Insight

Medicare Advantage Cuts in the Affordable Care Act: March 2013 Update

ROBERT BOOK | MARCH 7, 2013

The Centers for Medicare and Medicaid Services (CMS) recently announced proposed rules that would cut payments to Medicare Advantage (MA) Plans beginning in 2014. Assuming that the announced reductions go into effect, these will increase the already-scheduled cuts legislated in the Affordable Care Act (ACA) and American Taxpayer Relief Act (ATRA) and worsen their expected impact on MA plans, benefits, and enrollment. Accounting for all currently projected cuts, an updated analysis indicates a national average MA enrollment drop of 11 percent, and an average benefit value loss of $2,235 per beneficiary.

MA Payment Changes in the ACA

The ACA cuts to Medicare total $716 billion between 2013 and 2022. *A large portion of the cuts come about through changes to the payment formulas for the MA program, in which beneficiaries use their Medicare dollars to choose a privately-run health plan that best meets their needs.*
MA payments are tied to a "benchmark" monthly payment set individually for each county (or county-like jurisdiction) in the United States. Companies or organizations seeking to run an MA plan submit a "bid" for each county. For any particular plan, if the bid is less than the benchmark the difference is shared between the Medicare program and the beneficiaries; if the bid exceeds the benchmark, a beneficiary who selects that plan pays the difference. For each beneficiary, Medicare pays the plan the benchmark amount, adjusted for cost risk based on the health status of the beneficiary.

The ACA made several changes to the calculation of the benchmark for each county:

- *Benchmarks are now specifically tied to average spending in the fee-for-service (FFS) program in every county, with a percentage of FFS spending based on the quartile rank of each county.*
- *Changes to the FFS program will result in lower FFS payments, which will be passed through to the MA program and will result in lower MA benchmarks.*
- *A bonus system is established based on a plan's "star rating" on a five-star scale using CMS criteria; this rating system, originally developed only to assist beneficiaries in selecting a plan, is now being used to determine payment.*[ii]
- *The bonus will be doubled in certain "qualifying counties" based on demographic data.*

Based on the above changes, and on the CBO's estimates of spending cuts, we produced estimates of payment reductions by state and county.[iii] *Based on the CMS Office of the Actuary's estimates of the resulting enrollment reductions, we also estimated the reductions in enrollment by state and county, and the average reduction in available plan choices by state.*[iv] *In particular, we note that these legislative changes have the effect of reducing the benchmark in every county, without exception, even after taking into account the new bonuses.*

CMS Rule for Additional Payment Cut

In February 2013 CMS issued an "Advance Notice of Methodological Changes"[v] which includes, based on CMS regulatory authority, another factor that will reduce payments.

- *An adjustment to the calculation of health status cost risk based on each beneficiary's diagnosis codes will reduce the positive adjustments for high-risk patients and increase the negative adjustments for low-risk patients.*

This is known as the "coding intensity change." On average, MA enrollees have historically had more costly average health status than FFS beneficiaries; CMS argues that this is due not to MA enrollees being sicker, but rather the fact the MA providers have a greater incentive to record diagnosis codes. They argue that this is due to the fact that MA plans are paid based on diagnosis codes, not procedures and for FFS providers, the opposite is the case.

Giese and Carlson[vi] calculate, based on the CMS notice, that the overall average effect of the coding intensity change will be a 1.5 percent reduction in benchmarks.

Giese and Carlson also estimate the impact of another provision of the ACA that is not part of MA reform, but will undoubtedly affect MA plans as well. The ACA imposes an "annual fee" tax on health insurance. Unlike most excise taxes, the tax is not a set rate, but a fixed annual dollar amount that will be "allocated" to most health insurers according to a formula based on their market share of total premiums. The fixed amount will be $8 billion and increases to $14.3 billion in 2018 and indexed for premium growth thereafter. The tax will apply to MA plans on the same basis as other private insurers, except that non-profit organizations with at least 80 percent of their gross revenue from MA plans (or other government programs for the low-income, elderly, or disabled) are exempt from the tax.[vii]

Giese and Carlson point out that a tax on premiums is equivalent, in the case of Medicare Advantage, to a reduction in the benchmark. They estimate that the effect will be between 1.9 percent and 2.3 percent of average benchmarks.

Current State-by-State Analysis

We have updated our estimates of the state-by-state distribution of MA cuts, taking into account the statutory changes previously modeled, as well as the recently-announced coding intensity adjustment, and Giese and Carlson's estimate of the impact of the premium tax (see Figure 1 and Table 1).[viii]

Figure 1: ACA Medicare Advantage Cuts Per Beneficiary, 2014