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Alerts

The Impact of Health Care Reform on Medicare Advantage Plans and Medicare Prescription Drug Plans

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Health Care Alert

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This is the 10th in a series of health care alerts that Hinshaw & Culbertson LLP will publish on the topic of health care reform.

The Patient Protection and Affordable Care Act (PPACA) makes significant changes that will directly or indirectly impact Medicare Advantage Plans and Medicare Part D Prescription Drug Plans. Following is a summary of these modifications.

Medicare Advantage Plans

Medicare Advantage Payment Benchmarks. The recent health care reform will gradually phase down Medicare payments to Medicare Advantage Plans, to bring payments closer to the average fee-for-service costs of Medicare beneficiaries. In 2011, benchmarks for Medicare Advantage Plans will remain the same as they are in 2010. Between 2012 and 2013, Medicare Advantage Plan benchmarks will gradually be reduced to levels closer to the costs of fee-for-service Medicare enrollees in each county, with lower benchmarks (95 percent of fee-for-service costs) in counties with high fee-for-service Medicare costs, and higher benchmarks (115 percent of fee-for-service costs) in counties with lower fee-for-service Medicare costs. The new rates will be phased in over three to six years depending on geographic locations.

Risk Adjustment. Medicare Advantage Plan payments to private plans will be further reduced through changes in the method used to compensate plans for the health status of enrollees (risk adjustment). In 2011, risk scores will be reduced by 3.41 percent. Beginning in 2014, CMS will have the authority to further reduce risk scores, with a reduction of at least 5.7 percent in 2019 and in future years.

Quality Based Payments. Medicare Advantage will provide bonuses to plans receiving four or more stars, based on the current five-star quality rating system for Medicare Advantage Plans, beginning in 2012; qualifying plans in qualifying areas will receive double bonuses. The recent health care reform also modifies the rebate system, with rebates allocated based on a plan's quality rating. There will also be phased-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7 percent by 2019.

Minimum Loss Ratio Requirements. Starting in 2014, if the United States Secretary of Health and Human Services (the Secretary) determines that a Medicare Advantage Plan does not maintain a medical loss ratio (MLR) of 85 percent (meaning that 85 percent of plan revenues do not go towards benefits), the plan must remit a specified sum to the Secretary. If a plan fails to have an MLR of 85 percent for three consecutive years, the Secretary will preclude new enrollment in that plan. If a plan fails to have an MLR of 85 percent for five consecutive years, its contract must be terminated.

Benefit Protections and Simplifications. Starting in January 2011, Medicare Advantage Plans cannot impose cost-sharing for chemotherapy administration services, renal dialysis services, and skilled nursing care services that exceed the cost-sharing for those services under original Medicare. The Secretary has discretion to require that cost-sharing for other services also does not exceed original Medicare cost-sharing. Starting in January 2012, plans that receive rebates and/or performance bonuses and that offer supplemental benefits must: (1) apply the most significant share to reductions in cost-sharing for benefits available under Medicare Parts A, B and D; with reductions in out-of-pocket expenses applying to all benefits under Parts A and B; (2) apply the second most significant share to meaningful coverage of preventive and wellness benefits that are not benefits under traditional Medicare; and (3) use the remaining share to meaningfully provide coverage for benefits that are not covered under traditional Medicare, such as eye examinations and dental coverage.

Special Needs Plans (SNPs). SNPs are required to be National Committee for Quality Assurance (NCQA)-certified for 2012 and later years. CMS authority to restrict the types of members enrolling in SNPs has been extended through 2013.

Medicare Part D Drug Benefit Plans

Elimination of Exclusion of Coverage of Certain Drugs. Starting in 2014, Medicaid programs will no longer be able to exclude smoking cessation agents, barbiturates and benzodiazepines from coverage under Medicaid. Because Medicare Part D-covered drugs are defined generally as those drugs that are covered under Medicaid, this new provision will result in a small expansion of Medicare Part D coverage of barbiturates. Starting in 2013, Medicare Part D will cover benzodiazepines and barbiturates used in the treatment of epilepsy, cancer or a chronic mental disorder.

Closing the Medicare Prescription Drug "Donut Hole." The recent health care reform creates a multi-part process for closing the Medicare Part D coverage gap, or “donut hole.” In 2010, certain beneficiaries who reach the “donut hole” will receive a $250 rebate. In 2011 and later years the coverage gap will decrease each year until 2020 by decreasing beneficiaries’ costs through decreases in drug costs and member cost sharing. In 2020 the “donut hole” will be eliminated and beneficiaries will pay 25 percent co-insurance for prescriptions.

Formulary Requirements. Starting in 2011, drug plan sponsors must include in their plans' formularies all covered Medicare Part D drugs in a category or class identified by the Secretary. The Secretary has discretion to establish exceptions that allow a plan sponsor to exclude or attach utilization management requirements to a drug within a protected category or class. The criteria for determining drugs to be included under this section, and the exceptions described above, are to be established through notice and comment rulemaking. The current six protected classes of drugs remain protected until such time as the Secretary establishes new criteria.

Part D Premium Subsidies for High-Income Beneficiaries. Starting in January 2011, beneficiaries with higher incomes who pay the Medicare Part B income-related premium will also be subject to a Medicare Part D income-related premium. The increased premium amount will be based on a percentage of the base beneficiary premium for that year as determined by the Secretary. The Secretary will inform the Commissioner of Social Security (the Commissioner) of the base beneficiary premium amount by September 15 of each year and inform the Commissioner of the income threshold by October 15. The Commissioner will make determinations to carry out the income-related premium and will collect the amount through withholding from Social Security checks.

Long-Term Care Facility Outpatient Prescription Drugs. Starting in 2012, plans must use specific, uniform dispensing techniques for Medicare Part D-covered drugs provided to residents of long-term care facilities whose prescriptions are paid for under Medicare Part D. They may include weekly, daily or automated dose dispensing of Part D-covered drugs. The techniques are to be determined by the Secretary through consultation with relevant stakeholders, including both residents and their representatives.

Medicare Prescription Drug Plan and Medicare Advantage-PD Plan Complaint System. The Secretary is required to develop an easy-to-use complaint system that will allow for the collection and maintenance of complaints received through any source and by any mechanism against Prescription Drug Plan (PDPs) and Medicare Advantage-PD plans. The system must be able to report and initiate appropriate interventions and monitoring and to guide quality improvement. A model electronic complaint form is to be developed and maintained on www.medicare.gov and the Office of Medicare Ombudsman's websites. The Secretary is also required to report to Congress annually on the number and types of complaints, geographic variations in complaints, timeliness of responses to complaints, and resolution of complaints.

Uniform Exceptions and Appeals Process for PDPs and Medicare Advantage-PD Plans. For exceptions and appeals filed on or after January 1, 2012, prescription drug plan sponsors must use a single, uniform exceptions and appeals process and provide access to it through a toll-free telephone number and a website.

AIDS Drug Assistance Programs and Indian Health Service. Starting in 2011, prescription drug costs reimbursed by AIDS Drug Assistance Programs (ADAPs) and the Indian Health Service will count towards true-out-of-pocket (TROOP) costs when calculating eligibility for catastrophic drug coverage under Medicare Part D.

Deduction for Expenses Allocable to Medicare Part D Subsidy. Employers that continued to provide creditable drug coverage for their retirees after Medicare Part D was enacted are entitled to a 28 percent rebate from Medicare towards the cost of that drug coverage. They pay no tax on the rebate amount, and may deduct from their taxes the full amount of the cost of the retiree coverage as if they received no rebate. The recent health care reform eliminates employers' ability to deduct the 28 percent rebate from their taxes, effective 2012.

Medicare Advantage and Medicare Part D Drug Benefit Plans

Annual Beneficiary Election Period. The open enrollment period, during which a beneficiary may enroll in or disenroll from a Medicare Advantage Plan during the first three months of the year, is eliminated. Starting in 2011, an individual who enrolls in a Medicare Advantage Plan may return to original Medicare and a Medicare Part D plan during the first 45 days of the year. Starting in the fall of 2011, the annual coordinated election period for Medicare Part C and Part D plans will run from October 15 through December 7 of each year, rather than from November 15 to December 31.

Authority to Deny Plan Bids. The Secretary now has discretion to deny a bid that proposes significant increases in cost-sharing or decreases in benefits offered by the Medicare Advantage Plan or Prescription Drug Plan (PDP) sponsor. The provision applies to bids submitted for contract years beginning on or after January 1, 2011.

For further information, please contact Michael A. Dowell.

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