New York's Medicare Marketplace:

Examining New York's Medicare Advantage Plan Landscape in Light of Payment Reform

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Abstract

The Patient Protection and Affordable Care Act (ACA) provided for cost savings in the Medicare program, in part to underwrite coverage expansion to Medicare beneficiaries, to finance new coverage for those not eligible for Medicare and to strengthen Medicare's financial outlook. One cost-saving measure, a reformulation and reduction in payments to private health insurance plans that provide Medicare benefits through the Medicare Advantage (MA) program, had a sound policy basis but was criticized, particularly by opponents of the ACA, as a measure that would lead to increased costs, reductions in benefits and diminished plan choices to Medicare beneficiaries enrolled in MA plans. Despite dire predictions to this effect, a review of a sample of MA plan offerings in New York State in 2012 shows that Medicare beneficiaries enrolled in such plans did not experience significant benefit reductions or increased costs. While the number of plan offerings decreased, the reduction was mostly due to the elimination of duplicative plan choices in 2011.

Although the MA plan executives we interviewed indicated that further reductions in plan reimbursement in future years—tempered by potential bonus payments for meeting quality and performance metrics—could impact plan costs and benefits, they believed plans will employ a number of strategies to remain in the market and maintain beneficiary benefits and cost structures. However, government regulators and consumer advocates will need to examine MA plan offerings in the coming years to determine the effect of plan reaction to the ACA payments on beneficiaries' costs for coverage and access to care.

Background

The Patient Protection and Affordable Care Act (ACA) of 2010 set in motion a number of significant changes to health care and health insurance programs in the United States, including the Medicare program.[1] The changes to Medicare fall into three primary categories: 1) expansion of coverage for prescription drugs and preventive care, 2) cost-saving mechanisms to finance that coverage expansion and 3) new coverage for those not eligible for Medicare.[2] While cost savings to achieve these measures were produced in large part through curtailing future growth of reimbursement rates to health care providers such as hospitals, nursing homes and home health

[1] *See generally,* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 (2010) (*hereafter ACA*).
[2] These initiatives include increasing the number and scope of Medicare-covered preventive services, enacting delivery system reforms aimed at lowering the cost of health care and gradually closing the insurance coverage gap—or doughnut hole—that exists in the Medicare prescription drug program.

agencies,[3] the ACA also provided for significant reductions in payments to private health insurance plans that administer Medicare benefits through the MA program.

The reductions to MA plan reimbursement drew concerns from health insurance companies and Medicare beneficiaries, as well as dire predictions from opponents of the ACA, that MA plans would reduce benefits, increase premiums and cost-sharing and even eliminate some or all of their Medicare insurance offerings.[4,5] While MA plan enrollment varies across the country, such changes could have had a substantial effect on people with Medicare in MA plans, particularly in those regions where there is relatively high enrollment in MA plans, such as New York State.[6]

Nationally, roughly one in four Medicare beneficiaries is enrolled in an MA plan.[7] New York is one of 13 states where the MA penetration rate exceeds 30 percent.[8] Moreover, New York has a high total number of MA enrollees: over 900,000 New Yorkers are enrolled in MA plans, more than in any other state except Florida and California.[9] The urban counties of Queens, Kings and Erie each have approximately 100,000 plan enrollees and account for nearly one-third of the State's entire MA plan population.[10] In counties like Livingston and Genesee, more than 50 percent of Medicare-eligible beneficiaries are enrolled in MA plans. Breakdowns of the penetration rates and number of MA plan enrollees are detailed below in Tables 1 and 2: 'New York counties with the highest number of MA enrollees' and 'New York counties with the highest and lowest MA plan penetration rates.'

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[3] *Strengthening Medicare: Better Health, Better Care, Lower Cost,* CMS, available at: http://www.cms.gov/apps/files/medicare-savings-report.pdf. Payment rate reform is expected to save $55 billion in the Medicare program by 2015, and savings from reductions in payments to Medicare Advantage plans during that same time period will generate an estimated $50 billion.

[4] *See e.g.,* Statement for the Record to the Committee on Ways and Means, America's Health Insurance Plans, Thursday, February 10, 2011.

[5] Book, Robert and James Carpetta, *Reductions in Medicare Advantage Payments: The Impact on Seniors by Region,* The Heritage Foundation, September 14, 2010.

[6] Whelan, David, "Why ObamaCare Will Raise Your Bill," *Forbes Magazine Online,* available at: http://www.forbes.com/2010/01/16/obamacare-health-reform-lifestyle-health-health-care-insurance-premiums.html

[7] Cassidy, Amanda, Robert Berenson, Marsha Gold, Jeff Lemieux, Ted Agres and Susan Dentzer, *Health Policy Brief: Medicare Advantage Plans*, Health Affairs, June 15, 2011 (*hereafter* Cassidy, *Health Policy Brief*).

[8] *Id.*

[9] Kaiser Family Foundation, Statehealthfacts.org, available at: http://www.statehealthfacts.org/comparetable.jsp?ind=327&cat=6, last accessed February 6, 2012.

[10] www.cms.gov, March 2012 MA State/County penetration.

Table 1: New York Counties with the Highest Number of MA Enrollees		
New York counties with the highest number of MA plan enrollees	**Total number of MA plan enrollees**	**Percentage of Medicare-eligible beneficiaries enrolled in MA plans**
Queens	116,273	38%
Kings	112,581	35%
Erie	94,991	54%
Monroe	80,980	62%
Bronx	79,137	46%

Table 2: New York Counties with the Highest and Lowest MA Plan Penetration Rates		
New York counties with the highest and lowest rate of MA plan penetration	**Percentage of Medicare-eligible beneficiaries enrolled in MA plans**	**Total number of MA plan enrollees[11]**
Highest penetration		
Monroe	62%	80,980
Livingston	57%	6,271
Erie	54%	94,991
Ontario	54%	11,120
Genesee	53%	6,027
Lowest penetration		
Sullivan	8%	1,206
Orleans	13%	6,618
Essex	13%	1,030
Clinton	14%	2,171
Dutchess	15%	7,400

Given New York's higher-than-average MA enrollment penetration rate and high total number of enrollees, New York policymakers, plans, providers, beneficiaries and consumer advocates all have an interest in understanding the implications and impact of the ACA-mandated MA payment reforms on the MA plan landscape. It is particularly important to understand potential impact given that beneficiaries in particular regions of the state could be disproportionately affected by higher costs, decreased benefits and fewer MA plans in the market.

[11] Figures taken from 2012 County penetration data available at: www.cms.gov, March 2012 MA State/County penetration.

History of payment and enrollment in the Medicare Advantage program

Medicare Advantage is the latest iteration of a program that allows Medicare beneficiaries to receive their Medicare benefits through private insurance plans.[12] These plans are required to cover all of the same benefits and services as Original Medicare, the fee-for-service program administered by the federal government (Medicare FFS).[13] In addition, MA plans may offer other services and supports; in fact, certain monies paid to MA plans must be reinvested to provide supplemental benefits.[14] Since 1972, Medicare has been permitted to contract with managed care plans, including MA plans, to administer Medicare benefits, but managed care's financing and enrollment has changed considerably over time.

Until 1982 and the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA), enrollment in private Medicare managed care plans remained low.[15] TEFRA gave managed care plans the opportunity to provide additional benefits and reduced cost-sharing to attract beneficiaries.[16] Moreover, it attempted to generate savings for the Medicare program by paying private plans 95 percent of the estimated cost of treating an average beneficiary in Medicare FFS.[17] As more insurers offered managed care plans with additional benefits, more beneficiaries entered plans, and enrollment grew to approximately six million beneficiaries by 1997, nearly 16 percent of the Medicare population.[18]

The Balanced Budget Act of 1997 (BBA) made additional programmatic changes to Medicare managed care, changing the name of the program to Medicare Plus Choice (M + C) and allowing private insurers to offer additional coverage options besides the traditional Health Maintenance Organization (HMO), including Preferred Provider Organizations (PPOs), private fee-for-service plans (PPFSs) and medical savings accounts (MSAs).[19] In addition to expanding the variety of plan options, the BBA changed the plan payment system, allowing for risk-adjusted payment rates based on a beneficiary's health and setting payment floors for counties with lower beneficiary costs. These changes resulted in some insurers leaving the market: between 1998 and 2003,

[12] Although the Medicare Advantage program includes a range of health plan options, including private fee-for-service plans, which are more like fee-for-service Medicare, the plans examined in this report are HMOs and PPOs—managed care models rather than a fee-for-service model.
[13] Medicare Managed Care Manual, Chapter 4 Benefits and Beneficiary Protections, Section 10.2.
[14] *Id. At* Section 30.
[15] McDowell, Audrey and Steven Sheingold, *Payment for Medicare Advantage Plans,* Office of Health Policy, US Department of Health and Human Services, June 2009 (*hereafter* McDowell, *Payment for MA Plans*).
[16] *Id.*
[17] *Id.*
[18] *Medicare + Choice Fact Sheet,* Kaiser Family Foundation, April 2003, available at: http://www.kff.org/medicare/upload/Medicare-Choice-Fact-Sheet-Fact-Sheet.pdf.
[19] *See*, The Balanced Budget Act of 1997, Section 1851, Pub. L. No. 105-33 (1997).

the number of plan options declined from 346 to 148, and private plan enrollment decreased.[20] These changes resulted, in part, from the fact that the BBA's payment mechanism lowered plan payment rates in areas where Medicare FFS spending was high and increased plan payment rates in areas where FFS spending was low.[21] Ironically, this policy made it more difficult for insurers to serve areas where they would be most effective in negotiating provider discounts and providing health services to beneficiaries more efficiently than Medicare FFS.[22] Consequently, plans exited the Medicare market, and beneficiaries were left with fewer choices. By 2003, enrollment had fallen by nearly one million beneficiaries, with only approximately 12.2 percent of Medicare beneficiaries enrolled in a private Medicare plan.[23]

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was enacted in part to reverse this decline in private health plan enrollment. To achieve this end, the MMA created the Medicare Advantage program to succeed M + C, offering financial relief to MA plans by imposing a minimum per beneficiary payment, blending the benchmark calculation amount between national averages and county-specific costs and providing a minimum 2 percent increase from the previous year's payment rate.[24,25] The MMA also restructured the way in which MA plans are paid, by implementing a competitive bidding process.[26] Since the MMA was enacted, enrollment in Medicare managed care has grown from 5.1 million beneficiaries in 2003 to 11.5 million in 2011, with the Medicare private insurance penetration rate growing from 12.2 percent to 24.3 percent—nearly doubling over the course of eight years.[27]

Under the MMA, the plan bidding process began when MA plans submitted proposals to the Centers for Medicare & Medicaid Services (CMS), estimating anticipated costs per enrollee for Medicare-covered services.[28] CMS would compare these bids against a benchmark amount—the maximum amount the government would pay a plan to administer Medicare in a particular region.[29] The benchmark is a bidding target for MA plans. If a plan's bid exceeded the benchmark, the cost was absorbed by plan enrollees who paid the difference in the form of a monthly premium. Under the MMA, if the bid fell

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[20] *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission, March 2003 (*hereafter 2003 MedPAC Report*).
[21] *Id.*
[22] *Id.*
[23] McDowell, *Payment for MA Plans.*
[24] *See generally,* The Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, (2003); *see also,* Achman, Lori and Marsha Gold, *Medicare Advantage 2004 Payment Increase Resulting from the Medicare Modernization Act,* Mathematica Policy Research, February 2004.
[25] *Id.* Congress authorized a 6.3 percent payment update for 2004.
[26] *Id.*
[27] Cosgrove, James, *Medicare Advantage: Enrollment Increased from 2010 to 2011 while Premiums Decreased and Benefit Packages were Stable,* US Government Accountability Office (GAO), October 2011.
[28] 42 USC Section 1395w-23.
[29] *Id.* At Section 1395w-23(a)(1)(B).

below the benchmark, the plan received 75 percent of the difference and Medicare retained the other 25 percent.[30]

These rebates were intended to lower beneficiary cost-sharing, provide additional benefits not covered by Original Medicare and lower premiums.[31] However, while many beneficiaries in MA plans reaped the benefits of increased federal reimbursement to these plans, the federal government and beneficiaries in Medicare FFS paid the price. Specifically, the MA program, initially designed to provide the federal government an average 5 percent discount for each beneficiary enrolled, cost 9 to 13 percent more per beneficiary than Original Medicare.[32] These higher payments had negative consequences for the federal budget, pulled additional dollars from the Medicare Part A Trust Fund and raised the cost of the monthly Part B premium paid by all Medicare beneficiaries.[33]

The ACA-revised benchmark amounts and quality incentives

To address the overpayments to MA plans, the ACA reformed the MA bidding and payment process by revising MA plan benchmarks and incorporating quality measures into plan payments. These payment changes are being phased in over a number of years; the changes started in 2010 and will continue through 2019.[34] The Congressional Budget Office (CBO) estimates that over this period, MA plan payments will be reduced by $136 billion.[35]

The ACA moves the benchmark amounts closer to the average costs by county of Original Medicare. The counties in the top quartile of Original Medicare spending will have benchmarks set at 95 percent of Original Medicare costs, while counties in the bottom quartile of Original Medicare spending will have benchmarks set at 115 percent of Original Medicare costs.[36] These rates do not include quality bonus payments, which are discussed in greater detail below. How quickly these new benchmarks will be achieved will depend on the size and rate of the payment decrease. Starting in 2012, counties with relatively low payment decreases will have the new benchmark phased in within two years, and counties with larger payment decreases will have the new

[30] *Id. At* Section 1395w-23(a)(1)(E).
[31] *Id. At Section* 1395w-23(b)(1)(C).
[32] Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, March 2010.
[33] Foster, Rick "Letter to Congressman Stark," Office of the Actuary, CMS, June 25, 2009.
[34] *See generally,* ACA.
[35] *Selected CBO Publications Related to Health Care Legislation (2009-2010)*, Congressional Budget Office, December 2010.
[36] 42 USC 1395 w-23(n).

benchmark phased in within six years.[37] While the new benchmark is being phased in, CMS is using a 'blended benchmark.'[38]

In addition to revised benchmarks, the ACA financially rewards MA plans for increases in health care quality. To achieve this objective, CMS will look to its five-star rating system, which is designed to assess and reflect the quality of care provided by MA plans. This system rates plans based on 36 standard performance measures, which include member satisfaction, appeals processes, audit results and customer service.[39]

Starting in 2012, CMS began reviewing a plan's star rating in order to determine the percentage of the difference between the plan bid and the benchmark that CMS will pay to the plan, further tying plan payment to the plan's overall quality.[40] Although the maximum share of the difference between the plan bid and the benchmark paid to plans will be reduced, CMS will allow plans with higher quality ratings to retain a greater share of the difference between the bid and benchmark.[41] Plans receiving 4.5 or 5 stars out of 5 stars will be allowed to retain 70 percent of the difference between the bid and the benchmark, while plans receiving 3.5 or 4 stars will be allowed to retain 65 percent of the difference.[42] All other plans will be allowed to retain only 50 percent of the difference.

Star ratings will not only affect the benchmark payment; they will also affect supplemental or bonus payments received by MA plans. The bonus payment system began in 2012 and is aimed at further rewarding MA plans that achieve higher performance measures.

[37] 42 USC 1395w-23(n)(3).
[38] *Id.*
[39] Jacobson, Gretchen, Anthony Damico, et. al. *Reaching for the Stars: Quality Rating of Medicare Advantage Plans,* The Kaiser Family Foundation, February 2011.
[40] The star ratings are based on data that is two years old. *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings*, GAO, March 2011 (*hereafter GAO March 2011*).
[41] *Id.* At Section 1395w-23(o)(4)(A).
[42] *Id.*

Table 3: MA Plan Payments Before and After the ACA			
	Region A	**Region B**	**Region C**
Medicare's estimated per month, per member cost[43]	$100	$95	$110
Plan A's per month, per member bid (4-star plan)	$90	$80	$120
Plan's per month, per member payment before the ACA	$97.50	$91.25	$110 (with a member premium of $10)
Plan's per month, per member payment after the ACA	$96.50 (plus annual bonus payment)	$89.75 (plus annual bonus payment)	$110 (with a member premium of $10)

Initially, the ACA provided for bonus payments of 1.5 percent to plans that are awarded four or more stars.[44] CMS' 2012 call letter, however, provided for an even more generous payment demonstration, which began in 2012 and runs through 2014. Under this demonstration, MA plans that have three or more stars will be eligible for bonus payments, with 3 percent payments awarded to lower-starred plans and 5 percent payments awarded to plans with higher star ratings.[45] The demonstration has been criticized by the Government Accountability Office (GAO) for its more than $8.3 billion cost over the course of 10 years. The majority of that money would be paid to plans with 3 and 3.5 stars, not the higher quality 4- and 5-star plans.[46] Rather than make payments to these lower-performing plans, the GAO suggests moving forward with the revised

[43] The post-ACA estimates do not take into account the reductions in Medicare's benchmark amount. Additionally, the chart does not account for adjusted payments based on demographic factors and the beneficiary's predicted health status, determined by diagnoses that appear in Medicare claims in the prior year.
[44] *Id.* At Section 1395w-23(o)(1).
[45] *2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, The Centers for Medicare and Medicaid Services, April 4, 2011, available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/Announcement2012final.pdf, last accessed June 26, 2012.
[46] GAO March 2011.

benchmark and payment rates set by the ACA and adjusting the payment structure in the future, should current payments prove inadequate.[47]

Implications for New York State

In New York State, MA costs tend to be higher in downstate counties, particularly the counties that make up New York City and Long Island, than in their upstate counterparts. Consequently, benchmark amounts in downstate counties may decrease more dramatically than upstate benchmark amounts, though these reductions will take place over six years. Plan availability in 2012 did not seem to be affected by these reductions, but it is unclear what effect these changes will have over time, given that downstate counties may see more MA marketplace changes owing to payment reductions.

Bonus payments will undoubtedly affect MA plans in New York. Although in 2012, New York only has one plan with a 5-star rating, and the average plan rating is 3.5 stars, the average annual per enrollee bonus payment is projected to be over $300.[48] This places New York ahead of states like Mississippi, which has an average plan rating of 2.7 stars and an average expected bonus payment of $100 per enrollee, but slightly below states like Colorado, where the average plan rating is 4.3 stars and bonus payments are expected to be approximately $430 per enrollee.[49]

Because of the bonus payment demonstration, which allows for bonus payments to be made to plans with lower star ratings, insurers, including those with large market shares in New York, will see bonus payments increased well above what they would have been under the ACA alone. For example, because of the demonstration, UnitedHealthcare will see its total bonus payment in 2012 grow to $547 million, compared to $6 million under the ACA alone, without the demonstration.[50] This type of dramatic payment increase underscores concerns articulated by the GAO.

Research methodology

To begin to understand the impact of MA payment changes on New York beneficiaries, the Medicare Rights Center (Medicare Rights) examined five MA plan offerings from five separate insurers in New York, comparing the benefit packages in 2011 to the benefit packages in 2012. Project research consisted of two tracks of inquiry: 1) analyzing and comparing plan evidence of coverage (EOC) documents for 2011 and 2012 and 2)

[47] *Id.*
[48] Jacobson, Gretchen, Tricia Neuman, et al., *Medicare Advantage Star Ratings and Bonus Payments 2012,* Kaiser Family Foundation, November 2011.
[49] *Id.*
[50] *Id.*

conducting interviews with insurers.[51] Medicare Rights supplemented these two primary tracks of inquiry by conducting a literature review, reviewing data from its national helpline, analyzing case stories from New York State professionals and partners, such as Health Insurance Information, Counseling and Assistance Programs (HIICAPs) and reviewing the 2011 and 2012 plan year call letters issued by CMS, which contained further payment and regulatory initiatives affecting MA plans.[52]

Medicare Rights examined MA plan EOCs for five insurers that offer Medicare plans in New York State: EmblemHealth, UnitedHealthcare, Excellus, Humana and Empire Blue Cross Blue Shield (BCBS). To ensure a representative picture of the state's MA market, the insurers and plans were selected based on several considerations: insurer market share in New York State and nationally, the number of calls related to insurers on Medicare Rights' national helpline, geographic presence and the type of insurance offering.

- Insurer market share: Examining MA insurers with large shares of the market in New York helped ensure that plans analyzed were popular with New York beneficiaries and would be more likely to set the trend in plan design and benefit packages. In New York, the two MA insurers with the largest market shares are EmblemHealth and UnitedHealthcare.[53] Medicare Rights selected one plan offering from each of these insurers: EmblemHealth VIP HMO and AARP Medicare Complete Essential HMO.

- National presence: Although Humana has a relatively low market share in New York, it has a large market share nationally: in 29 states, it is one of the top three insurers based on total MA enrollments. By selecting a plan from Humana—specifically HumanaChoice PPO, Southern Tier New York—trends would be observed that might be emerging in the national MA market.

- Number of calls to Medicare Rights' national helpline: Each year the helpline responds to more than 12,000 questions, and more than 5,000 of these questions are from New Yorkers. Medicare Rights often receives calls from beneficiaries with questions about how their coverage has changed between plan years. By selecting the insurer whose beneficiaries most often called the helpline, Medicare Rights would capture plans that are popular in the New York market and whose members are calling with questions about their coverage. Plan selections included: Empire BCBS MediBlue Freedom I PPO and Excellus BCBS Medicare Blue PPO Plan.

[51] Evidence of coverage documents outline covered services and costs in an MA plan.
[52] HIICAPs comprise New York's State Health Insurance Information and Assistance Program (SHIP) network.
[53] Gold, Marsha et al., *Medicare Advantage 2010 Data Spotlight: Plan Enrollment Patterns and Trends*, Kaiser Family Foundation, June 2010.

- State geographic presence: To ensure the capture of trends in areas with both high MA penetration rates (downstate) and low MA penetration rates (some upstate counties), Medicare Rights selected plans with service areas across the state. Examined plans had a combined service area of 37 of the 62 counties in New York.[54]

- Type of insurance offering: To further diversify the study of the five plans, Medicare Rights selected two HMOs and three PPOs. In New York, there is a higher rate of HMO enrollment among beneficiaries, but recent years have seen increased enrollment into PPOs.[55]

Medicare Rights gained further insight by conducting hour-long interviews with insurance plan staff members who oversee Medicare plans, structuring the conversations around a set of five questions (Appendix 1). Questions centered on plan benefit and cost changes, these changes' relation to the ACA-mandated payment reforms and anticipated adaptation to future changes in payment. Staff overseeing MA products at UnitedHealthcare, Excellus BCBS and EmblemHealth participated in the interview process.

2011 Medicare Advantage landscape

As noted above, the MA benchmark amount in 2011 was frozen at the 2010 level, keeping plan payment rates relatively stable between 2010 and 2011. In 2011, MA plans were required to adopt a maximum out-of-pocket threshold, over which the beneficiary could not be required to contribute cost-sharing. Additionally, beginning January 1, 2011, MA plan cost-sharing levels were limited to the levels under Medicare Parts A and B for chemotherapy administration, renal dialysis and skilled nursing care. Some critics of the ACA predicted that this payment freeze would cause plans to leave markets, increase beneficiary costs and decrease benefits. To date, these predictions have proved untrue. Specifically, in 2011, the average monthly MA plan premium decreased from $28 to $24,[56] and the average plan benefit package remained stable.[57] National MA plan enrollment increased by approximately 6 percent between 2010 and 2011.[58]

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[54] Plan service areas included the following counties: Allegany, Broome, Cattaraugus, Chautauqua, Chemung, Chenango, Cortland, Delaware, Schuyler, Seneca, Stuben, Tioga, Yates, New York, Bronx, Queens, Kings, Richmond, Nassau, Suffolk, Westchester, Cayuga, Jefferson, Lewis, Onondaga, Oswego, St. Lawrence, Tompkins, Orange, Rockland, Columbia, Dutchess, Greene, Putnam, Sullivan and Ulster.

[55] Kaiser Family Foundation Health and Prescription Drug Plan Tracker, available at: http://healthplantracker.kff.org/georesults.jsp?r=41&yo=2&n=&c=1&pt=8.

[56] Cosgrove, James, *Medicare Advantage: Enrollment Increased from 2010 to 2011 while Premiums Decreased and Benefit Packages were Stable,* US Government Accountability Office (GAO), October 2011.

[57] *Id.*

[58] *Id.*

Nationally, the number of plan offerings decreased from 2,307 in 2010 to 1,964 in 2011. However, this change was caused primarily by a CMS initiative, not mandated by the ACA, to eliminate plans with low enrollment or plans that duplicated other plan offerings from the same insurer.[59] Interestingly, reducing plan offerings in counties with a high number of plans may have actually helped increase MA plan enrollment in 2011, by simplifying an overly complex landscape that impeded potential enrollees from shopping for, comparing and ultimately enrolling in MA products.[60,61]

New York followed the national trend: the state plan landscape remained relatively stable in 2011. Moreover, in line with the national trend, between 2010 and 2011, New York's MA enrollment rate increased by approximately 4 percent.

2012 Medicare Advantage landscape

Despite the initiation of payment rate reductions, the MA market has remained relatively stable in 2012. A smaller number of plan options have exited the national marketplace in 2012 compared to 2011. Further, as in 2011, MA plan premiums have continued to decrease, and plan enrollment has continued to increase.[62] Nationally, MA plan premiums have fallen on average 7 percent and plan enrollment has increased by 10 percent in 2012 compared to 2011.[63]

New York was no exception to the national trend.[64] Medicare Rights' survey of the five New York plan offerings found that benefits and cost-sharing were kept stable or in some instances made more favorable for beneficiaries in 2012 compared to 2011. General trends are summarized in Table 4: 'Plan changes between the 2011 and 2012 plan year.' Increases in cost-sharing or reductions to supplemental benefits among the five plans were characteristic of year-to-year benefit structure changes rather than a particularized response to the ACA-mandated plan payment restructuring. Although historically, MA plans have been very responsive when faced with payment changes, based upon the survey of both the larger New York market and these five insurance

[59] Gold, Marsha, Gretchen Jacobson, et al., *Medicare Advantage 2011 Data Spotlight*, Kaiser Family Foundation, October 2011.
[60] McWilliams, J. Michael, Christopher Afendulis, Thomas McGuire, Bruce Landon, *Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decision Making*, *Health Affairs,* September 2011.
[61] *Id.*
[62] Bunis, Dena, *Medicare Advantage Premiums Down, Enrollment Up*, CQ HealthBeat News, February 1, 2012.
[63] *Id*.
[64] One MA insurer, Touchstone, left the upstate New York market, though it continued to sell plans downstate. On Wednesday, October 26, 2011, CMS and Touchstone held a meeting in response to a request from Touchstone for a Service Area Reduction (SAR) of Broome, Delaware and Chenango Counties. Touchstone agreed to a mutual contract modification for 2012 that removes five Plan Benefit Packages (PBPs) from their current service area. About 3,100 beneficiaries in Broome, Delaware, Chenango and Onondaga Counties are affected, as well as about 400 members in the remaining seven downstate counties. This change in service area did not appear to be related to ACA payment modifications.

offerings, insurers have not clawed back benefits or exited the New York market in 2012.[65]

Table 4: Plan Changes Between the 2011 and 2012 Plan Year

	Added or increased supplemental benefits	Decreased or maintained premium prices	Generally reduced or kept cost sharing stable	Generally reduced or kept utilization controls stable
Humana HumanaChoice PPO, Southern Tier New York	X	X	X	X
EmblemHealth VIP HMO	X		X	X
Excellus BCBS Medicare Blue PPO	X	X	X	X
Empire BCBS Mediblue Freedom I PPO		X		X
AARP Medicare Complete Essential HMO		X		X

Detailed assessment of plan changes

Humana HumanaChoice PPO, Southern Tier New York

Benefits: Overall, this plan did not have any significant reduction in benefits in 2012. While the plan instituted some small frequency limitations for certain services, it has not eliminated or significantly curtailed benefits. In fact, coverage for some services has increased, and two new supplemental benefits have been added: additional hearing benefits (including hearing aid coverage) and an over-the-counter drug and supplies benefit.

Costs: The plan has a lower premium for 2012. Further, the plan has lowered out-of-network cost-sharing for several services to match its in-network cost-sharing rates. Where members would have paid out-of-network coinsurances for many services in 2011, coinsurances have turned into set co-payments for several of those services.

[65] *See generally,* 2003 MedPAC Report.

EmblemHealth VIP HMO

Benefits: The plan has made some small changes to its additional benefits for 2012. The additional podiatry benefit has been reduced, now limiting beneficiaries to one routine visit per year. The plan has simultaneously expanded other benefits: the additional hearing benefit, for example, now includes more hearing exams. In terms of access, the plan has eliminated or reduced its prior authorization requirements for many services and added prior authorization for a small number of other services. On the whole, the plan has scaled back its prior authorization requirements.

Costs: The plan's premium has increased by a small amount for 2012. It has reduced co-payment rates for many services and increased co-payments for only two services: ambulance services and emergency care.

Excellus Blue Cross Blue Shield Medicare Blue PPO

Benefits: Where the plan previously covered multiple bone mass measurements per year, it now limits coverage to one measurement per year (matching Original Medicare). As with EmblemHealth and Humana, this Excellus plan has increased its additional hearing benefit and now covers more routine hearing exams for 2012. Overall, the benefit package has remained largely unchanged.

Costs: The plan has eliminated the plan premium and reduced copayments for some services. Only one service, emergency care, has a higher co-payment for 2012. As with the Humana plan, out-of-network coinsurance rates have been turned into set co-payments for many services. Elsewhere, some in-network coinsurances have been reduced, and one service which previously required an in-network co-payment now requires a coinsurance.

Empire Blue Cross Blue Shield MediBlue Freedom I PPO

Benefits: The plan has eliminated several additional benefits for 2012. Specifically, it has removed its fitness club benefit. It has also removed its supplemental vision care benefits from the regular plan package and now offers them only for an additional fee. Additionally, where the plan previously offered worldwide coverage for urgently needed care, it no longer offers this coverage for 2012. The plan has also removed language on prior authorization requirements for one service: inpatient care following an emergency care visit.

Costs: While the plan continues to have no premium for 2012, it has an out-of-pocket limit that has been increased by $1,000 for 2012. Co-payments for many services have increased; only one service has a smaller in-network co-payment for 2012.

AARP MedicareComplete Essential HMO, insured through UnitedHealthcare

Benefits: The plan has removed several of its additional benefits for 2012. Specifically, it has eliminated its supplemental nutrition services and instituted a new limit on the number of covered hearing aids per year. It has also instituted new caps on several preventive services.

Costs: While the plan's members will continue to pay no premium in 2012, co-payments for outpatient surgery and inpatient care have increased. In terms of access, requirements for prior authorization for many services have been removed.

Insurer interviews

Medicare Rights contacted four of the five insurers surveyed to participate in an hour-long interview to gather additional information about the targeted plans, the broader New York market and potential insurer responses to payment changes in 2012 and the outer years of the ACA's implementation.[66] Employees who oversee Medicare products for three of the five insurers (hereafter, the insurers) participated in these interviews and informed Medicare Rights that:

- Payment changes in 2012 were largely absorbed by insurers and not passed on to Medicare beneficiaries.
- Reduced payments in later years may result in increased premiums and/or benefit changes. However, benefit changes are less likely to occur because star ratings are adversely affected by reductions in a plan's benefit package.
- There is a growing need to engage physicians in conversations about MA payment reductions, particularly if these reductions will result in lower provider payments.
- Insurers must engage beneficiaries to better understand their plan experiences, and engagement should take place through a variety of media, including online tools.

[66] Though Humana has a large market share nationally, Medicare Rights focused its interviews on trends emerging in New York plans and consequently reached out to Excellus BCBS, UnitedHealthcare, EmblemHealth and Empire BCBS.

During interviews, targeted insurers expressed concerns regarding both benefits and plan choice in the years beyond 2012. Overall, there was a sense that the payment changes in 2012 were absorbed by the insurance companies and not passed on to beneficiaries in the form of reduced benefits or higher cost-sharing, but insurers had concerns about their ongoing abilities to shoulder these costs. One insurer estimated that their plan would receive a 3 percent reduction in payments each year for the next five years, even assuming a robust quality bonus payment—and that this could affect plan benefits and costs. And all insurers anticipated larger reductions in payments in the outer years of the ACA's implementation. The insurers' concerns mirror the concerns expressed by the health insurance lobby, which predicts that the biggest MA payment reductions would not occur until 2015, and that by 2019, MA plan enrollment will have decreased from 25 percent of all Medicare enrollment to 13 percent of all Medicare enrollment.[67]

Despite anticipated reductions in payments, all insurers expressed a reluctance to tinker with the benefit package. As one insurer stated, the quickest way to lose a member is to change the plan benefit. Another insurer noted that the star ratings and related bonus payments are affected by the richness of the benefit package, and cuts to benefit packages could thus result in further payment reductions. Instead, insurers indicated that they would first look to other cost-saving tactics, such as increasing focus on preventive services, working with physicians and other providers to reduce preventable hospital admissions and working to drive down the costs of medical services. One specific initiative would involve bringing physician and health professional services to beneficiaries who are homebound; in addition to home health services, the plan would also provide homebound beneficiaries with a care manager who could help assess which supports and services they would need to stay healthy.

One insurer feared that financial pressures on the insurance industry, owing to decreased payments, would be passed on, in part, to providers, who might reject patients with private Medicare insurance. Another plan representative expressed concern that if insurers did not engage physicians, they risked health professionals turning away from the commercial insurance market altogether. This sentiment was echoed by a third insurer, who predicted that doctors could begin moving away from MA plans within the next three years. To avoid this outcome, multiple insurers noted that physician engagement will be a key component of conversations moving forward.

The need for increased communication with members was another common theme among insurers. All insurers surveyed for this report indicated that they would be prioritizing communications with beneficiaries, through care managers, online tools and

[67] Weber Serafini, Marilyn, *Is HHS Medicare Advantage Celebration Premature?*, Kaiser Health News, February 1, 2012.

services and satisfaction surveying. Insurers expressed that they want beneficiaries to be fully informed of the range of services, particularly preventive services, available to them at low or no cost. Additionally, many insurers identified online tools—particularly as baby boomers age into Medicare—as a priority.

Another interview finding was that while insurers are working to improve their plans' star ratings, they also expressed concerns regarding the star rating program as a whole. Several insurers interviewed pointed to the fact that ratings reflect data that is two years old. One pointed to the need to develop star rating measurements that account for populations with additional needs, particularly the dually eligible. Overall, there was concern that older data and non-specialized measurements could lead to higher-quality plans being branded with a lower star rating. Because the star ratings will be increasingly important to the survival of plans within the MA market, insurers expressed that they want to be certain that stars accurately reflect the current beneficiary experience. Despite concerns regarding the metrics of the star ratings, as previously mentioned, the 3-star demonstration will bolster plan payments, particularly in New York, where the average plan rating is approximately 3.5 stars.

Conclusion

The 2012 MA plan landscape in New York State did not reflect the predictions that insurers would exit the market, reduce benefits or immediately pass costs to Medicare beneficiaries in response to reduced plan payments. Instead, plan availability and plan affordability has remained unchanged and in some areas improved. The insurers who offer these plans indicated that payment changes mandated by the ACA have not affected benefit packages or cost-sharing. Instead, the landscape appears to be as robust as and perhaps more beneficiary-friendly than the landscape in 2011.

That said, insurers and consumer advocates anticipate larger payment changes in the outer years of the ACA's implementation and question insurer ability to weather the storm without passing some of the costs onto beneficiaries or changing benefit packages. However, the insurers surveyed for this report all viewed benefit reductions as the least attractive option to control costs. Instead, insurers indicated a preference to curb health care costs overall and promote preventive medicine before looking to overhaul benefit packages. Yet concerns over star rating methodology, physician engagement and the MA payment reduction implementation timeline pose challenges to achieving these goals.

How these insurance plans will look and how the MA landscape in New York will look beyond 2012, particularly as payment reductions are phased in through 2019, requires further study. The benchmark amount in New York will continue to decrease throughout the state, resulting in reduced payments to MA insurers. However, plans will begin to

build their star rating programs and may look to recoup these losses through increasing plan ratings and thus higher bonus payments. Based on insurer interviews, the insurance industry seems likely to engage CMS in conversations about changing star rating metrics and reporting times.

As payment changes move forward, consumer advocates must monitor changing plan benefits. Efforts to improve star ratings and retain benefits are laudable, but only if done in a way that keeps the beneficiary informed and engaged. Moreover, like insurers, advocates must engage with CMS to ensure that the star rating system reflects timely quality measures so that beneficiaries are making choices based on as close to real-time data as possible. Similarly, advocates must ensure that any effort between insurers and providers to rein in costs involves the beneficiary and that insurers engage with their members if they undertake larger plan benefit package redesigns.

APPENDIX I

SAMPLE MEMO AND QUESTION SET SENT TO INSURERS

Project background

Medicare Rights has received a grant from the United Hospital Fund (UHF) to survey Medicare Advantage (MA) plan benefits between the 2011 and 2012 plan year. The survey will examine plan offerings from five insurance carriers in New York. The carriers selected include: UnitedHealth, Excellus, BlueCross, Emblem and Humana.

The genesis of the UHF grant was the concern over changes in the scope of plan benefits and cost sharing due to payment reforms triggered by the Affordable Care Act (ACA) set to go into effect in 2012. Medicare Rights and the Fund wanted to explore how these payment changes may affect both the benefit structure and the focus of the managed care plan. To that end Medicare Rights is comparing evidences of coverage between 2011 and 2012. Medicare Rights is also conducting interviews with representatives of the five plans to determine the anticipated effects of the payment changes and how the plans are adapting to these changes in 2012.

The plan Medicare Rights is examining from your company is the _____.

The product of the research will be a report released mid-year that summarizes the findings of the plan comparison and interviews and makes predictions about the MA plan landscape in New York in future years.

Call Questions

1) What are the major plan benefit changes you would highlight between the 2011 and 2012 plan year?
2) What was the impetus for these changes? ACA regulations? Actuarial findings? Member utilization?
3) What is the expected effect of the payment reform changes on the plans your company offers?
4) What initiatives, is your company considering to assist consumers in understanding their insurance and how to manage their care?
5) With new payment mechanisms providing additional monies to 4 and 5 star plans, what initiatives is your company pursuing to increase plan ratings?