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Medicare Advantage: Five Years after the ACA

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA), passed in March 2010, brought about many changes to the health insurance industry. For the Medicare Advantage (MA) program, the most significant changes were to reduce MA benchmark payment rates such that federal payments under this program are more consistent with payments made for beneficiaries in fee-for-service (FFS) Medicare, to introduce incentives for higher-quality care, and to foster a more competitive market environment. While there were also changes made to the Part D program as a result of the ACA, this article focuses on MA (Part C).

Five years later, MA enrollment is at an all-time high, increasing more than 40 percent since 2009. Quality of care also continues to improve, and the number of affordable and competitive MA plan options remains strong.

CHANGES INTRODUCED BY THE ACA

Benchmark Payment Rates

Possibly the most significant impact to MA as a result of the ACA is the reduction in MA benchmark payment rates. Starting in 2012, all counties began a phase-in process whereby published county-specific benchmark payment rates would be based entirely off FFS costs and star ratings. The Centers for Medicare and Medicaid Services (CMS) developed a county-specific transition period using predetermined metrics. Each county was assigned a six-, four-, or two-year phase-in period. By 2017 all counties will be fully phased in.

Counties are also stratified into four quartiles based on estimated FFS costs for each county. Once fully phased in, counties in the first quartile (i.e., those with the highest FFS costs) will receive payments equal to 95 percent of the estimated FFS costs, prior to any bonus adjustments for star ratings. The second, third, and fourth quartiles receive 100 percent, 107.5 percent and 115 percent of the estimated FFS costs (subject to ACA payment rate caps), respectively. The quartiles are re-ranked every year, so mobility across quartiles is allowed.

The impetus of the change was to have payments based on FFS costs, as illustrated in Figure 1. In the years before the ACA was passed, MA plan payments were consistently higher than 110 percent of FFS costs, reaching a high of 114 percent in 2009. As shown in Figure 1, in 2015 MA plan payments dropped to 102 percent of FFS and are expected to continue to drop in the future years.

In addition to plan payments being reduced, the ACA also introduced a new excise tax on the health insurance industry starting in 2014. The tax applies with some exceptions to all qualifying health insurers and is allocated based on premium revenue of the previous year. The total fee collected started at $8 billion in 2014, is gradually increasing to $14.3 billion in 2018, and will be indexed to premium growth thereafter.

QUALITY

Another significant change for plans and members in MA as a result of the ACA was a larger focus on quality of care. To encourage plans to make this a primary focus, the ACA introduced a star rating system. Higher-star plans receive quality bonus payments in addition to their ACA-defined payments. The star ratings, ranked on a scale from 1 to 5 stars, in half-star increments, are based on criteria such as customer service and management of chronic conditions. For 2015

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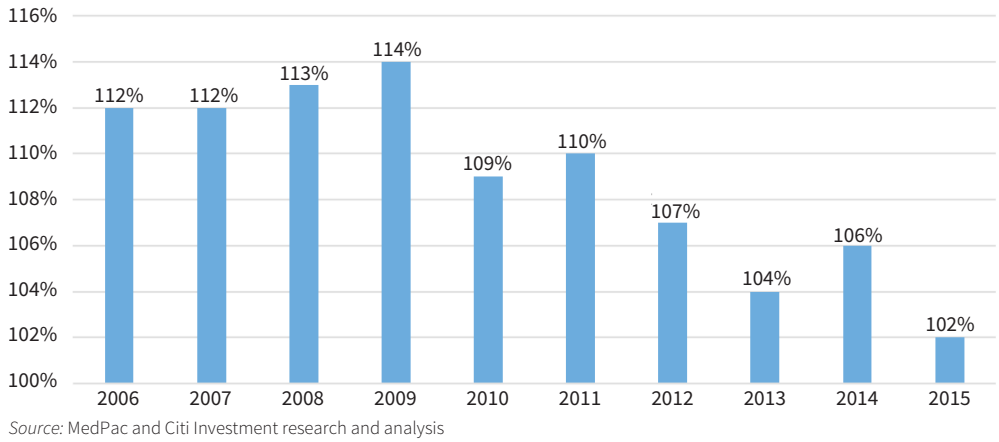
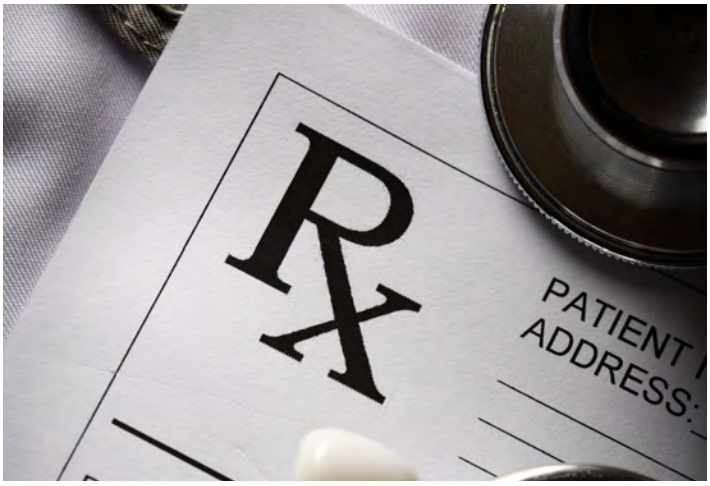
Figure 1

Average Differential Between MA Plan Payments & FFS Cost



Source: MedPac and Citi Investment research and analysis

Note: MedPAC changed its methodology for estimating FFS expenditures in 2010 in a way that reduced the estimated MA payment ratio. Data for years 2006 to 2009 reflect projection of FFS experience under current law, which includes the expected cut in physician fee schedule that is due to the Sustainable Growth Rate (SGR) system. This understates the actual FFS payments, and overstates the ratio of MA payments to FFS. For 2010 to 2015, the FFS projection is based on a scenario of 0 percent physician update.



through 2017, plans with a 4-, 4.5-, or 5-star rating receive a 5 percent bonus to their benchmark payment rates (subject to ACA payment rate caps). Plans with star ratings of 3.5 or under receive no quality bonus.

The ACA also reduces plan revenue by cutting Part C rebates. Prior to the ACA, plans that bid below the benchmark retained 75 percent of the savings to provide additional benefits regardless of their star ratings. Plans now retain only 50 to 70 percent of the savings, depending on the star rating (50 percent for under 3.5 stars, 65 percent for 3.5 or 4 stars, and 70 percent for 4.5 or 5 stars).

PLAN RESPONSES TO ACA

To combat the decline in payment rates, MA plans have taken a variety of measures, as summarized below, in an attempt to remain profitable while also staying competitive in the marketplace and retaining membership.

Implementing higher levels of medical management

Prior to the implementation of the ACA, plans were able to achieve reasonable profits without focusing heavily on medical management. However, as the ACA continues to drive down payment rates, plans need to manage medical costs, both from a unit cost and a utilization perspective, to remain competitive and profitable.

Improved coding efforts

Because payments to plans are risk-adjusted using the CMS-Hierarchical Condition Categories (HCC) risk model, capturing more patient diagnoses will increase plan revenue via increased risk-adjusted payment rates. However, plans only benefit from improved coding if the level of improvement exceeds the MA coding intensity adjustment. The MA coding intensity adjustment was introduced in 2010 to account for MA plans having better overall coding than FFS Medicare. The coding intensity adjustment was introduced as a 3.41 percent reduction to MA risk scores in 2010 but has grown to 5.41 percent for the 2016 plan year and will get larger in the coming years. This increase is meant to offset increases in coding specific to the MA program. CMS has indicated it will be analyzing this coding intensity adjustment for plan year 2017 to determine if a larger adjustment is more appropriate.

Re-contracting with providers

In recent years, plans have been focusing more and more on contracting efforts to lower costs and align incentives with providers. These efforts include lower reimbursement, risk-sharing deals, and/or partial or full capitation arrangements with providers. CMS has instituted some restrictions on these arrangements, particularly for related parties, to avoid the over- or under-subsidizing of providers to make a plan's results look more favorable.

Also related to contracting with providers, plans have begun implementing narrow network products to help manage increasing unit costs and to better align the plan with providers that are more effective at managing utilization. This allows plans to focus their year-over-year changes away from member cost sharing and premium changes.

Achieving higher star ratings

Plans have clearly understood both the impact of high star ratings on member retention and attraction as well as increased payments. In 2015, approximately 60 percent of MA enrollees will be in 4-, 4.5-, or 5-star plans, which is an increase of 36 percentage points since 2011. Figures 2 and 3 illustrate how the percentage of plans with higher star ratings has increased over the years.

Figure 2

Nationwide Enrollment by 2011 Star Ratings

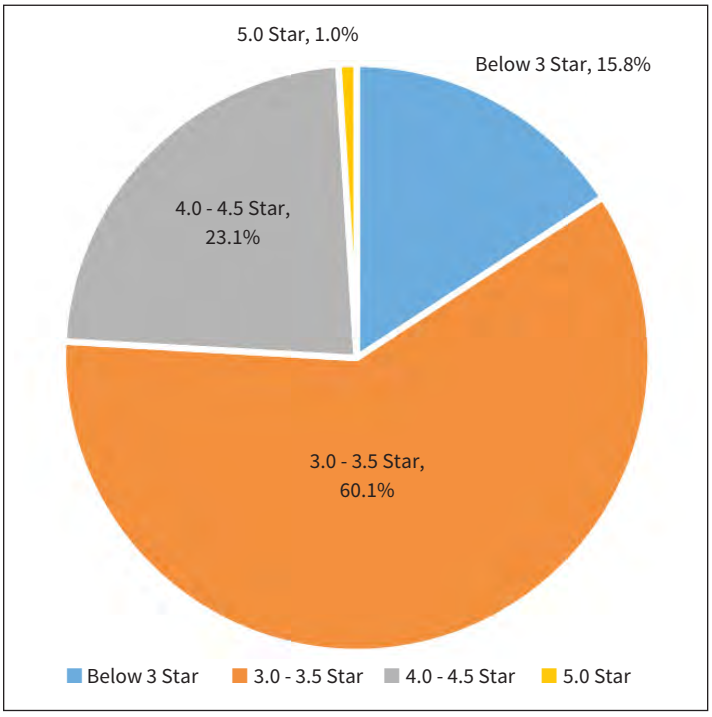
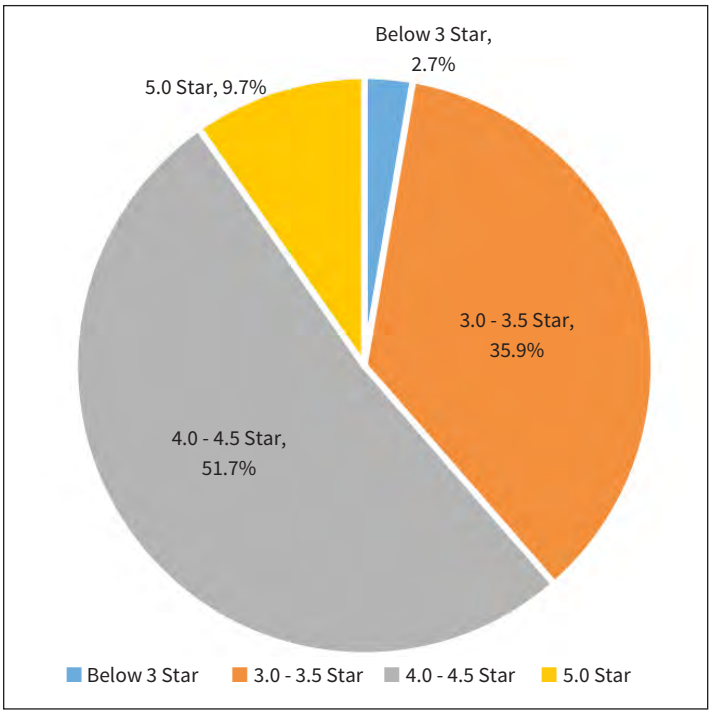


Figure 3

Nationwide Enrollment by 2015 Star Ratings



Decreasing benefits and/or increasing member premiums

Inevitably, once plans had maxed out the increases in revenue or decreases in costs they could achieve from reductions in administrative costs, increases in risk scores, increased star ratings, and increased medical management, plans began to focus required changes on plan benefits, including member cost sharing and member premiums. Plans typically try to avoid significant changes in benefits and premiums to avoid member disruption and loss of membership. However, continued decreases in payment rates have led plans to target benefit and premium changes on a plan-by-plan basis to maintain profitability. Using the total beneficiary cost (TBC) tests, CMS limits on an annual basis the value of benefits, cost-sharing and premium changes a plan can make to avoid member disruption. With that said, plans have continued to be able to offer plans with low member premiums in certain areas, albeit with higher cost sharing than five years ago.

A side effect of these member cost-sharing and premium changes as a result of the ACA is a reduction in the "value add" that members are receiving. "Value add" is defined as the value of benefits provided to a plan's beneficiaries above traditional Medicare that are not funded through member premiums. A recent Milliman study done in conjunction with the Better Medicare Alliance[1] showed Part C benefit value and premiums in composite (i.e., net of the effect of plan additions and terminations and with more members enrolling in lower-premium plans) have been decreasing every year, but benefit value has been decreasing faster than premium, resulting in a decrease in value add every year.

Managing administrative costs

One of the first steps plans took in managing the reduction in payment rates was to focus on reducing administrative costs. By doing so, plans attempted to avoid passing the cuts directly on to the members in the form of reduced benefits and/or increased premiums. Early on, plans were able to realize reductions that were due to increased efficiency or synergies (including mergers and acquisitions). However, five years after the ACA was implemented, plans are finding it harder to continue to reduce administrative costs.

Decreasing profit targets

Some plans have dropped their target profit margins, understanding that margins that may have been achieved prior to the implementation of the ACA may not be plausible or allowed under increased scrutiny from CMS. Moreover, minimum loss ratio (MLR) requirements included in the ACA essentially limit the profits a plan can achieve before having to return a portion of its revenues back to the government.

ACA'S IMPACT ON THE MARKET

At the onset of the ACA, many were concerned that the payment reductions introduced by it would irreparably harm the MA market by causing plans to either withdraw or significantly reduce member benefits to the point where members would leave MA in masses. The transformation the market went through in the past five years has proven that the majority of plans were able to weather the storm by a combination of benefit reductions, utilization management, and reductions in administrative costs. Inevitably, some plans succumbed to the rate pressures of the ACA and either exited the market or merged with other plans. That is evidenced by a reduction of a little more than 10 percent in the number of MA contracts from 2009 to 2014. Similarly, members saw a reduction in the number of plans to choose from of nearly 30 percent from 2009 to 2014. Some of this reduction can be attributed, though, to CMS rules, which limit the number of plans any particular contract can offer in the same area.

Even with the decline in the number of plan options, MA enrollment has been growing at a higher-than-expected rate, from 11.3 million in 2009 to

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16.5 million members in 2014. The MA penetration rate has also steadily risen, from 23 percent in 2008 to nearly 31 percent in 2014, and is expected to continue to grow in many states.

Not to be overlooked, quality of care has also significantly improved, as evidenced by the increase in plans' star ratings since the ACA was introduced. The bonus payments for higher star ratings properly incentivized plans to focus on quality of care. As noted earlier, more than 60 percent of MA enrollees will be covered by plans with a 4-star or higher rating, as compared to 24 percent of enrollees in 2011. In addition, many of the other ways plans coped with the ACA changes have led to improved quality, directly or indirectly. For instance, medical management initiatives that were meant to control costs likely resulted in plans more closely monitoring patients' treatments.

WHAT LIES AHEAD

MA is likely to continue to grow as more baby boomers transition into the Medicare population. With that continued growth, plans will look for new ways to increase efficiency. CMS will likely continue to put pressure on plans, through payment cuts and other methods, to become even more efficient in order to maintain profitability. As a result, a likely theme in the years to come is the continued growth of alternative payment arrangements whereby plans put more pressure on providers to ensure they are providing good value without sacrificing quality. Providers who can do this will also likely see success in the MA market through increased volume and better reimbursement arrangements. ■

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ENDNOTE

[1] Swanson, B.L., and E.P. Goetsch (Feb. 18, 2015). Medicare Advantage Funding Cuts and the Impact on Beneficiary Value. Milliman Report. Retrieved March 11, 2015, from *http://www.bmadev.org.php53-22.ord1-1.websitetestlink.com/sites/default/files/Report-Medicare-Advantage-Funding-Cuts-and-the-Impact-on-Beneficiaries.pdf.*

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