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Medicare Program: Opportunities & Roles for Private Payers

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July 2012

General Overview of Program Constructs

Program Overview & History

- Medicare established in 1965 under the *Social Security Act Amendments of 1965*.
- Medicare laws are generally codified in Title XVIII of the Social Security Act (42 U.S.C. § 1395).
- Provides health care coverage for all Americans age 65 and older—as well as other specified populations—and maintained total enrollment of 50 million beneficiaries in 2011.
- Originally covered inpatient hospital (and other inpatient facility) costs (Part A); and physician services, outpatient services, and supplies costs (Part B).
- Expanded to provide voluntary prescription drug coverage (Part D) under the *Medicare Prescription Drug, Improvements, and Modernization Act (MMA) of 2003.*
- Medicare beneficiaries may elect to enroll in a private Medicare Advantage plan (under "Medicare Part C"), which provides coverage of Part A and Part B—and usually Part D drug coverage—in lieu of traditional Medicare Fee-for-Service.
- Both programs are administered at the federal level by the Centers for Medicare and Medicaid Services (CMS).

Beneficiary Eligibility

- Medicare has three major eligibility categories, with beneficiaries qualifying under age-related eligibility representing the vast majority of the program's 50 million beneficiaries:
  - **Age-Related Eligibility**—all United States citizens and permanent legal residents age 65 and over qualify for Medicare coverage (with the exception of a small number of individuals who paid Medicare payroll taxes for less than 40 calendar quarters during their working years, though these individuals may enroll in Medicare Part A and Part B upon agreeing to pay additional premiums).
    - **Population**—Roughly 43 million Medicare beneficiaries qualified for the benefit through age-related eligibility.
    - **Part B Enrollment**—Although Medicare Part B coverage involves voluntary enrollment, all beneficiaries eligible for Medicare Part A are eligible for Medicare Part B, and roughly 48 million of Medicare's 50 million beneficiaries pay the additional Medicare Part B premium to become enrolled in Medicare Part B.
  - **Disabled Population**—United States citizens and permanent legal residents under age 65 with disabling medical conditions are eligible for Medicare Part A coverage and Medicare Part B enrollment, despite failing to meet the age requirement; regardless of whether they paid Medicare payroll taxes for 40 calendar quarters. These beneficiaries become eligible after receiving disability payments under the Social Security Disability Income (SSDI) benefit for 24 consecutive months.
  - **Special Disease Populations**—United States citizens and permanent legal residents under age 65 with certain serious medical conditions become eligible for Medicare Part A coverage and Part B enrollment immediately upon receiving SSDI payments, without having to wait 24 months—again regardless of whether they paid Medicare payroll taxes for 40 calendar quarters. The two disease populations that meet this special eligibility standard are individuals with: (1) end-stage renal disease (ESRD); or (2) Lou Gehrig's disease.

Beneficiary Options Within The Medicare Program

- Medicare beneficiaries have two major choices regarding their Medicare enrollment:
  - **Medicare FFS or Medicare Advantage**—beneficiaries may choose to enroll in Medicare Fee-for-Service (FFS), which provides beneficiaries with Part A and Part B coverage—where Medicare reimbursement for providers is dictated directly by CMS—*or,* beneficiaries may enroll in Medicare Advantage (MA) plans which pay for all Part A and Part B services, and negotiate provider reimbursement individually. MA plans can often offer coverage of additional services not included under the traditional Medicare FFS benefit and can provide wrap-around coverage that reduces or eliminates Medicare beneficiary cost-sharing; but also can apply provider network restrictions that are not mirrored in Medicare FFS and require plan enrollees to pay additional premiums above the Medicare Part premium rate.
  - **Medicare Part D Coverage**—Medicare coverage of prescription drugs is a voluntary benefit, which requires beneficiaries that choose to enroll in a drug plan to pay additional costs. Outpatient prescription drug benefits are offered through private health plans that are either stand-alone prescription drug plans (PDPs) offered in conjunction with Medicare FFS; or Medicare Advantage prescription drug (MA-PD) plans, offered within, or in conjunction with, an MA plan.

Medicare Part C: Medicare Advantage Benefit

History of Private Plan Participation in Medicare

- **<u>Early Structure</u>**—Beginning with the *Social Security Amendments of 1972*, Congress continued to pass legislation over time that increased the ability for private health plans to enroll Medicare beneficiaries in an alternative to Medicare FFS. Two types of Medicare private plans were authorized in the 1972 legislation:
  - *Medicare Cost Plans*—Government pays the plan for the actual costs incurred in providing Medicare-covered services for beneficiaries, so long as the services furnished were "reasonably necessary."
  - *Medicare Risk-Sharing HMOs*—Medicare pays health maintenance organizations (HMOs) a fixed price per beneficiary, for all services provided to the enrollee for that plan year. If HMO costs for an enrollee were higher than the fixed price, HMO absorbs the difference as a loss; but it the costs were below the fixed price, Medicare and the HMO split the savings evenly. HMOs required to enroll at least 25,000 beneficiaries to be eligible to participate.
- **<u>Intermediate Changes</u>**—From 1972 to 1982, only one HMO elected to contract with Medicare on the risk-sharing basis—and Congress enacted the *Tax Equity and Fiscal Responsibility Act of 1982* (TEFRA) to better encourage risk-based HMO contracts by:
  - (1) Reducing minimum HMO enrollment from 25,000 to 5,000 beneficiaries;
  - (2) Allowing HMOs maintain *all* of the savings below pre-set amount; and
  - (3) Setting the pre-set amount at 95 percent of projected Medicare FFS costs that HMO enrollees would be expected to incur in traditional Medicare, to ensure "savings" relative to Medicare FFS.
- **<u>Enrollment Spike</u>**—Structural incentives worked, and Medicare private plan enrollment tripled, from 1 million enrolled beneficiaries to over 3 million, between 1982 and 1996.

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Continued Development of Medicare Private Plans

- **"Medicare+Choice" Era**—Congress passed the *Balanced Budget Act of 1997* (BBA), and formally established Medicare Part C, with all Medicare HMOs being rolled into the new Medicare+Choice program.
  - *Changes in Capitation Rates*—In Medicare+Choice, pre-set per beneficiary expenditure payment rates for each county based on the highest of: (1) a blended national/local rate; (2) a minimum floor; or (3) a minimum payment rate increase.
  - *New Types of Plans*—BBA authorized participation from: Preferred Provider Organization (PPO) plans; and Private Fee for Service (PFFS) plans that were permitted to charge higher premiums for beneficiaries and were not restricted in the cost-sharing that physicians could charge enrollees, in exchange for fewer restrictions on beneficiary service utilization (e.g. prior authorization).
- **Slow Enrollment Growth Period**—These changes did not spur increased enrollment in Medicare+Choice, as lawmakers and actuaries had expected, with enrollment growing by only 1.5 percent in 1998.
- **MMA Changes to Part C**—Medicare+Choice was renamed the Medicare Advantage (MA) Program under the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA). Allowed beneficiaries may choose from additional plan options, including regional PPO (RPPO) plans and special needs plans (SNPs). MMA further established the Medicare prescription drug benefit (Part D) program, and amended the Part C program to allow (and, for organizations offering coordinated care plans, require) most MA plans to offer prescription drug coverage.

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Medicare Advantage: Benefits and Structure

- **General MA Structure**—Medicare Advantage-participating private health plans pay for all benefits covered under Medicare Part A and Part B (and usually Part D prescription benefits) for beneficiaries opting for private coverage *instead* of Medicare FFS coverage of Part A and Part B benefits.

- **MA Plan Requirements**—CMS contracts with private plans including HMOs and PPOs, which must meet minimum actuarial benefit requirements and network adequacy requirements (essentially requiring beneficiary access levels equivalent to Medicare FFS) in order to offer MA coverage to beneficiaries in particular county or region.

- **Costs for MA Enrollees & Other Benefits**—MA enrollees pay a variety of premiums and co-payment amounts, in a fashion similar to Medicare FFS, to help finance the MA program, and often are offered prescription drug coverage and other benefits in connection with MA plan enrollment:
  - **Premiums & Cost-Sharing**—MA enrollees pay the same monthly Part B premium as Medicare FFS beneficiaries; and often pay an additional premium directly to the health plan. Many MA plans offer reduced cost-sharing, relative to Medicare FFS.
  - **Drug Coverage & Other Benefits**—MA plans are not required to offer prescription drug coverage pursuant to Part D—but 85 percent of MA plans do. Some MA plans offer non-covered FFS benefits including wellness programs and financial assistance for fitness center memberships.

MA Plan Bidding and Payments

- **MA Plan Bidding**—CMS pays MA plans based on a competitive bidding process, where plan submits bids that estimate their costs per-enrollee—on a risk-adjusted basis—for services covered under Part A and Part B.
  - If plans bid higher than the county-level benchmark, enrollees are required to pay the difference through heightened premiums.
  - Plans that bid lower than the county-level benchmark are awarded 75 percent of the difference to pass along to plan enrollees in form of extra benefits/reduced premiums or cost-sharing—with CMS retaining the remaining 25 percent of the difference.
- **Changes to MA Bidding Structure**—Beginning in 2011, MA's county and regional benchmarks will gradually be aligned with risk-adjusted Medicare FFS costs for beneficiaries in the particular bidding area—so that by 2017, average MA benchmarks will equal 101 percent of Medicare FFS costs per-beneficiary nationally.
  - MA benchmarks in high-cost areas pegged at 95 percent of Medicare FFS, and benchmarks in low cost areas set at 115 percent of FFS.
  - Change amounts to significant reduction in MA benchmarks, which averaged 112 percent of Medicare FFS costs in 2010.
  - Starting in 2011, MA plans achieving quality "star ratings" of 4 stars or more, out 5 stars, were to receive bonus payments, under new MA Star Quality Bonus program established by Affordable Care Act.
  - However, under the CMS "demonstration," all MA plans that receive 3 stars or more in the star rating quality measurement system receive bonus payments for 2012 through 2014.

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New Medicare Delivery Models & Medicare Reform Proposals

Impact of New Delivery Models on Private Plans

- **Accountable Care Organizations**—section 3022 of the Affordable Care Act (ACA) establishes a Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs). Under the program, CMS allows integrated provider groups to share a percentage of savings (below a set, risk-adjusted per-beneficiary expenditure benchmark) generated through care coordination and elimination of duplicative services.
  - Final Rule implementing the MSSP for ACOs required all ACOs to eventually assume "downside risk" for a percentage of expenditures exceeding benchmarks—and a total of 115 ACOs are enrolled in the MSSP for 2013.
  - Requiring providers to assume financial risk for the costs of care that exceed pre-set budget target borrows heavily from capitated payment structures originally developed by private managed care plans—except CMS, rather than private payers, are directly administering the shared financial responsibility arrangement.
  - Role of private plans in the developing Medicare ACO space remains unclear—but increased hospital and physician practice consolidation resulting from ACO formation is expected to have detrimental affect on private insurers' ability to negotiate competitive provider payment rates for both MA plan and employer-sponsored group plan networks.
- **Comprehensive Primary Care Initiative**—beginning this fall, CMS will provide per-beneficiary-per-month (PBPM) care management fee (in addition to ordinary Medicare Physician Fee Schedule) ranging from $8 to $40 PBPM to the selected primary care practices (PCPs). Tested in seven regions for 4-year period.
  - In years 2-4 of the initiative, the PCPs have potential to share in any savings to the Medicare program.
  - PCPs also receive per-patient-per-month fees from other payers participating in the initiative, including private insurance companies and other health plans.

Ryan-Wyden Premium Support Proposal

- **Premium Support Overview**—Both the Fiscal Year (FY) 2012 and FY 2013 House-passed budget resolutions included provisions calling for a gradual conversion of the traditional Medicare Fee-for-Service (FFS) benefit into a premium support option.
  - Medicare FFS competes with private health plans in a competitive bidding regime, with the second lowest cost bid setting the benchmark of the premium support subsidy.
  - Each Medicare beneficiary (enrolled after 2023) would receive premium support subsidy, equal to the benchmark, that must be used to purchase health coverage from a private health plan offering Medicare benefits on a "Medicare Exchange," or pay for Medicare FFS costs, if they choose to remain in Medicare FFS.
  - Benefit package offered by private plans on the Medicare Exchange would need to be actuarially equivalent to the traditional Medicare FFS benefit.
  - The maximum annual growth rate for premium subsidies, regardless of plan bids, would be capped at the growth rate in gross domestic product (GDP) plus 0.5 percent [the addition of this budget cap caused chief co-sponsor Senator Ron Wyden (D-OR) to withdraw his support for Rep. Paul Ryan's Medicare Premium Support proposal].
- **Political Future for Premium Support**—While House Republicans have passed two budgets that would require the establishment of Premium Support, the Democrat-controlled Senate has defeated the measure each year, with convincing vote tallies: 57-40 (2011), and 58-41 (2012).
  - President Obama opposed on the grounds that the budget cap on premium subsidy growth will result in a shift of the cost-burden for Medicare coverage, with beneficiaries making up the difference between the capped premium subsidy level and the actual cost of coverage in the form of higher out-of-pocket costs.
  - Mitt Romney has endorsed Premium Support plan, and the proposal would have a more likely chance of being adopted under a Romney Administration.

Questions?