



SOCIETY OF ACTUARIES

**SOA 09 Annual Meeting & Exhibit
October 25-28, 2009**

**Session 49 PD, Changing Landscape for Medicare
Advantage Plans**

Moderator:

Patrick J. Dunks, FSA, MAAA

Presenters:

JoAnn Bogolin, ASA, FCA, MAAA

Patrick J. Dunks, FSA, MAAA

Carl B. Wright, FSA, MAAA

2009 Society of Actuaries Annual Meeting

Session 49: The Changing Landscape for Medicare Advantage Plans

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October 27, 2009

AGENDA

1. Summarize Recent Trends
2. Outline Recent Reform Proposal (Senate Finance Committee's Competitive Bidding)
3. Discuss Market Impact of Proposed Competitive Bidding
4. Questions & Discussion

2009 Society of Actuaries Annual Meeting

Session 49: The Changing Landscape for Medicare Advantage Plans

Recent Trends in Medicare Advantage

Presented by:

Patrick J Dunks, FSA, MAAA
Principal & Consulting Actuary

October 27, 2009



Recent Trends: AGENDA

- Membership & Product Trends
- 2010 Bid Changes & Challenges
- 2010 Market Reaction
- Future Challenges

Background

- Medicare Advantage enrollment is about 25% of Medicare population in 2009
- Over 95% of seniors have prescription drug coverage
- Recent MA growth is impressive
- Private Fee-for-Service plan growth spurred much of the action
 - PFFS changing due to network requirements

Background *(continued)*

- Other Medicare Advantage plan growth (except MSAs) strong
- Changes occurring may create Medicare Supplement opportunities
- Our focus is on Medicare Advantage market

August 2009 Medicare Advantage and Part D Enrollment (000's)

| Current Contract Summary: | Number of Contracts | MA Only Enrollees* | Drug Plan Enrollees* | Total Enrollees* |
|---|---------------------|--------------------|----------------------|------------------|
| Total "Prepaid" Contracts | 756 | 1,660 | 9,532 | 11,191 |
| Local CCPs | 545 | 424 | 7,484 | 7,908 |
| PFFS | 69 | 999 | 1,438 | 2,438 |
| MSA | 2 | 3 | 0 | 3 |
| Employer Directed PFFS | 2 | 12 | 2 | 14 |
| Regional PPOs | 14 | 33 | 398 | 431 |
| Other (1) | 123 | 188 | 209 | 397 |
| Total PDPs | 96 | 0 | 17,507 | 17,507 |
| Employer / Union Only Direct Contract PDP | 8 | 0 | 123 | 123 |
| All Other PDP (2) | 88 | 0 | 17,384 | 17,384 |
| TOTAL | 852 | 1,660 | 27,039 | 28,698 |

Totals reflect enrollment as of the August 1, 2009 payment. The August payment reflects enrollments accepted through July 9, 2009. *(000's)

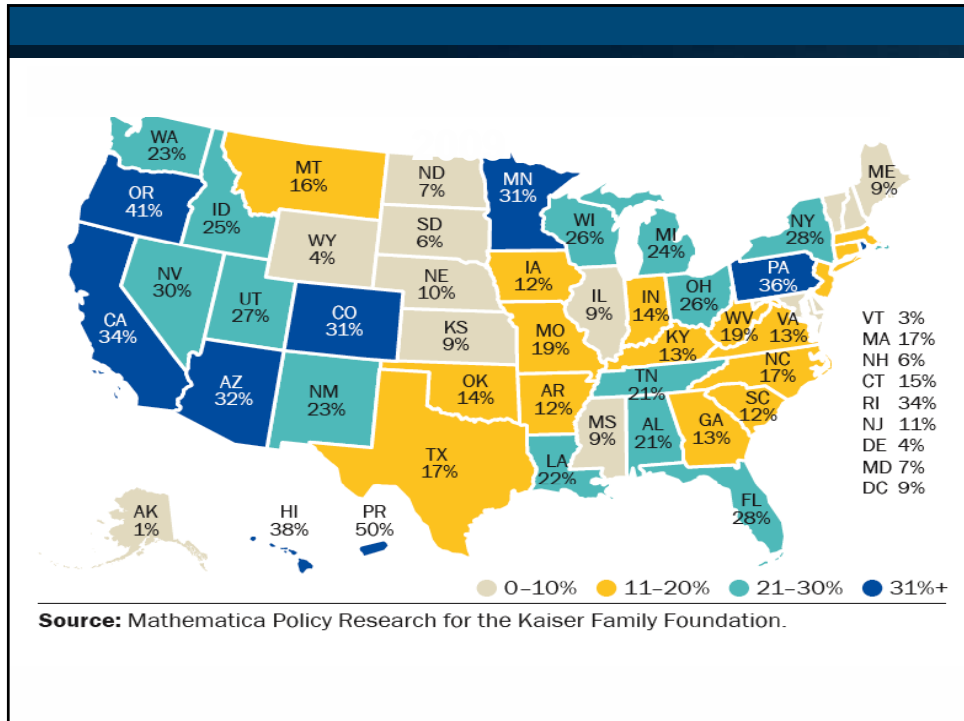
(1) Others include: Demos, Cost, PACE, Pilot, MSA
(2) Totals include beneficiaries enrolled in employer / union only group plans (contracts with "800 series" plan IDs)

Source: CMS

August 2009 Coordinated Care Plan Enrollment

| Local CCP | MA Only | Drug Plan | Total |
|------------------|----------------|------------------|------------------|
| HMO / POS | 384,853 | 6,546,447 | 6,931,349 |
| PPO | 37,797 | 921,552 | 960,378 |
| PSO | 396 | 15,847 | 16,243 |
| TOTAL | 424,046 | 7,483,846 | 7,907,970 |

Source: CMS



Medicare Advantage Enrollment Growth 2006 – 2009 (000's)

| Plan Type | Enrollment | | | | Total Change |
|---------------------------|------------|--------|--------|--------|--------------|
| | Aug 06 | Aug 07 | Aug 08 | Aug 09 | |
| Medicare Advantage Total | 7,405 | 8,749 | 10,097 | 11,172 | 50.9% |
| PFFS Total (Subset of MA) | 802 | 1,699 | 2,271 | 2,438 | 204.0% |
| PDP Total | 16,263 | 17,102 | 17,391 | 17,507 | 7.6% |

Source: CMS

Medicare Advantage Enrollment Growth

- Significant growth in membership and number of plans
 - Likely to slow with 2010 revenue cuts and impending legislation
 - PFFS has been significant growth driver
 - Attracting a lot of attention
 - Nationally, tend to operate in most favorable financial areas
 - Brokers used extensively
 - 2009 enrollment data shows PFFS growth slowing significantly due to large carriers executing migration strategies from PFFS to PPO
 - Non-PFFS MA growth rate about 10% annually

PFFS Plans Account for Most of Those Affected by 2009 MA Withdrawals

- Significantly more PFFS enrollment changes expected for 2010

| Contract Type | 2008 MA Enrollment | 2008 MA Enrollees in Plans Not Available in 2009 | Percentage of MA Enrollees Affected Within Contract Type |
|---|--------------------|--|--|
| All Plans (excluding SNPs) | 6,463,601 | 353,220 | 5.5% |
| HMOs | 4,230,799 | 79,413 | 1.9% |
| Local PPOs | 528,317 | 22,378 | 4.2% |
| Private-Fee-for-Service (PFFS) Plans | 1,511,607 | 234,366 | 15.5% |
| Medical Savings Accounts (MSAs) | 1,723 | 1,365 | 79.2% |
| Regional PPOs | 191,155 | 15,698 | 8.2% |
| Special Needs Plans (SNPs) | 929,888 | 14,003 | 1.5% |
| PFFS as a % of MA (excluding SNPs) | 23.4% | 66.4% | |
| <small>Note: Excludes group plans.</small> | | | |
| <small>Source: Mathematica Policy Research analysis of CMS's Medicare Options data for AARP, March 2009</small> | | | |

Number of SNPs Declines in 2009

- Due to regulation limiting new plans

| SNP Type | Number in 2007 | Percentage in 2007 | Number in 2008 | Percentage in 2008 | 2007 – 2008 Change | Number in 2009 | Percentage in 2009 | 2008 – 2009 Change |
|--------------------------------|----------------|--------------------|----------------|--------------------|--------------------|----------------|--------------------|--------------------|
| Chronic or Disabling Condition | 73 | 15.3% | 232 | 32.2% | 217.8% | 206 | 30.6% | -11.2% |
| Dual-Eligible | 320 | 67.1% | 400 | 55.6% | 25.0% | 382 | 56.7% | -4.5% |
| Institutional | 84 | 17.6% | 88 | 12.2% | 4.8% | 86 | 12.8% | -2.3% |
| TOTAL | 477 | 100.0% | 720 | 100.0% | 50.9% | 674 | 100.0% | -6.4% |

Source: CMS

Medicare Advantage Observations

- Market is increasingly segmented
 - Examples include income level, ethnicity, and risk segment
- Risk score improvement continues to be critical to success
- Administration costs and profit margins getting a lot of attention
- Enrollment period limits and competition was pushing plans to use brokers much more than previously but some rethinking due to new broker regulations
- Member out-of-pocket costs increasing overall, but variations seen by plan type and enrollee health status

2010 Plan Year Activity – MA Challenges

- 2010 revenue cuts (as compared with trend) more drastic than 2009
- Average 2009 to 2010 CMS revenue decrease projected at 4%
- Average 2009 to 2010 CMS cost increase projected at 4%
- Physician fee schedule SGR provision contributes to problem

2010 Plan Year Activity – MA Challenges (continued)

- Without benefit or member premium changes, other plan savings, or revenue generation, MA organizations stood to lose 6% on 2010 MLR
 - Benchmark revenue update very low
 - MA risk scores decreased 3.41% (decreases revenue)
 - DE# bid details challenging
 - Definition changed between preliminary instructions and final
 - Hard to locate good state information
 - Bid MSP requirements were difficult to embrace

2010 Plan Year Activity – MA Organization Reactions

- Many organizations working risk scores to increase revenue and help mitigate revenue reduction
- Some organizations getting back to managing care
- Organizations looking for operational efficiencies, but increasing regulatory burden makes it quite difficult
- New broker commission limits offer savings for some organizations
- Will vary significantly by geographic region

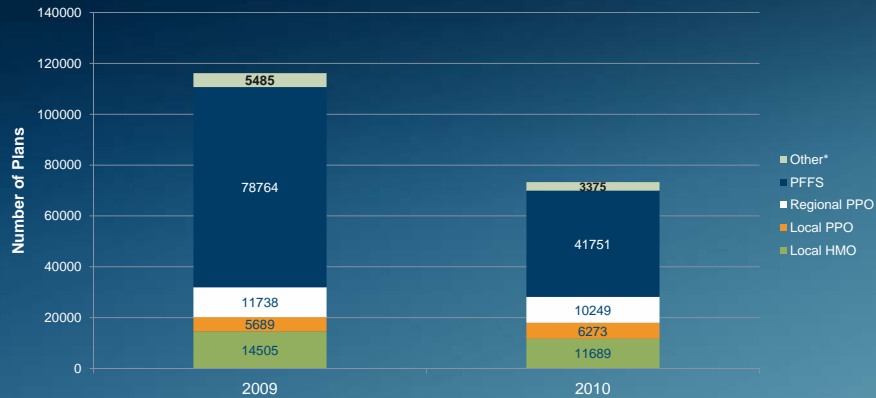
2010 Plan Year Activity – MA Organization Reactions *(continued)*

- MA-PD premiums up 12%, on average
- Benefit reductions are very common
- Percent of MA-PD plans with \$0 premium decreased from 21% to 12%
- United reports 20% of membership will have premium increases but most less than \$10 pmpm (expect managed with benefit changes)

2010 Plan Year Activity – MA Organization Reactions *(continued)*

- Some organizations adding products
 - PPO to replace PFFS is common
 - Some others
- Some organizations reduced or eliminated service areas
- Numerous PFFS withdrawals

Local PPOs Represent the Lone Growth Area for Number of MA Plans in 2010



• Includes Cost, Medical Savings Account, Demo and unspecific plans.

Source: Medicare Advantage News 10/8/09

Medicare Advantage Dilemma Beyond 2010

- Reform looms large
- Plans salivate over upcoming boomers (2011+), who will likely be more accepting of MA products given similarity to employment-based products

2009 MA Plan Payments Relative to Traditional FFS



MA Critics vs. Supporters

- MA critics point out:
 - HMO plans paid 13% more than traditional Medicare
 - Regional PPO plans paid 12% more
 - PFFS and local PPO plans paid 18% more
 - Drives up Part B premium for all Medicare beneficiaries
 - Source is MedPAC's March 2009 report
- MA supporters point out:
 - Private plans provide extra benefits to many low income seniors, don't get to keep additional funding solely for profits
 - Innovation is more likely to come from this program than traditional Medicare

Recent Trends' SUMMARY

- Product growth strong through 2009
- 2010 MA-PD offerings to provide less value to members – may temper member growth
- Future is Unclear

Thank You!

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Medicare Advantage Payment Reform – A Summary of the Chairman’s Mark: America’s Health Future Act

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Presented by:
JoAnn Bogolin, ASA, MAAA
October 27, 2009

Role of Public Programs Dual-Eligible Benefit Coordination

- Background
 - In February 2009, an estimated 7.9M individuals were dually eligible
 - Two types of dual-eligible beneficiaries:

| | |
|--|--|
| <ol style="list-style-type: none"> 1. Full-benefit dual <ul style="list-style-type: none"> – Approximately 80% of duals – Entitled to Medicare and full-Medicaid benefits – Medicaid pays Medicare premiums and cost-sharing and covers additional services not covered by Medicare | <ol style="list-style-type: none"> 2. Partial-benefit dual <ul style="list-style-type: none"> – Entitled to Medicare, but not full Medicaid coverage – Medicaid pays Medicare premiums |
|--|--|
 - In 2005, dual-eligible beneficiaries represented less than 20% of either Medicare or Medicaid beneficiaries; however, they accounted for 25% and 46%, respectively, of expenditures.

Role of Public Programs Dual-Eligible Benefit Coordination

- Chairman's Mark
 - Establishes Federal Coordinated Health Care Office (CHCO)
 - Established by March 1, 2010
 - Reports directly to the Administrator of CMS

Purpose:

- Integrate benefits under Medicare and Medicaid program.
- Improve coordination between Federal and state governments to ensure beneficiaries get full access to the items and services to which they are entitled.

Goals:

- Provide dual-eligible beneficiaries full access to their benefits.
- Simplify the processes for access to benefits and services.
- Improve the quality of health care and long-term care services.
- Increase beneficiary understanding and satisfaction.
- Eliminate regulatory conflicts between the two programs.
- Improve care continuity.
- Eliminate cost-shifting between the two programs and related health care providers.
- Improve the quality of performance of providers and services under the two programs.

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Promoting Disease Prevention and Wellness

- Beginning in 2011, Medicare beneficiaries would have access to a comprehensive health risk assessment (HRA)
 - Detect chronic diseases, modifiable risk factors and urgent health needs
 - Completed prior to or as part of welcome visit
 - Medicare would pay for assessment and personalized prevention plan
 - Personalized prevention plan would include:
 - Schedule of preventive services
 - Strategy to address risk factors
 - List of all medications currently prescribed
 - List of all providers involved in the patient's care
 - Referral to interventions for modifiable risk factors, such as nutrition and smoking
- Removing Barriers to Preventive Services
 - Remove cost sharing for preventive services covered by Medicare
- Evidence-Based Coverage for Preventive Services
 - Provide funding for CMS to improve provider education and patient awareness

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Promoting Disease Prevention and Wellness

- Study on Beneficiary Access to Immunizations
 - Evaluate impact on access of covering adult immunizations under Part D
- Incentives for Healthy Lifestyles
 - Appropriate \$100M over five years
 - Provide incentives to beneficiaries who successfully participate in healthy lifestyle programs
 - Programs target:
 - Risk factors
 - High blood pressure
 - High cholesterol
 - Tobacco use
 - Overweight or obesity
 - Diabetes and falls
 - Establish a system to monitor participation and validate changes in health risk and outcomes
 - Prior to establishing incentive, will review evidence concerning healthy lifestyle programs

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Medicare Advantage Payment
 - The calculation of MA benchmarks would be based on actual plan costs as reflected in plan bids, rather than statutorily set rates
 - Transition plan for MA local benchmarks – by 2015 the benchmark will equal the enrollment weighted average of all MA bids in each payment area
 - Regional plan benchmark would continue to be calculated the same
 - Statutory portion would be based on the new MA benchmarks, though
 - Detail on proposed payment changes in Company Perspective section

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Medicare Advantage Payment
 - Bonus Payments
 - Beginning in 2014
 - Based on care coordination and management activities by MA plans
 - ½% of the USPPCC is available for each of the following criteria that a plan meets:
 1. Care management programs that target individuals with one or more chronic conditions, identify gaps in care, and facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.
 2. Programs that focus on patient education and self-management of health conditions, including interventions that help manage chronic conditions, reduce declines in health status and foster patient/provider collaboration.
 3. Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and re-admissions.
 4. Patient safety programs, including provisions for hospital-based patient safety programs in their contracts with hospitals.

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Medicare Advantage Payment (continued)
 5. Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements or pay-for-performance programs.
 6. Medication therapy management programs that focus on poly-pharmacy and medication reconciliation, periodic review of drug regimens, and integration of medical and pharmacy care for chronically-ill, high-cost beneficiaries.
 7. Health information technology programs, including electronic health records, clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.
 8. Programs that address identify and ameliorate health care disparities among principal at-risk subpopulations.
 - 2nd bonus payment based on prior achievement or improvement in plan quality performance
 - Could receive 2% or 4% of USPPCC depending on how well they rank above an average score.
 - Accommodations will be made for new and low-enrollment plans, so they may receive up to 2% based on certain criteria. In the third year, new plans will be evaluated in the same manner as other plans with comparable enrollment.
 - Plans must use 100% of these bonus payments to offer additional benefits to enrollees

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Medicare Advantage Payment
 - Grandfathering
 - Plans allowed to grandfather extra benefits to current enrollees
 - Grandfather begins in 2012
 - Beginning in 2013, extra benefits will be reduced by 5% each year
 - Must submit a separate bid for enrollees with grandfathered benefits
 - Performance bonuses not available for grandfathered plans
 - Transitional Benefits
 - Provides for transitional benefits for enrollees who would experience a significant reduction in additional benefits due to competitive bids
 - CMS Actuary Certification
 - If the Chief Actuary of CMS certifies that beneficiaries would lose Medicare-covered benefits when the provisions of the Chairman's Mark are implemented, the Mark would strike the provisions related to competitive benchmarks and bonus payments
 - This determination must be made three months after the enactment of this legislation

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Benefit Protection and Simplification
 - Prohibits MA plans from charging cost sharing greater than under original Medicare for certain services such as chemotherapy treatment, renal dialysis and skilled nursing care
 - Reserves the right to identify additional services for which this provision applies
 - Modifies how plans can use their rebates and bonuses beginning in 2012:
 - Use most significant share to meaningfully reduce Part A, B and D cost sharing
 - No more reducing or eliminating the Part B premium
 - Out of pocket maximums would apply to all Part A and B benefits
 - Use next share to add preventive and wellness benefits
 - Use remainder to add non-covered benefits
 - Simplify information to beneficiaries by classifying plans according to the share that rebates, bonuses and supplemental premiums are of each plan's bid
 - A plan's marketing materials must reflect this category

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Simplification of Annual Beneficiary Election Periods
 - Beginning in 2011, annual enrollment period dates for MA and Part D will be 10/15 – 12/7
 - Beginning in 2011, annual open enrollment period (1/1 – 3/31) for MA plans will be eliminated
 - Beginning in 2011, new 45-day period (1/1 – 2/15) in which beneficiaries who enroll in MA or PDP plans during the AEP could disenroll and return to FFS

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Extension for Specialized MA Plans for Special Need Individuals
 - Extend SNP authority through 12/31/2013
 - Require all dual-eligible SNPs to have established contracts with state Medicaid programs by 1/1/2013
 - Changes related to payments, rebates and bonuses mentioned above apply to SNPs as well
 - SNP bids will be used in the determination of the MA benchmarks from 2012-2013
 - As under current guidelines, dual-eligible SNPs would not be allowed to charge premiums if their bids exceed the new benchmarks
 - Provide authority for a frailty adjustment for fully-integrated dual-eligible SNPs
 - New enrollees would be assigned a risk score that reflects the known underlying risk profile and chronic health status of each enrollee
 - Beginning in 2012, SNP plans must be certified by the NCQA in order to serve the targeted populations

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Extension of Reasonable Cost Contracts
 - Cost contracts may continue operating regardless of any other MA plans serving the area for three years, from 1/1/2010 to 1/1/2013
- MA Private Fee-for-Service Plans
 - Allows employer-based PFFS plans a waiver from the network requirements
 - For plans not sponsored by employers, a network area would be defined as an area served by two or more MA organizations
- Medigap
 - Requests that the NAIC create new plans for C and F that include normal cost sharing
 - Encourages the use of appropriate Part B physician services
 - Available in 2015

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Improving Medicare for Patients and Providers

- Medicare Part D Improvements
 - Improving Coverage in the Part D Coverage Gap
 - Discount program for beneficiaries who have drug spending that falls into the coverage gap
 - Provides for 50% discount on brand-name drugs available during the entire coverage gap
 - Only for beneficiaries enrolled in Part D who do not qualify for the low-income subsidy and are not enrolled in an ER sponsored plan
 - 100% of the negotiated price of discounted drugs count toward TrOOP
 - If a manufacturer does not participate in the discount program, their drugs will not be covered under Part D
 - Improving the Determination of Part D Low-Income Benchmarks
 - Effective in 2011, MA rebates and bonus payments will be excluded from the MA-PDP premium amount when calculating the regional LIS benchmark amount
 - Voluntary De Minimus Policy for Low-Income Subsidy Plans
 - Plans that bid a nominal amount above the regional LIS benchmark amount can choose to absorb the cost of the difference between their bid and the LIS benchmark in order to qualify as an LIS-eligible plan

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Improving Medicare for Patients and Providers

- Medicare Part D Improvements
 - Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance
 - Beginning in 2011, the surviving spouse of an LIS-eligible couple undergo a redetermination of his or her eligibility status no earlier than one year from the next scheduled redetermination
 - Facilitation of Reassignments of Beneficiaries in Low-Income Subsidy Plans
 - Plans whose LIS members are reassigned must submit utilization data to the beneficiary's new plan within thirty days of notification of the reassignment
 - Funding Outreach and Education of Low-Income Programs
 - Provides \$45M for outreach and education activities related to low-income assistance programs
 - Strengthening Formularies with Respect to Certain Categories or Classes of Drugs
 - Provides authority to determine classes of clinical concern
 - These classes of clinical concern will be protected on plan formularies

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Improving Medicare for Patients and Providers

- Medicare Part D Improvements
 - Reducing the Part D Premium Subsidy for High-Income Beneficiaries
 - Applies to beneficiaries with adjusted gross income of \$85,000 (individual) and \$170,000 (couple) in 2009
 - Instead of setting the Medicare premium subsidy at 74.5% of total Part D premiums, the subsidy would vary based on annual income
 - Simplifying Part D Plan Information
 - Beginning in 2011, establishing two or more categories of prescription drug plans, based on ranges of the actuarial values
 - Develop standardized nomenclature, definitions and language to describe and present the benefits on Plan Finder
 - Limitation on Removal or Change of Coverage of Covered Part D Drugs Under a Formulary Under a PDP or MA-PD
 - Cannot remove a covered drug from plan formulary
 - Cannot apply a cost or utilization management tool that limits coverage of such a drug
 - Cannot increase cost sharing of such a drug other than the date on which Part D sponsors begin marketing their plans

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Improving Medicare for Patients and Providers

- Medicare Part D Improvements
 - Medicare Part D Copayment Equity – cost sharing for beneficiaries under a home or community based service would be equal to those receiving institutional care, beginning 1/1/2011
 - AIDS Drug Assistance Programs and Indian Health Service – count toward annual out of pocket threshold, beginning 1/1/2011
 - Generic “First Fill” – plan sponsors allowed to waive copayments for first fills of generic drugs
 - Long-Term Care Pharmacy – provisions to reduce waste associated with 30-day fills for residents in long-term care facilities
 - Pharmacy Benefit Manager Transparency – PBMs provide information to HHS and plans regarding prescription utilization and costs
 - Office of the Inspector General – must report annually on the inclusion of drugs commonly used by dual-eligibles on Part D plan formularies
 - HHS Ongoing Study on Coverage for Dual-Eligibles – report on retroactive coverage for full benefit dual eligibles who enroll in a plan under Part D

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Additional Information

Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Medicare Advantage Payment
 - The calculation of MA benchmarks would be based on actual plan costs as reflected in plan bids, rather than statutorily set rates
 - Encourages plans to compete on the basis of price and quality, rather than on the level of extra benefits offered to enrollees
 - Provides cost savings
 - Transition plan for MA local benchmarks:
 - 2011: Per capita growth percentage decreased by 3%
 - 2012: Blended 33% enrollment weighted plan bids / 67% current law MA benchmarks
 - 2013: Blended 67% enrollment weighted plan bids / 33% current law MA benchmarks
 - 2014: 100% of the enrollment weighted average of the 2013 plan bids, increased by national MA growth percentage for 2014
 - 2015: Enrollment weighted average of all MA bids in each payment area
 - Regional plan benchmark would continue to be calculated the same
 - Statutory portion would be based on the new MA benchmarks, though

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Medicare Advantage Payment
 - Plan Rebate:
 - 2011, 2012, and 2013 local and regional MA plans will still receive 75% of the difference between their bid and the benchmark rates as a rebate payment
 - Beginning in 2014, MA plans would receive 100% of the difference between their bids and the new benchmarks if their bid is below the new benchmark
 - As is now, if a plan's bid is equal to or above the new benchmark rates they must charge an enrollee premium equal to the difference
 - Bidding Rules
 - Beginning in 2012, establish bidding rules to protect the integrity and fairness of the bidding process
 - Bids not meeting actuarial standards or abiding by the rules established will be denied
 - Plan actuaries who certified these bids will be reported to the ABCD

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Improving the Quality and Efficiency of Health Care *Medicare Advantage*

- Medicare Advantage Payment
 - Payment Areas
 - Beginning in 2012, establish new MA payment areas for urban areas
 - In urban areas, payment areas will be based on MSAs, as determined by the OMB
 - Divide MSAs that cover more than one state
 - Allow for adjustments to reflect patterns of actual health care use
 - Beginning in 2015, one or more rural counties in a state would be combined into a single service area
 - In 2012, bidding service areas and payment areas will be the same
 - Plans must bid and serve the entire payment area
 - Limited exception to payment area requirements for plans can be made if:
 - » There are historical licensing agreements that preclude the offering of benefits throughout the entire payment area
 - » There are historical limitations in a plan's structural capacity to offer benefits throughout an entire payment area

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Improving the Quality and Efficiency of Health Care *Linking Payment to Quality Outcomes in the Medicare Program*

- Hospital Value-Based Purchasing (VBP)
 - Establish a VBP that pays for actual performance on quality measures
 - Make value-based incentive payments to acute care IPPS hospitals beginning FY2012
 - Adjust hospital payments based on performance under the VBP beginning FY2013
 - Measures would focus on same areas of the current quality measures:
 - Heart attack
 - Heart failure
 - Pneumonia
 - Surgical care activities
 - Patient perception of care
 - Funding for VBP incentive payments would be generated through reducing Medicare IPPS payments to hospitals and would be phased in as follows:
 - 1.00% in FY2013
 - 1.25% in FY2014
 - 1.50% in FY2015
 - 1.75% in FY2016
 - 2.00% in FY2017
 - DSH, IME, low-volume and outlier payments would not be impaired by payment reductions

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Improving the Quality and Efficiency of Health Care

Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing
 - Physician Quality Reporting Initiative (PQRI)
 - Currently:
 - Physician quality reporting system
 - Successful reporting yields a bonus payment of 2% of allowable charges
 - Program ends in 2010
 - Proposed:
 - Incentive payments extended beyond 2010
 - CMS to provide timely feedback to providers and establish an appeals process for providers who participate in the PQRI
 - Beginning in 2011, CMS will make incentive payments to physicians who participate in a new PQRI set of criteria
 - CMS will also issue penalties to eligible professionals who failed to participate in the program
 - » 1.50% in 2013
 - » 2.00% in 2014 and beyond

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Improving the Quality and Efficiency of Health Care

Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing (continued)
 - Expansion of Physician Feedback Program
 - Currently:
 - MEDPAC and GAO recommended providing physicians with feedback on resources used
 - Expectation is physicians can study their practice patterns to determine if they use resources more than peers or what evidence-based research recommends
 - MIPPA established a feedback program, which will provide physicians confidential reports that measure the resources involved in furnishing care to Medicare beneficiaries
 - Proposed
 - Beginning in 2012, CMS will provide reports to physicians that compare their resource use with that of other physicians or groups of physicians caring for patients with similar conditions
 - Beginning in 2014, payment would be reduced by five percent if an aggregation of the physician's resource use is at or above the 90th percentile of nation utilization

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Improving the Quality and Efficiency of Health Care

Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing (continued)
 - IP Rehabilitation Facility, Long Term Acute Care Hospital and Hospice Quality Reporting
 - Currently
 - IRFs, LTCHs and hospices are not required to report quality data to CMS
 - IRFs do submit a clinician's comprehensive assessment of each patient upon admission and at discharge
 - Proposed
 - Establishes quality reporting programs for IRFs, LTCHs and hospices
 - Failure to report quality measures would result in reduction of annual market basket update by 2.00%

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Improving the Quality and Efficiency of Health Care

Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing (continued)
 - IPPS Exempt Cancer Hospital Quality Reporting
 - Currently:
 - Eleven cancer hospitals are exempt from the Medicare IPPS
 - Paid on reasonable cost basis
 - Also are held harmless under the OPSS
 - Proposed
 - Establish quality reporting programs for IPPS-exempt cancer hospitals
 - By FY2013, quality measures would be selected
 - In FY2014, would implement mandatory quality measure reporting
 - Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plan
 - Currently:
 - HHAs are required to submit data for a set of quality measures
 - Received a 2.00% reduction in Medicare annual update for failure to submit
 - Proposed:
 - Develop value-based purchasing implementation plans for HHAs and SNFs by 2011 and 2012, respectively

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Improving the Quality and Efficiency of Health Care

Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing (continued)
 - Reducing Hospital Acquired Conditions
 - Currently:
 - Hospitals will not receive additional Medicare payment for complications that were acquired during a patient's hospital stay
 - Beginning FY2008, CMS required hospitals to report whether certain conditions for Medicare patients were present at admission
 - Starting FY2009, IPPS hospitals will not receive additional payment for secondary diagnoses resulting from hospital acquired conditions
 - Proposed:
 - Apply a new payment adjustment to hospitals ranked in the top quartile of national, risk-adjusted HAC rates
 - CMS would calculate national and hospital-specific data on the HAC rates

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Improving Medicare for Patients and Providers

- Ensuring Beneficiary Access to Physician Care and Other Services
 - Addresses:
 - Sustainable Growth Rate – Annual update to Medicare fee schedule would be 0.5% increase in 2010. The conversion factor for 2011 and subsequent years would be computed as if the 2010 increase had never applied.
 - Extension of Floor on Medicare Work Geographic Adjustment
 - Mis-valued Relative Value Units
 - Therapy Caps
 - Extension of Treatment of Certain Physician Pathology Services under Medicare
 - Extension of Increased Payments for Ambulance Services under Medicare
 - Extension of Long-Term Care Hospital Provisions
 - Extension of Payment Adjustment for Medicare Mental Health Services
 - Permitting Physician Assistants to Order Post-Hospital Extended Care Services
 - Recognizing Attending Physician Assistants as Attending Physicians to Serve Hospice
 - Medicare Diabetes Self-Management Training
 - Medicare Improvement Fund
 - Medicare Part B Special Enrollment Period for Disabled TRICARE Beneficiaries

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Improving Medicare for Patients and Providers

- Rural Protections
 - Extend Medicare Rural Hospital Flexibility Program
 - Extend Hospital Outpatient Department Hold Harmless for Small Rural Hospitals
 - Extend and Expand Hospital Outpatient Department Hold Harmless for Sole Community Hospitals
 - Extend Reasonable Cost Reimbursement for Lab Services in Small Rural Hospitals
 - Extend Rural Community Hospital Demonstration Program
 - Extend Medicare Dependent Hospital Program
 - Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals

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Resources

- The America's Health Future Act and related sites
 - Senate Finance
 - http://finance.senate.gov/sitepages/Americas_Healthy_Future_Act.html
- Senate HELP Committee Affordable Health Choices Act (S. 1679)
 - Senate HELP
 - <http://help.senate.gov/>
- House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
 - Ways and Means
 - <http://waysandmeans.house.gov/media/pdf/111/AAHCA09001xml.pdf>
- Side by side comparison of major health care reform proposals
 - Kaiser Family Foundation
 - http://www.kff.org/healthreform/upload/healthreform_sbs_full.pdf

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Medicare Advantage Payment Reform – Company Perspective

Society of Actuaries Annual Meeting
Session #49 10/27/09
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1

Transition to Competitive Bidding – Determination of Benchmarks

- 2011: CMS National Growth Rate minus 3%
- 2012: $\frac{2}{3}$ rds current law benchmark + $\frac{1}{3}$ rd current year competitive bids for basic Medicare A/B
- 2013: $\frac{1}{3}$ rd current law benchmark + $\frac{2}{3}$ rds current year competitive bids for basic Medicare A/B
- 2014: 2013 enrollment weighted competitive average bid for basic Medicare A/B adjusted for 2014 National Growth Rate
- The above would be calculated at the MSA level for urban areas and county level for rural areas.
- For RPPO, the statutory portion would be based on the new MA benchmarks instead of statutory rates.

2

Examples - Assumptions

- CMS National Growth Rate = 0%
- MA Claim Trend = 0%
- MA Risk Score = 1.0
- Coding Intensity adjustment = 0%
- A/B Cost = average bid amount
- The above is to show the impact without addressing the effect of CMS growth rates, MA claim trends and changes in risk scores, including coding intensity adjustments.

3

Example – Dade County, FL

| Year | Benchmark | A/B Cost | Rebate | Supp Bens | RxPrem | MberPrem |
|------|-----------|----------|--------|-----------|--------|----------|
| 2010 | \$1,230 | \$870 | \$270 | \$170 | \$100 | \$ 0 |
| 2011 | \$1,193 | \$870 | \$242 | \$142 | \$100 | \$ 0 |
| 2012 | \$1,085 | \$870 | \$161 | \$ 61 | \$100 | \$ 0 |
| 2013 | \$ 978 | \$870 | \$ 81 | \$ 0 | \$100 | \$ 19 |
| 2014 | \$ 870 | \$870 | \$ 0 | \$ 0 | \$100 | \$100 |

- The current rebate approach applies through 2013.
- The above example assumes that MA benefits are reduced first, and that rebates are applied to the Rx premium to the extent available.
- As the rebate continues to decline, it ultimately leads to a member premium, assuming no reduction in Rx benefits.
- 2012 BM = $(2 * 1193 + 870) / 3$
- 2013 BM = $(1193 + 2 * 870) / 3$

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Example - Roosevelt County, MT

| Year | Benchmark | A/B Cost | Rebate | RxPrem | MberPrem |
|------|-----------|----------|--------|--------|----------|
| 2010 | \$ 740 | \$720 | \$ 15 | \$ 25 | \$ 50 |
| 2011 | \$ 718 | \$720 | \$ 0 | \$ 25 | \$ 67 |
| 2012 | \$ 718 | \$720 | \$ 0 | \$ 25 | \$ 67 |
| 2013 | \$ 718 | \$720 | \$ 0 | \$ 25 | \$ 67 |
| 2014 | \$ 718 | \$720 | \$ 0 | \$ 25 | \$ 67 |

- This example, assumes the benchmark can not exceed the benchmark that would apply under existing law, thus it remains constant. Chairman's Mark not clear.
- Value of supplemental benefits = $\$50 - \$25 + \$15 = \40 .
- Supplemental benefits are assumed to be kept constant.
- 2011+ member premium = $\$720 - \$718 + \$40 + \25 .

5

Payment Areas

- For plan years 2012 & later, CMS would be required to establish new MA payment areas for urban areas.
- In urban areas, payment areas would be based on the definition of Core Based Statistical Areas (CBSAs). A CBSA would be an urban area with a population of 10,000+.
- CMS would be required to divide CBSAs that cover more than one state.
- For plan years 2015 & later, CMS would be required to combine one or more rural counties in a state into a single service area.
- Bidding and service areas would be the same as payment areas.
- Plans would be allowed to choose which payment areas they would like to serve, but they must bid and serve the entire payment area.

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2015 & Later

- MA local benchmarks would be determined by the enrollment weighted average of all MA bids in each payment area.
- Local plans include HMO, LPPO and PFFS.
- In a payment area where only a single plan is offered, the weight would be equal to one.
- In a payment area where no MA plans were offered in a prior year and multiple plans bid in the following year, the MA benchmark in that area would use a simple average.
- Benchmarks could not exceed the levels that would have existed under current law.

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Other Issues - MA

- The SFC Chairman's Mark provides for offsetting the SGR adjustment for 2010 only. The SGR adjustment will continue to negatively impact benchmarks after 2010.
- There is a provision that if a plan's A/B cost is less than 75% of the benchmark for 2011, the associated rebate can be carried forward through 2019, but with an annual 5% amortization. No details are provided as to how to prepare a bid.
- The introduction of a competitive element will significantly change the bid submission process for 2012 and later bids. The Mark does not contain any guidance as to how this would be implemented.

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Payments Under Competitive Bidding

- Example assumptions:
 - Three plans in marketplace, each with equal number of enrollees
 - Plan bids: A = \$900; B = \$850; C = \$800
 - Current law benchmark = \$1,000
 - Competitive bidding benchmark = \$850 (weighted average of plan bids)

| | Payment to Plan | | Rebate | | Member Premium | |
|--------|-----------------------------|---------------------|---------------------------------|---------------------|----------------|---------------------|
| | Current = Plan Bid + Rebate | Competitive Bidding | Current = .75 * (BM – Plan Bid) | Competitive Bidding | Current | Competitive Bidding |
| Plan A | \$975 | \$850 | \$75 | n/a | n/a | \$50 |
| Plan B | \$962.50 | \$850 | \$112.50 | n/a | n/a | \$0 |
| Plan C | \$950 | \$850 | \$150 | \$50 | n/a | n/a |

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Other Issues – MA (continued)

- Quality Bonuses – Beginning in 2014
 - Up to 6% of National USPPC PMPM
 - Up to 2% (1/2% each) for implementing up to four of eight areas for care coordination and management activities.
 - 2 - 4% for prior year achievement or improvement in plan quality performance for achieving at least three stars on a five star rating system.
 - If < 3 stars, 1% for improvement over prior year.

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Part D Changes

- MA rebates applied to buy down premiums for standard Rx coverage would be excluded from the calculation of the LIS benchmarks. This would serve to increase the number of plans eligible to participate in LI auto-assignment.
- In 2011, companies bidding a de minimis amount (determined by CMS) above the LIS benchmarks could choose to absorb the excess and receive LIS beneficiary auto-assigns.
- Proposal to provide 50% discount, in the coverage gap, for negotiated cost of prescription drugs (excludes dispensing fee) for non-LIS eligible beneficiaries who earn less than \$85,000 (single) or \$170,000 (couples). Drug manufacturers would be required to provide this discount, if they wished to participate in the Medicare prescription drug program.
- Beginning in 2011, beneficiary premiums would be means tested. The government premium subsidy would be reduced for beneficiaries whose income exceeds \$85,000 (single) or \$170,000 (couples). The member premium payable for higher incomes would be based on the same percentage as applies to Part B premiums.

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Questions & Discussion