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Medicare Advantage Part C Revenue: Challenges Ahead

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The Centers for Medicare & Medicaid Services (CMS) issued a press release Sept. 19, 2012 announcing modest premium increases in the Medicare Advantage (MA) program for 2013 and a prediction that MA enrollment will increase by 11 percent in 2013. Health and Human Services Secretary Kathleen Sebelius said, "Thanks to the Affordable Care Act, the Medicare Advantage and Prescription Drug programs have been strengthened and continue to improve for beneficiaries."[1]

Will modest premium increases and increasing MA enrollment continue in the years ahead? The answer depends on many factors, including the impact of the Affordable Care Act (ACA) payment reforms in 2014 and beyond, plan star ratings, medical cost trends, administrative efficiency and regulatory changes, to mention just a few. This article primarily focuses on one of these factors—the impact of ACA payment reforms on Part C revenue trends over 2014 through 2017. As highlighted in this article, these reforms are intended to accomplish several policy goals, including:

- Bring Medicare Part C payments in line with the fee-for-service (FFS) program
- Reward health plans for providing quality health care
- Ensure an appropriate risk adjustment for a health plan's underlying population.

Because ACA reforms are phased in gradually over time, these goals have not been fully realized yet; however, big changes are in store for the next few years. These changes will put significant pressure on MA plans to do everything possible to avoid potentially significant reductions in Part C payments.

Brief History of the MA Payment Formula

Medicare Prescription Drug, Improvement and Modernization Act of 2003

The basic elements of the current MA payment scheme were established with the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The formula for payment is:

MA Payment = (Risk Score x 1.00 Bid) – MA Basic Member Premium + Rebate,

where MA Basic Member Premium = Max{1.00 Bid – 1.00 Benchmark,0}

where Rebate = Max{(Risk-Adjusted Benchmark - Risk-Adjusted Bid) x (Rebate %),0}

Below is a brief description of the components of this formula:

- **Risk Score.** A factor reflecting the relative morbidity of each beneficiary. The risk score is based on a CMS prospective model, where diagnoses from the prior year are used to predict the costs in the current year.

  Beginning in 2010, the risk score produced by the CMS model has been adjusted downward by a "coding difference" factor for purposes of determining MA payment. This coding difference factor was based on a CMS study that concluded MA risk scores were trending faster than FFS scores, even after adjusting for demographics and other factors. Since it is a statutory requirement that risk scores need to average 1.00 across MA and FFS, a coding difference adjustment was implemented to bring average scores into balance. The adjustment factor since 2010 has been 0.9659, or a 3.41 percent reduction.

- **1.00 Bid.** A plan's estimate of the cost to cover the standard Medicare benefit for a beneficiary with a risk score of 1.00.

- **MA Basic Member Premium.** The difference between a plan's 1.00 bid and the benchmark. If the 1.00 bid is below the benchmark (which is common), then the basic member premium is $0, and a rebate is calculated. The benchmark is set by CMS for each county and generally reflects estimated costs for FFS beneficiaries. The Balanced Budget Act of 1997 (BBA) created rules where the benchmarks for some counties were set higher than FFS levels due to minimum trend updates and "floor" benchmark levels.

- **Rebate.** The portion of "savings" a plan keeps, with the condition that these amounts are spent on extra benefits or reduced cost sharing. Savings is defined as the difference between the risk-adjusted benchmark and risk-adjusted bid. The risk-adjusted benchmark and bid is the 1.00 value multiplied by the risk score. The portion of savings kept by plans, or "rebate percentage," was set at 75 percent under MMA.

The Patient Protection and Affordable Care Act of 2010

While the Patient Protection and Affordable Care Act (ACA) of 2010 kept the same formula as MMA, the legislation altered the determination of the benchmark, reduced the rebate percentage, and mandated minimum increases to the coding difference adjustment beginning in 2014. The goals of the ACA reforms were to gradually bring MA payments closer to FFS levels and to provide incentives for plans to improve patient outcomes through a quality bonus payment system tied to star ratings.

Under the ACA, benchmarks would be migrated to a new calculation as follows:

County Benchmark = FFS Cost Estimate x (Applicable Percentage + Quality Bonus)

The applicable percentage varied based on a county's ranking in one of four quartiles, while the quality bonus added a fixed percentage if a plan achieved a star rating of four or more. The quality bonus was set at 1.5 percent in 2012, 3 percent in 2013, and 5 percent for 2014 and future years. Certain "double bonus" counties that met CMS criteria received two times these bonus percentages. The table below shows the applicable percentage plus the quality bonus for non-double bonus counties.

	Original ACA: Applicable Percentage + Quality Bonus			
		Qualifying Plan (Star Rating of 4 or More)		
County Ranking by Quartile	Star Rating less than 4	2012	2013	2014+
100% (Highest)	95.0%	96.5%	98.0%	100.0%
75%	100.0%	101.5%	103.0%	105.0%
50%	107.5%	109.0%	110.5%	112.5%
25% (Lowest)	115.0%	116.5%	118.0%	120.0%

For example, a four-star plan serving a three-county area in Philadelphia, Pa. would have received the following applicable percentages and quality bonus percentages in 2012:

County Name	Quartile	2012 Applicable %	Double Bonus County?	Quality Bonus	Applicable % + Bonus
DELAWARE	100%	95.0%	YES	3.0%	98.0%
MONTGOMERY	75%	100.0%	YES	3.0%	103.0%
PHILADELPHIA	100%	95.0%	NO	1.5%	96.5%

Starting in 2012, a transition began between the benchmark calculation under MMA (also called "pre-ACA") and ACA. The transition period is two, four or six years, depending on the county. Each successive year of transition places more weight on the ACA benchmark and less on the pre-ACA value.

The rebate percentage under ACA was reduced from the pre-ACA value of 75 percent to one of the following percentages: 50 percent, 65 percent or 70 percent, depending on a plan's star rating. Similar

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to the benchmark calculation, a phase-in period was established over three years. The table below shows the percentages by star rating and transition rules.

Year	Pre-ACA/ ACA Weight	<3.5 stars	≥3.5, <4.5 stars	≥4.5 stars
2012	⅔/⅓	66.7%	71.7%	73.3%
2013	⅓/⅔	58.3%	68.3%	71.7%
2014+	0%/100%	50.0%	65.0%	70.0%

In addition to the benchmark and rebate changes, a mandated minimum increase in the coding difference adjustment was also established according to the following schedule.

Year	Minimum Increase	Implied Coding Difference Adjestment	Coding Difference Adjustment Factor
2012	0.00%	-3.41%	0.9659
2013	0.00%	-3.41%	0.9659
2014	1.30%	-4.71%	0.9529
2015	0.25%	-4.96%	0.9504
2016	0.25%	-5.21%	0.9479
2017	0.25%	-5.46%	0.9454

Note that ACA sets the minimum incremental changes in 2014 through 2017. The final coding difference adjustment factor in future years will be higher if the minimum increase is exceeded in any year.

Quality Bonus Payment Demonstration

In November 2010, CMS proposed to waive the ACA rules for determining quality bonus payments in favor of a national quality bonus payment (QBP) demonstration to be in effect from 2012 through 2014. This proposal was later affirmed in the April 4, 2011 Rate Announcement and Final Call Letter. The QBP demonstration increased quality bonus percentages and lowered the star-rating threshold to qualify for quality bonus. No changes were made to risk adjustment or to the rebate percentage.

The table on page 18 shows how each component of the payment formula is calculated under the original pre-ACA formula, ACA and QBP demonstration.

The most important differences between ACA and the QBP demonstration were the application of the quality bonus to the pre-ACA benchmark and the quality bonus definition.

This change has had a significant impact. During 2012 and 2013, MA payments under the QBP demonstration are much higher as compared with the original ACA language for plans with a star rating of three or more. Figure A on page page 19 compares risk-adjusted benchmarks under ACA and the QBP demonstration with the pre-ACA benchmarks and FFS costs.

Figure A shows that MA plans with three stars or more had higher benchmark levels under the QBP demonstration than they would have under original ACA. In addition, 2012 benchmarks under the QBP demonstration for those same plans actually exceeded pre-ACA levels due to the application of the quality bonus payment to the pre-ACA benchmarks.

Part C Payments in 2014 through 2017

Over the next four MA contract years (2014 through 2017), the transition to full implementation of ACA payment reforms will take place; however, it will not be a uniform transition by year due to the expiration of the QBP demonstration and the beginning of mandated coding difference adjustment increments in 2014.

The key changes affecting MA payments each year will be:

2014

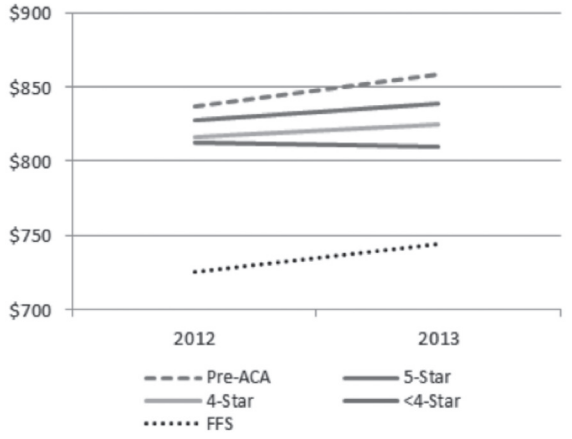
- Coding difference factor will change from 3.41 percent to at least 4.71 percent.
- Plans with four- and 4.5-star ratings will see an increase in the quality bonus percentage from 4 percent to 5 percent.
- Rebate percentage no longer blended with pre-ACA value of 75 percent.
- Counties on a four- or six-year transition schedule continue to have benchmarks blended with pre-ACA values, though the weight decreases on pre-ACA.

Medicare Advantage Part C Payment By Component			
Component	**Pre-ACA**	**ACA**	**Quality Bonus Payment Demonstration 2012-2014**
Risk Score	Part C risk score x coding difference adjustment	Part C risk score x mandated minimum coding difference adjustment	Part C risk score x mandated minimum coding difference adjustment
Benchmark	USPCC cost by county x growth rate, with periodic re-basing to FFS minimum	Blend of: Pre-ACA, FFS x (Applicable Percentage + Quality Bonus)	Blend of: Pre-ACA x **(1+ Quality Bonus),** FFS x (Applicable Percentage + Quality Bonus)
Benchmark Maximum	None	Blended Benchmark can be no higher than Pre-ACA Benchmark	Blended Benchmark can be no higher than Pre-ACA Benchmark, **except no maximum for plans with 3 stars or more**
Applicable Percentage	None	95%, 100%, 107.5%, 115%; varies by "quartile"	95%, 100%, 107.5%, 115%; varies by "quartile"
Quality Bonus	None	If 4 Stars or higher, then: 2012: 1.5% 2013: 3.0% 2014+: 5.0%	**For 2012-2014: 3 Stars: 3.0% 3.5 Stars: 3.5% 4-4.5 Stars: 4.0% (5% in 2014) 5 Stars: 5.0%**
Rebate %	75%	Phased-in blend of 75% and: >=4.5 Stars: 70% 3.5 or 4 Stars: 65% <=3 Stars: 50%	Phased-in blend of 75% and: >=4.5 Stars: 70% 3.5 or 4 Stars: 65% <=3 Stars: 50%

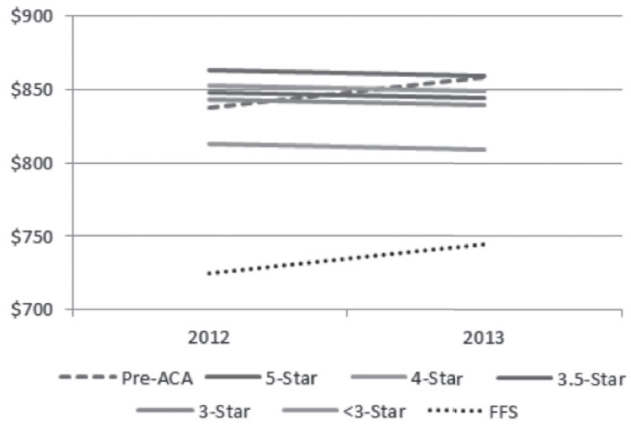
Bold items represent change versus ACA

Figure A

Nationwide Average 1.00 Benchmarks- Original ACA



Nationwide Average 1.00 Benchmarks- QBP Demonstration



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2015

- QBP demonstration expires.
- Plans with a star rating of three or 3.5 no longer get a quality bonus. Risk-adjusted benchmarks will decrease by 4.5 percent to 5 percent (due to decreased benchmarks and coding difference factor) for these plans.
- Quality bonus no longer applies to the pre-ACA benchmark.
- Blended benchmarks are capped at pre-ACA level, regardless of star rating.
- Benchmarks for all two- and four-year transition counties are now based entirely on ACA formulas.
- Coding difference must increase by at least 0.25 percent versus 2014.

2016

- Benchmark calculations for counties on a six-year transition schedule move from a pre-ACA weight of 33.3 percent in 2015 to 16.7 percent in 2016.
- Coding difference must increase by at least 0.25 percent versus 2015.

2017

- All benchmarks now based entirely on ACA formulas.
- Coding difference must increase by at least 0.25 percent versus 2016.

Nationwide Benchmark Trends

The impact of the numerous changes to Part C payments is best performed at a plan-specific level; however, it is still useful to look at the average effect of reform on a nationwide average basis. Below is a high-level discussion of the impact of Part C payment reforms on benchmark trends, showing flat to decreasing benchmark trends over 2014 and 2015, with the most significant reductions occurring for three- and 3.5-star rated plans.

Any such discussion must address the important issue of mandated reductions to physician payments. The Balanced Budget Act (BBA) of 1997 implemented the Sustainable Growth Rate (SGR) system, which included a mechanism to adjust future physician payments under Medicare to be consistent with targeted levels, subject to certain limits. This mechanism has dictated payment decreases in every year from 2002 through 2011, but the decrease has been overridden by Congress in every year except 2002. Due to these overrides, the cumulative reduction has become very large.

Since Medicare county benchmarks are based on estimated National Per Capita Growth Rate, the mandated BBA reductions directly impact benchmarks. For example, the growth rates underlying 2013 benchmarks include an assumption that physician fees will decrease by -30.8 percent in 2013. At the same time, the growth rate also reflects a positive restatement of the prior year trend to recognize the override of the physician payment reduction in 2012. The projections presented below assume that the historical pattern of assumed physician payment decreases in the current year together with restatement of prior years (due to congressional override) will continue. It is an important caveat, however, that if the BBA mandates to physician payments are ever permanently eliminated, the growth rate for the subsequent year would be much higher. For example, if the BBA payment reduction were eliminated for 2014, we estimate that the 2014 growth rate would be 4.5 to five points higher than if the reduction were assumed as usual.

Figure B shows estimated nationwide standardized (i.e., 1.00) benchmarks from 2012 through 2017. Enrollment is based on MA membership by county as of March 2012 and trends are based on the 2012 Medicare Trustees report, adjusted to reflect the historical pattern of assumed physician payment reductions and subsequent restatements when the reductions do not occur.

The projections in Figure B do not tell the full revenue picture because they ignore the impact of the reduced rebate percentage and the coding difference factor increase. It is not practical to generalize a nationwide impact of the reductions to the rebate percentage; however, it is possible to analyze the impact of the coding pattern adjustment.

Making an assumption that risk scores keep pace with FFS normalization but do *not* increase such that coding pattern changes in 2014–2017 are offset, Figure C shows a slightly different pattern of benchmarks versus Figure B.

Even though Figure C only captures two of three ways in which payment reform impacts Part C revenue (benchmarks and coding difference, but not rebate percentage), a few key points can be made:

Risk-adjusted benchmark trends in 2014 and 2015 will be negative if plans maintain their star ratings. The expiration of the QBP demonstration in 2015 causes a significant decrease in risk-adjusted benchmarks for three-star and 3.5-star plans.

Risk-adjusted benchmarks for plans with less than three stars are nearly the same as FFS costs. In fact, they will likely be lower than FFS because actual FFS costs will almost certainly be based on higher trends than shown here if the physician payment reduction is not eliminated.

Plan-Level Projections

While it is useful to analyze the impact of ACA and QBP demonstration reforms on Part C revenue at a high level, the real impact needs to be assessed at the plan, or Plan Benefit Package (PBP), level. The elements of ACA and QBP payment reforms are

Figure B
Nationwide Average 1.00 Benchmark
No Permanent Physician Payment Reduction Fix

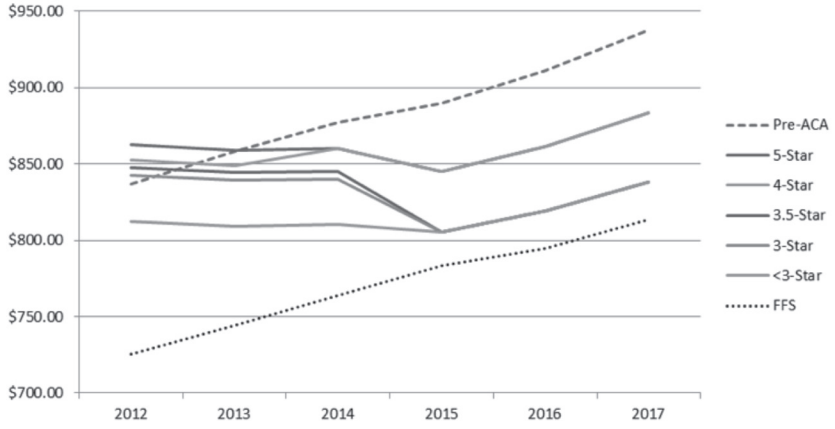
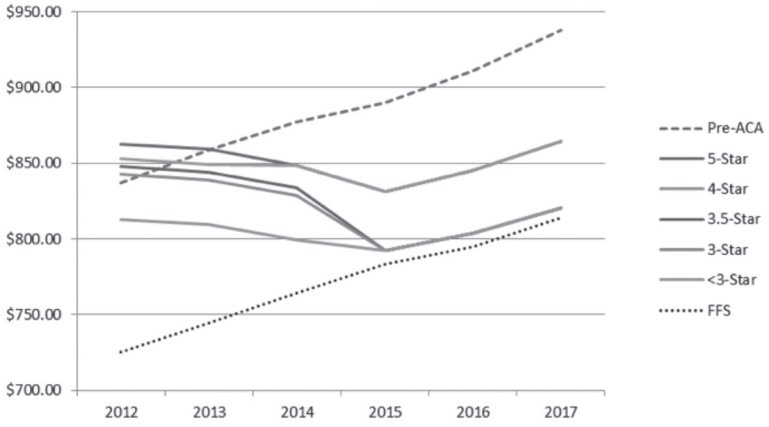


Figure C
Nationwide Average Risk-Adjusted Benchmark
No Permanent Physician Payment Reduction Fix



fixed, but plans can control several other factors in order to meet member premium, benefit level and profit goals.

Payment reform over the next few years will likely present the biggest challenge yet of plans' ability to affect these controllable factors in order to maintain an acceptable balance of these three goals. This challenge is the result of several factors. First, benchmarks will be decreasing. In particular, plans with a three- or 3.5-star rating will see a dra-

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matic drop in 2015, due to the loss of the quality bonus. Second, the rebate percentage will be further reduced in 2014 as the ACA formula becomes fully phased in. Third, the coding difference factor will change dramatically in 2014. It will go from 0.9659 (1 - 0.0341) to at most 0.9529 (1 - 0.0471) in 2014. If trends in risk scores do not keep pace with this change, plans will see reduced revenue due to the coding difference factor change.

Despite these downward pressures on revenue, plans can attempt to change controllable factors to achieve member premium, benefit level and profit goals. These controllable factors include:

- Star rating
- Medical expense trend
- Administrative expenses
- Process for coding and submitting diagnoses that drive risk score
- Profit level

Scenario testing one or more of these factors will create a wide range of financial results for the plan. For example, the difference between a 3.5-star plan and a four-star plan that are otherwise identical could easily mean a $0 premium offering for the four-star plan and a $25 or more offering for the 3.5-star plan.

As the ACA reforms continue to phase in for 2014, and the QBP demonstration expires in 2015, MA plans will face unprecedented Part C revenue reductions, barring an regulatory change or new demonstration.

Conclusion

The reforms in the 2010 ACA are intended to reduce Part C payments to MA organizations; however the impact of these reductions has not been felt yet due to the quality bonus demonstration. As the ACA reforms continue to phase in for 2014, and the QBP demonstration expires in 2015, MA plans will face unprecedented Part C revenue reductions, barring any regulatory change or new demonstration. Looking beyond 2015, the revenue outlook for MA plans should stabilize, and by 2017 should behave more like the year-to-year changes experienced prior to 2011.

In order to emerge successfully from these upcoming challenges, plans will need to focus with more diligence than ever on changing factors they can control like the star rating, expense trend, administrative expenses and diagnosis coding. Plans that do not efficiently manage these factors will struggle to maintain a competitive plan offering. More than ever, it could make the difference between being a successful MA plan and one that is not in the MA market at all.

END NOTES

1 CMS Office of Public Affairs Sept. 19, 2012 press release: "Medicare Advantage Remains Strong."