment Period where beneficiaries may disenroll and return to FFS and choose a Part D plan between January 1-February 15.

SNPs – The SNP authority is extended through December 31, 2013.

There is also a temporary extension of dual SNP contracts without Medicaid contracts to December 31, 2012, however service area expansions are prohibited. MA payment changes are extended to SNPs and the Secretary is authorized to approve a frailty adjustment for fully integrated dual SNPs.

The Secretary is also authorized to modify the risk adjustment for new-to-Medicare members joining chronic care SNPs to reflect the high risk of chronic conditions. This compensates for the lack of prior year claim-based risk adjustment data for new-to-Medicare members. This new risk adjustment will be effective in 2011.

All SNPs must be approved by NCQA beginning in 2012. Erikson demonstration projects may qualify as SNPs.

PFFS – Service area waivers are allowed for employer based plans that have direct contracts with CMS and enrollment as of October 2009.

Cost Contracts – Cost contracts are extended through December 31, 2012 regardless of any other plans operating in the area.

Part D

Discounts for Brand Name Drugs – Effective January 1, 2011, drug manufacturers will provide a 50 percent discount off the negotiated price for brand name drugs covered by the plan's formulary in the coverage gap (or treated as being on the plan's formulary). Beneficiaries would pay the other 50% and the dispensing fees of the discounted drugs. One hundred percent of the negotiated price of the discounted drugs would count towards the annual out of pocket threshold. LIS beneficiaries and beneficiaries enrolled in an employer retiree plan receiving the Retiree Drug Subsidy (RDS) are excluded from this discount.

Drugs from a manufacturer that does not sign a discount agreement with the Secretary would be prohibited from Part D coverage. The Secretary may contract with a third party to administer the discount program and conduct audits. Fines are authorized for manufacturers that do not comply.

Closing the Coverage Gap – Beneficiaries that reach the coverage gap in 2010 receive a one-time rebate of \$250. Payment must be made by the 15th day of the third month following the end of the quarter after the beneficiary reaches coverage gap. Beneficiary costs in the coverage gap are phased down from 100 percent to 25 percent of the negotiated price (or actuarially equivalent) by 2020.

Generic drug coinsurance is phased down in seven percent increments starting in 2011 and by 2020 Medicare pays 75 percent of the cost and the beneficiary pays 25 percent. Brand name drug coinsurance is reduced starting in 2013 and by 2020 after the enrollee receives the 50 percent discount, the beneficiary will pay 25 percent coinsurance and there will be a 25 percent federal subsidy.

Catastrophic Limit — Beginning in 2014, the formula used to set the catastrophic limit (currently tied to the increase in Part D costs) would be modified to slow the rate of growth, thus providing additional benefits for seniors with high drug costs by letting them emerge from the coverage gap sooner. For 2014-2015, the rate is reduced 0.25% and for 2016-19 the rate is the lesser of the CPI plus two percent or the current law amount.

LIS Provisions – Effective in 2011, the LIS program is strengthened including:

- Excludes MA rebates and bonus payments from the MA-PD premium amount when calculating LIS benchmarks;
- Allows plans to voluntarily adopt the de minimums policy where they absorb a nominal amount if their bid is over the regional LIS benchmark;
- Allows a surviving spouse of a LIS couple to redetermine eligibility no later than one year from the next redetermination;
- Plans who bid above the LIS benchmark must transmit drug utilization data to the new plan where LIS beneficiaries are auto-assigned within 30 days.

\$45 million is approved to conduct outreach and education activities.

Protected Classes – the current six protected classes are codified. The MIPPA criteria to identify protected classes are repealed and will be established through rulemaking.

Means Tested Premium – Beginning in 2011, the Part D premium is means tested for individuals with adjusted gross income over \$85,000 and couples over \$170,000. These thresholds are updated by the CPI after 2019.

Medication Therapy Management Programs – Requires Part D plans to include an annual comprehensive medication review in person or using telehealth technologies and follow up interventions. Plans will automatically enroll targeted beneficiaries in the MTM program and allow them to opt out. Plans are required to assess quarterly the medication use of at risk enrollees who are not enrolled in the MTM program including individuals who have experienced a transition in care.

Copayment Equity — Effective January 2011, cost sharing for full benefit duals receiving care under a home and community based waiver would be equal to the cost sharing for those who receive institutional care.

LTC Pharmacy — Effective in 2012, Part D and MA-PDs are required to use UM techniques to reduce the quantity dispensed per fill for beneficiaries who reside in long term care facilities to reduce the waste associated with 30 day fills.

Uniform Exceptions and Appeals and Complaint Tracking – Medicare Advantage and Part D plan sponsors must develop a uniform exceptions and appeals process by 2012. The Secretary will maintain and report a complaint tracking system for complaints from MA and D individuals through resolution.

AIDS and HIS Drugs — Effective January 2011, drugs provided by AIDS Drug Assistance Program (ADAP) and IHS would count towards the annual out-of-pocket threshold.

PBM Transparency — PBMs are required to share information with the Secretary and Part D plans and plans in the exchange they contract with regarding the percent of prescriptions provided through retail vs. mail order pharmacies and respective generic dispensing and substitution rates; aggregate rebates and discounts and the aggregate amount that are passed through to the plans and average aggregate difference between the amount the plan pays the PBM and the PBM pays retail and mail order pharmacies. There is no pass through mandate.

Penalties — False statements and misrepresentation of material facts by MA and Part D plans are grounds for permissive exclusion from federal health programs and larger civil monetary penalties. New penalties are added for marketing abuses by MA and PDP plans including: enrolling individuals into plans without their consent; transferring individuals to another plan for purpose of commission; failure to comply with marketing requirements including guidance; and employment or contracts with individuals or entities that commit a violation subject to sanctions.

Recovery Act Audits — The RAC program is extended to Parts C and D and Medicaid by the end of 2010.

Retiree Drug Subsidy Tax Treatment — The tax deduction of the RDS subsidy is eliminated in 2013.

Demonstrations, Pilot Programs and Studies

Independent Medicare Advisory Board – The Board is responsible for developing proposals to reduce Medicare costs and improve quality. Proposals may include recommendations to reduce Medicare payments under Parts C and D such as reductions in Part D direct subsidy payments related to administrative expenses, denying high bids, and reductions in MA payment related to administrative costs.

Center for Medicare and Medicaid Innovation – This new Center in CMS will test innovative payment and service delivery models to reduce costs and enhance quality and improve coordination of care. Testing of models in Phase I is focused on models where there is evidence that there are deficits in care leading to poor clinical outcomes or potentially avoidable costs.

Seventeen specific models are listed. One of the models is promoting broad payment and practice reform in primary care including patient centered medical home models for high-need individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from FFS toward comprehensive payment or salary based payment.

Part D Studies and Reports – OIG will conduct two studies: Part D Formularies Inclusion of Drugs Commonly Used by Dual Eligibles and Prescription Drug Prices under Part D and Medicaid. The Secretary shall report for each branded prescription drug covered by Part D the product of the per unit ingredient cost as reported by Part D plans minus any rebate or discount and the number of units of the branded prescription drug paid by Part D.

Accountable Care Organizations — A Medicare Shared Savings program is to be established no later than January 2012 to promote accountability for patient populations and coordination and redesign of the provision of services under Medicare FFS Parts A and B. The annual Shared Savings shall be the percent difference between the risk adjusted per capita expenditure under the ACO and a benchmark for the ACO set by the Secretary. MA plans may not participate.

Independence at Home Demonstration — The Secretary shall test a payment incentive and service delivery model in the FFS program that utilizes physician and nurse practitioner directed home based primary care teams designed to reduce expenditures and improve health outcomes.

The model is accountable for coordinated care for high risk populations at home and coordinated across all treatment settings resulting in reduce hospitalizations, readmissions, ER visits, improved outcomes, improved efficiency and costs.

For additional information:

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P.L. 111-148, [Patient Protection and Affordable Health Care Act \(PPACA\)](#) was enacted March 23, 2010.

P.L. 111-152, [Health Care and Education Reconciliation Act of 2010](#) was enacted March 30, 2010

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