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MACRA Ramifications to Medicare Supplement

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PAYMENT REFORMS

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; HR 2) is effective Jan. 1, 2017. It is known as the "Doc Fix" because it is permanent legislation that will not cause Congress to address the Medicare Sustainable Growth Rate (SGR) each year in an attempt to assist the Centers for Medicare and Medicaid Services (CMS) to control spending on physician services. The Medicare SGR was introduced in 1997 as a methodology to limit Medicare physician expenses per beneficiary not to exceed the growth in the gross domestic product (GDP).

To replace the SGR, CMS is introducing alternative reimbursement methodologies to the physicians. At the time of passage, the bill averted a 21 percent physician pay cut and eliminated the SGR. Between 2015 and 2019, there is a 0.5 percent annual update to the reimbursement rates. These rates will be maintained at the 2019 levels through 2025. During this period of time, physicians will be provided the opportunity to receive additional adjustments through the new Merit-Based Incentive Payment System (MIPS). In 2026 and beyond, physicians will be permitted to participate in alternative payment models (APMs). The physicians who participate in APMs and meet a certain criteria would receive a 0.75 percent fee schedule increase; all others would only receive a 0.25 percent fee schedule increase. Physicians will be allowed to participate in MIPS or APMs, but not both.

The MIPS streamlines and improves upon three current law incentive programs—meaningful use of electronic health records (EHR MU), the Physician Quality Reporting System (PQRS) and the Value-Based Modifier (VBM), which is a budget-neutral program. The penalties associated with these incentives sunset in 2018. The VBM will be incorporated into the MIPS. From 2017 until 2022, the MIPS adjustment to the Medicare fee-for-service (FFS) payments will range from +/-4 to +/-9 percent in 2022, where it will level out. MIPS will only apply to doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists beginning in 2019. The list may expand to include other professionals who treat Medicare patients in 2021. Those exempt are new, rural and low-volume providers. MIPS will also assess the performance of eligible professionals in quality, resource use, EHR meaningful use and clinical practice improvement activities. Measures for the performance will be updated and published annually.

Physicians who participate in the APMs can obtain a qualifying participant status or partially qualifying participant status. By doing so, the providers could receive a 5 percent lump-sum bonus. An APM can be comprehensive care for joint replacement, comprehensive end stage renal disease (ESRD) (large dialysis organization (LDO) and non-LDO), comprehensive primary care plus, Medicare Shared Savings Programs Tracks 1, 2 and 3, a next generation accountable care organization (ACO) and an oncology care model—one- and two-sided. An advanced APM is a subset of this—comprehensive ESRD care (LDO), comprehensive care primary plus, Medicare Shared Savings Programs Tracks 2 and 3, a next-generation ACO, and an oncology care model two-sided. To become a qualifying participant, the provider must participate in an advanced APM and meet a claim-dollar or a patient-count threshold.

There are still many details to be worked out on these reimbursement payment schemes. The American Medical Association (AMA) is asking for the start of these alternative payment strategies to be pushed back from Jan. 1, 2017. Andy Slavitt, the acting administrator of CMS, is in support of the AMA and working with Congress to push back the start date of MIPS.

As the FFS reimbursement methodology changes, financial reporting and experience evaluation implications, such as historical claim lag patterns, may not be representative of the new, or at least initial, claims administration environment. The total impact upon Medicare Supplement is not yet known, as the goal of these payment reforms is to bend the cost curve and promote efficient and cost-effective care.

MEDICARE SUPPLEMENT CHANGES

However, one of the biggest changes as an outcome of this legislation from a Medicare Supplement insurer perspective is that the Part B deductible will no longer be covered for those becoming eligible for Medicare as of Jan. 1, 2020, referred to as "newly eligible." Part B covers physician and outpatient services. Plans C and F, considered to be first-dollar coverage since they cover the Part B deductible, will go away for this portion of the senior population. However, these plans will remain open for those who became eligible for Medicare prior to Jan. 1, 2020 (i.e., non–"newly eligible"). Those insureds would be known as the possible switchers. Plans C and F have also been the guaranteed issue plan[1] up to this point. Plans D and G, plans very similar to C and F but not covering the Part B deductible, will become the guaranteed issue plans. The High Deductible Plan

F is going away too, and will be replaced with a High Deductible Plan G. This legislation also affects the waiver states—Massachusetts, Minnesota and Wisconsin. The Medicare Supplement plans offered in these states are unique.

For all of this to happen, the Model Medicare Supplement regulation needs to be modified. The National Association of Insurance Commissioners (NAIC) Senior Issues (B) Task Force has assigned a Medicare Supplement workgroup to address how to interpret the implications of MACRA. They will address the issues mentioned previously. Since the model regulation is being reopened, the NAIC Health Actuarial Task Force has requested that recommended changes to the Medicare Supplement rate refund formula be considered.[2] Among the recommendations was a call for separate benchmark and premium factors for issue age and attained age rated plans. This would produce four sets of factors—two for group and two for individual, per the American Academy of Actuaries. The American Academy of Actuaries has also proposed that a definition of "issue age" plans be included in the Model Regulation as well as that the third-year 65 percent loss ratio requirement be removed for issue age plans. However, the NAIC Senior Issues (B) Task Force has completed the Model Regulation 651 changes required in order to comply with the federal law change, and the rate refund calculation changes were omitted. The waiver states will also need to update their regulations.

The pricing implications for Plans D and G will change. In the past these plans have been able to be cheaper than Plans C and F by more than the Part B deductible due to the favorable underwriting selection. Plans D and G will now need to include the guaranteed issue provisions in the pricing considerations. Ken Clark, principal at Milliman, has written a detailed article on the pricing considerations.[3] From a rerate perspective, the pooling of plans D and G will need to be considered. This change in underwriting criteria could be enough to warrant a separate pooling for rerate purposes. However, they could be pooled together for the rate refund calculations, if the same thought process is used as was used for the Modernized plans. Plans C and F will now only be available to the non–"newly eligible" through either guarantee issue provisions or medical underwriting.

Due to the change in reimbursement methods, many new carriers may decide that this is a good time to enter the Medicare Supplement marketplace. Other carriers may view this as a "fresh start." As the FFS reimbursement methodology changes, financial reporting and experience evaluation implications, such as historical claim lag patterns, may not be representative of the new, or at least initial, claims administration environment. In the marketing of Medicare Supplement, the senior market will be divided into two sections according to Medicare eligibility as of Jan. 1, 2020. Issues regarding policy applications and the outline of coverage need to be addressed. Since Plans C and F will be available for the non–"newly eligible," companies will need to decide if there is a need for two outlines of coverage to make it easier for seniors to understand which plans are available to them. Agents too will need to be educated well on the impacts of MACRA. These changes will need to be explained well on web pages to those carriers who offer Medicare Supplement on the internet. If it becomes too burdensome to administer, companies may elect to no longer even offer Plans C and F to those who became eligible for Medicare prior to Jan. 1, 2020. However, this would eliminate a significant segment of the senior population that is older and subject to medical underwriting and in good health. Presumably, the guarantee option would also still be limited to Plans C and F for this segment.

There are many IT issues introduced by this legislation. One of the first issues is how to check the insured's eligibility date of Medicare Part B since this information will be key as to what plans are available and can be issued. To administer a High Deductible Plan G, there will need to be a check to make certain that the Part B deductible claims are not reimbursable, but count toward the high deductible. This nuance could be very confusing to the consumer and to the agent and make the sale of this plan very difficult. MACRA has also mandated that the Social Security numbers can no longer be used in the Health Insurance Claim Number (HICN), the Medicare beneficiary's ID number. This is to be phased out by 2019, and will be replaced with a Medicare Beneficiary ID (MBI). New ID cards will need to be sent out by CMS. From an insurer's standpoint, there will need to be a crosswalk from the HICN to the MBI in order for claims to be paid. Whether this will be sent to the insurer from CMS or if it will be up to the insurer to figure out is yet to be determined. However it is ascertained, this will still be a modification to the claims IT platforms.

There are still many decisions to be made before MACRA becomes effective as of Jan. 1, 2017, and much to be learned. However, it is not too early to start creating a strategy for how to implement. ■

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ENDNOTES

1 *https://www.medicare.gov/supplement-other-insurance/when-can-i-buy-medigap/guaranteed-issue-rights-scenarios.html*

2 *http://www.actuary.org/files/Academy_Med_Supp_Refund_Formula_Report_Nov112014.pdf*

3 *http://us.milliman.com/insight/2016/Are-Medicare-Supplement-carriers-prepared-for-2020-Implications-of-new-legislation-and-an-opportunity-to-critique-old-rate-structures*