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Healthcare Reform Law Cuts Medicare Advantage Payments and (Mostly) Increases Prescription Drug Program Payments

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The Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010 (Healthcare Reform Law) makes substantial changes to the Medicare Part C Medicare Advantage (MA) and Medicare Part D prescription drug programs. According to the Congressional Budget Office (CBO) combined scoring estimate, the MA payment changes in the Healthcare Reform Law will result in an approximately $135 billion reduction in direct federal spending over the next 10 years, one of the largest spending reduction line items in the Healthcare Reform Law. On the other hand, the Healthcare Reform Law increases subsidies and benefits for the Medicare drug benefit—approximately $44 billion over the next 10 years. While increasing overall expenditures, the Healthcare Reform Law also cuts approximately $16 billion from the Part D program, primarily by reducing Part D premium subsidies for high-income beneficiaries. Companies that offer MA and Part D plans and pharmaceutical manufacturers will be the most directly affected by these changes.

Changes to the Medicare Advantage Program

According to a recent Medicare Payment Advisory Commission (MedPAC) report, in 2009 the Medicare program spent roughly $14 billion more for beneficiaries enrolled in MA plans than for beneficiaries in the Medicare fee-for-service (FFS) program (Parts A and B).[1] This difference in spending was often cited in the policy discussions leading up to the passage of the Healthcare Reform Law as the reason for the MA payment reductions. To bring MA spending in line with FFS costs, the Healthcare Reform Law will phase in a new payment methodology tied to a percentage of Medicare FFS costs. However, the new methodology also builds in a number of incentive payments that, in effect, will likely act to reduce the rate of reduction in payment to MA plans that achieve the quality goals. In some instances, these incentive payments may actually result in an increase in payments to an MA plan.

New Benchmark Methodology

The Healthcare Reform Law establishes a new MA benchmark rate methodology that is pegged to a fixed percentage of the Medicare FFS costs for the MA plan's payment area. To determine the applicable percentage, each MA payment area (i.e., county) will be ranked based on its Medicare FFS costs and will be grouped into four quartiles ranging from 95% for areas that are ranked as high FFS cost areas to 115% for low FFS cost areas. This new methodology will be phased in using a three-tiered

[1] MedPAC, Medicare Payment Policy, Report to Congress, p. 260 (Mar. 2010).

approach, beginning in contract year (CY) 2011, with the full methodology in effect for CY 2017 and subsequent years.

For all MA plans, payments for CY 2011 will be frozen at the CY 2010 levels. Thereafter, the new methodology will be phased in over a three-year period for most MA plan payment areas. For MA plans in payment areas where the difference between the current CY 2010 payment rate and the CY 2010 projected benchmark rate (calculated under the new methodology) is $30 or more, the phase-in will occur over a four-year period. In those payment areas where the difference is $50 or more, it will occur over a six-year period. All MA plans will be paid under the new methodology beginning in CY 2017.

Percentage Increases for Quality

Despite the overall reduction in MA payments, the Healthcare Reform Law builds bonuses into the new payment methodology for MA plans that achieve four stars or higher under the MA plan five-star quality rating system currently used by the Centers for Medicare & Medicaid Services (CMS). These bonuses will be awarded in the form of a five-percentage-point increase in the applicable percentage of Medicare FFS costs for the MA plan's payment area, beginning in CY 2014 (with lower percentage increases available for CY 2012 and CY 2013). Further, qualifying MA plans that are located in counties meeting certain criteria may be eligible for a double increase in the bonus percentage points. For MA plans that qualify, these quality bonus percentage increases would mean a slower rate of reduction in payments. For some MA plans, this could mean an increase in overall payments.

Rebate Reductions

The bonus percentage increases, however, will be offset by reductions in the rebate percentages for MA plans whose bids are below the payment area benchmark. The Healthcare Reform Law also builds in quality incentives in the rebate reduction based on the five-star quality rating system. The Healthcare Reform Law phases in the rebate reductions beginning in CY 2012 so that by CY 2014 the rebate percentage will be reduced from the current 75% level as follows: for MA plans that do not qualify for quality bonuses, the rebate will be reduced to 50%; for MA plans that receive a quality rating of at least 3.5 stars but less than 4.5 stars, the rebate percentage will be 65%; and for MA plans with at least a 4.5-star rating, the rebate percentage will be reduced to 70%.

In addition to the percentage reduction in the rebates, the Healthcare Reform Law requires that any rebates received by an MA plan must first be used to "meaningfully reduce" cost sharing otherwise applicable for benefits under the Medicare FFS program, then to provide coverage of preventive and wellness healthcare benefits (as defined by the Secretary of Health and Human Services (Secretary)) that are not benefits under the Medicare FFS program, and finally to "meaningfully provide" coverage of other healthcare benefits that are not benefits under the original Medicare FFS program, such as eye examinations and dental coverage. These provisions are effective beginning with CY 2012.

Medical Loss Ratio

In addition to the new payment methodology, the Healthcare Reform Law also implements a medical loss ratio (MLR) requirement for MA plans of at least 85%, beginning in CY 2014. MA plans that fail to meet this requirement will be required to rebate to CMS the percentage of the MA plan's MA revenue equal to the difference between 85% and the MA plan's actual MLR, which could mean further reductions in MA plan payment. Furthermore, MA plans that do not meet the 85% MLR requirement for three consecutive years will not be permitted to accept new enrollees in the subsequent year. The

Healthcare Reform Law also requires that CMS terminate MA plans that do not meet the 85% MLR requirement for five consecutive years.

Cost-Sharing Limitations and Annual Election and Open Enrollment Periods

The Healthcare Reform Law restricts MA plans' ability to impose enrollee cost sharing for certain services above the cost sharing required for those services under the Medicare FFS program. Those services include chemotherapy administration services, renal dialysis services, skilled nursing care, and such other services that the Secretary determines appropriate, "including services that the Secretary determines require a high level of predictability and transparency for beneficiaries." Since many of these services are costly, they could result in further increases in MA plan costs, to the extent an MA plan currently has in place higher cost-sharing requirements for those services. This provision is effective beginning with CY 2011.

The Healthcare Reform Law also reduces the open-enrollment period for enrollees to the first 45 days of the year beginning in CY 2011 (instead of the current three-month period). MA plan enrollees' choice will be limited to the Medicare FFS program; they will no longer be allowed to change their election to another MA plan. The Healthcare Reform Law also shortens the annual coordinated election period by approximately three weeks. Beginning in 2012, the annual coordinated election period will be between October 15 and December 7.

Special Needs Plan Extension

The Healthcare Reform Law extends the authorization for special needs plans (SNPs) to 2014. The Healthcare Reform Law provides the Secretary with the authority to adjust payments to SNPs to reflect the costs of treating high concentrations of frail individuals. Additionally, for CY 2012 and subsequent years, all SNPs must be accredited by the National Committee for Quality Assurance (NCQA) based on standards established by the Secretary.

Secretary's Authority to Deny Bids

As an additional cost-cutting measure, the Healthcare Reform Law grants the Secretary the specific authority to deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost-sharing or decreases in benefits offered under the plan. This authority also applies to bids submitted by Medicare Part D prescription drug plans (PDPs).

Part D Prescription Drug Program

Unlike the MA program, the Healthcare Reform Law does not provide for significant cuts in payments to PDPs under the Part D program, although PDPs will have to collect increased premium amounts from certain high-income beneficiaries. The Healthcare Reform Law also provides for a reduction in beneficiary cost-sharing responsibilities.

Closing the "Donut Hole"

The Healthcare Reform Law provides for a phased-in reduction of the gap between the initial coverage limit and the catastrophic coverage threshold under the Part D program, i.e., the "donut hole." The Healthcare Reform Law provides for some immediate benefits. As a one-time benefit, Medicare beneficiaries whose covered Part D drug spending reaches the donut hole in 2010 (between $2,830 and $4,550) will receive a $250 rebate.

Beginning in 2011, the Healthcare Reform Law begins closing the donut hole by reducing beneficiary cost sharing for generic drugs by 7% each year through 2019. Beginning in 2020, the generic drug subsidy for beneficiaries who reach the donut hole will be 75%. Beginning in 2013, the Healthcare Reform Law also phases in a subsidy for brand-name drugs for beneficiaries who reach the donut hole.

Medicare Prescription Drug Coverage Gap Discount Program

In addition to the donut-hole reduction, the Healthcare Reform Law requires the Secretary to establish a program for Medicare Part D beneficiaries to receive a 50% discount on brand-name drugs for beneficiaries who reach the donut hole beginning in 2011, thus further reducing a beneficiary's donut-hole expenditures. To implement the discount program, the Healthcare Reform Law requires the Secretary to enter into agreements with pharmaceutical manufacturers to provide beneficiaries with access to discounted prices for covered drugs. To ensure manufacturer participation, the Healthcare Reform Law conditions coverage of the manufacturers' drugs under the Part D program on the manufacturers' participation in the discount program.

Limited-Time Reduction in Growth of Catastrophic Coverage Threshold

The Healthcare Reform Law also provides for a temporary reduction in the growth rate of the catastrophic coverage threshold, i.e., the upper limit of the donut hole. This reduction will be in effect from 2014 through 2019. In 2020, the growth rate will be calculated as if the Healthcare Reform Law had never been enacted.

Subsidy Changes for High- and Low-Income Beneficiaries

In the cost-cutting category, the Healthcare Reform Law implements a further 25% reduction in the premium subsidy for high-income earners (as defined under current law) beginning in CY 2011. However, at the other end of the income spectrum, the Healthcare Reform Law eliminates coinsurance for full-benefit dual-eligible individuals who are receiving services under a Medicaid home- and community-based waiver program. However, this provision cannot go into effect any earlier than CY 2012.

Formulary Changes

In the category of substantive benefit changes, the Healthcare Reform Law requires Part D sponsors to offer PDPs that include all covered Part D drugs in certain categories and classes identified by the Secretary. The Healthcare Reform Law leaves it up to the Secretary to establish the criteria for determining the categories and classes of drugs to be included in the formulary. However, until such time as the Secretary establishes such criteria, the Healthcare Reform Law specifies the categories and classes to be included in the formulary, which include anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppresants for the treatment of transplant rejection. This requirement goes into effect for CY 2011.

Fraud and Abuse Enforcement

In addition to these benefit and payment changes, the Healthcare Reform Law also provides for increased enforcement of fraud and abuse in the MA and Part D programs. Notably, the Healthcare Reform Law provides for increased obligations concerning overpayment refunds, expansion of recovery audit contractor (RAC) activities to the MA and Part D programs, and establishment of civil monetary

penalties and sanctions (including exclusion) against MA plans and PDPs for false statements or misrepresentation of material facts in any application, bid, agreement, or contract to participate in the MA or Part D programs. A summary of the Healthcare Reform Law's fraud and abuse and program integrity provisions is available at http://www.morganlewis.com/pubs/WashGRPP_PrgmIntegrityProvisions_LF_31mar10.pdf.

Morgan Lewis's FDA and Healthcare Practice has counseled organizations offering MA plans and Part D PDPs on compliance with the Medicare Part C and Part D requirements. We will continue to monitor implementation of the Healthcare Reform Law requirements relating to Medicare Part C and Part D, including the upcoming issuance of the final Medicare Advantage and Part D revised regulations (proposed by CMS in the October 22, 2009 *Federal Register* at 74 Fed. Reg. 54,634) and the final 2011 Medicare Advantage and Part D Call Letter.

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