Fact Sheet

How Health Reform Adjusts Medicare Advantage Payments and Rewards Quality of Care

Recent health care reform legislation will increase the availability of health insurance, affect the delivery of health care, and strengthen and improve the Medicare program. This Fact Sheet looks at its effects on Medicare Advantage.

Health care reform legislation made significant changes to the way Medicare pays Medicare Advantage (MA) plans. These changes are intended to address flaws in the current payment approach that result in excess payments to MA plans compared to the traditional Medicare program, geographic disparities in payment, and lack of incentives to provide high-quality care.

MA payment changes will result in significant savings to the federal government that can be used for other priorities such as improving prescription drug benefits and preventive care for all Medicare beneficiaries.

- The Congressional Budget Office (CBO) estimates that federal spending for MA will be reduced by $135 billion between 2010 and 2019.
- CBO also projects that over this period, there will be 4.8 million fewer MA enrollees than there would have been under current law. More than half of the decrease will likely occur in plans located in high-cost areas such as Miami and Los Angeles.

MA payments will gradually move closer to fee-for-service Medicare payments. Geographic location and quality will affect payment.

- In 2011, the benchmarks upon which payments are based will be frozen at 2010 levels. In 2012, new benchmarks will be phased in; they will be set to different percentages of fee-for-service spending rates and will range from 95 percent of Medicare fee-for-service spending in higher cost areas to 115 percent in low-cost areas.
- How plans will respond to these changes will depend on their location and level of quality. Plans in urban areas, where Medicare fee-for-service spending is higher, will likely see the greatest payment reductions. Higher quality plans will be eligible for higher payments.

Plans that provide high-quality care will be eligible for bonuses if they achieve at least four stars in a five-star evaluation system.

- Starting in 2012, plans that qualify for a quality bonus will receive higher payments. High-quality plans in certain locations (generally, low-payment urban areas) will be eligible to have their bonuses doubled.
- Newer and low-enrollment plans will also qualify for bonuses, but at lower rates.

Extra MA benefits will likely be reduced.

- Extra benefits (or "beneficiary rebates"), such as dental services or vision care, or reduced cost sharing, will likely be reduced because the amount of money available to provide such benefits is reduced. In 2014, when the new rebate amounts are fully

phased in, plans will have between 50 and 70 percent of the difference between their bids and county benchmarks to spend on extra benefits.

- Plans operating efficiently compared with the Medicare fee-for-service program in their areas, and those providing high-quality care, will have more money available for extra benefits. These changes are designed to encourage beneficiaries to choose high-performing plans.

Cost-sharing charges for specified services will be pegged to Medicare limits.

- Starting in 2011, MA plans will not be allowed to impose higher cost-sharing charges than prevail in traditional Medicare for chemotherapy administration services, renal dialysis services, skilled nursing care, and other services that the secretary of Health and Human Services (HHS) decides require a high level of predictability and transparency for beneficiaries.

Amount allowed to be spent on administrative expenses will be limited.

- Starting in 2014, plans must spend at least 85 percent of revenues from premiums on medical benefits or activities that improve quality.
- If a plan fails to meet the required target for medical spending for three consecutive years, the secretary of HHS will suspend new enrollment in the plan for one year. If such failure persists for five years, the plan's Medicare contract will be terminated.

Adjustments to MA payments for coding practices related to enrollee health status could affect level of MA payments.

- Even after controlling for patient characteristics, the risk scores used to adjust MA plan payments to reflect their enrollee health status are higher for beneficiaries in MA than those in fee-for-service Medicare and have resulted in higher MA payments.
- Because Medicare analysts assume that the higher risk scores reflect differences in coding behavior between MA and providers in the traditional Medicare program and not differences in the health status of the two groups of beneficiaries, the secretary of HHS will be able to make adjustments to account for coding differences.

MA enrollees will be able to switch plans at newly specified times.

- Starting in 2011, MA enrollees will be allowed to switch to the traditional Medicare program during the first 45 days of a calendar year. Under current law, they may switch during the first three months of the year.
- Starting in 2012, the annual, coordinated election period (i.e., the open season period) will be October 15 through December 7. (It is currently November 15 through December 31.) During this time, beneficiaries may switch to another MA plan or traditional Medicare, or to another Part D plan.

Special Needs Plans are extended through 2013.

- Starting in 2012, Special Needs Plans must be certified by the National Committee for Quality Assurance and must meet standards promulgated by the secretary of HHS.

Fact Sheet 181, April, 2010

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