



New York's Medicare Marketplace

Update: Examining New York's Medicare Advantage Plan Landscape after the Affordable Care Act

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Casey Schwarz

520 Eighth Avenue, North Wing, 3rd Floor
New York, NY 10018
212.869.3850

1825 K Street NW, Suite 400
Washington, DC, 20006
202.637.0961

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Executive Summary

Changes to Medicare Advantage (MA) payment methodologies and rates initiated by the Affordable Care Act (ACA), have been met with doomsday predictions that such adjustments—intended to bring MA payments closer in line to the cost of providing the same care under Original Medicare—will lead to a collapse of the Medicare Advantage marketplace and dramatically increase costs for beneficiaries enrolled in these plans.¹ Our evaluation and analysis of the MA market shows that such predictions have failed to materialize and that Medicare beneficiaries in New York and nationwide continue to have broad access to affordable MA plans.

Following up on the Medicare Rights Center’s (Medicare Rights) previous analysis of the Medicare Advantage marketplace in New York,² supported by the United Hospital Fund and examining the New York plan landscape and benefits changes over the first two years of ACA implementation, this paper evaluates changes in costs, quality, benefit structure and plan availability for New York beneficiaries through 2014. We reviewed several Medicare Advantage plans offered in New York State and evaluated differences in premiums, benefits, cost sharing and prior authorization requirements. We conducted interviews with plan administrators, reviewed academic literature examining Medicare Advantage payment changes, and examined the annual payment rates and policy adjustments captured in announcements from the Centers for Medicare & Medicaid Services (CMS).³

Ultimately, we found that despite fears that the ACA-mandated changes to Medicare Advantage plan payments would undermine the program and harm beneficiaries, changes to the plans we examined have been modest—similar in scope and nature to the changes advocates and beneficiaries saw in plans before enactment and implementation of the ACA. The overall size of the MA market in New York State has remained consistent, and although the plans we looked at have made small year-to-year changes, tinkering with costs, benefits, and restrictions, they have thus far avoided passing the bulk of the cost of payment reductions on to beneficiaries through overall higher copayments or premiums. Moreover, Medicare Advantage plans continue to be popular with beneficiaries, with penetration rates and enrollment in New York and nationally continuing to grow. Plan interviewees indicated that larger cost-shifting to beneficiaries may be more likely in coming years as additional payment reductions are applied, but also spoke of the promise of cost savings through the use of targeted, efficient provider networks, technological improvements, and beneficiary outreach that could forestall or temper any cost-shifting.

¹ See generally, Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 (2010) (*hereinafter* ACA).

² Goggin-Callahan, Doug, “New York’s Medicare Marketplace: Examining New York’s Medicare Advantage Plan Landscape in Light of Payment Reform,” available at: <http://www.uhfnyc.org/publications/880842>.

³ Announcement of Calendar Year (CY) [2011, 2012, 2013, 2014, 2015] Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, CMS. Available at: <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Announcements-and-Documents.html>. (*hereinafter* Call Letter).

Medicare Advantage and New York's Plan Landscape in Context

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.⁴ Medicare is affected by these changes in two key ways: 1) the expansion of coverage for prescription drugs and preventive care, and 2) cost-saving mechanisms to finance this expansion.⁵ 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 providers, the ACA also provided for significant reductions in payments to private health insurance plans that provide Medicare benefits through the Medicare Advantage (MA) program.⁶

Reductions to MA plan reimbursement raised concerns among some health insurance companies and Medicare beneficiaries and led opponents of the ACA to predict that these reductions would cause MA plans to cut benefits, increase premiums and cost-sharing, and even eliminate some or all of their Medicare insurance offerings.^{7,8} 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, such as New York State.⁹

Focus on New York

Today, roughly one third of Medicare beneficiaries nationally are enrolled in an MA plan, up from closer to a quarter in 2011.^{10,11} New York is one of 18 states in which the MA penetration rate exceeded 30 percent in 2014, at 35%.¹²

In fact, more than one million New Yorkers are enrolled in MA plans, more than in any state except Florida and California.¹³ The urban counties of Queens, Kings and Erie

⁴ See generally, ACA.

⁵ 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 prescription drug program.

⁶ *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 to 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.

⁷ See e.g., Statement for the Record to the Committee on Ways and Means, America's Health Insurance Plans, Thursday, February 10, 2011.

⁸ Book, Robert and James Carpetta, *Reductions in Medicare Advantage Payments: The Impact on Seniors by Region*, The Heritage Foundation, September 14, 2010.

⁹ 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>.

¹⁰ Kaiser Family Foundation *MA 2014 Spotlight*, November, 2013, available at

<http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8520-medicare-advantage-2014-spotlight2.pdf>

¹¹ Kaiser Family Foundation *Medicare Advantage Fact Sheet*, 2013 <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet>.

¹² *Id.*

each have over 100,000 MA enrollees each.¹⁴ Counties like Livingston and Genesee have relatively small enrollment numbers, but more than 50 percent of Medicare-eligible beneficiaries in those counties are enrolled in MA plans. County penetration rates and number of MA plan enrollees are summarized below.

Table 1: New York Counties with the Highest and Lowest MA Plan Penetration Rates, 2014

County	Percentage of Medicare-Eligible Beneficiaries Enrolled in MA Plans	Total Number of MA Plan Enrollees ¹⁵
<u>Highest penetration</u>		
Monroe	63.09%	87,441
Livingston	58.52%	6,904
Ontario	57.50%	12,705
Erie	55.50%	101,515
Wayne	55.40%	10,926
<u>Lowest penetration</u>		
Sullivan	8.40%	1,304
Orange	13.87%	7,653
Clinton	16.06%	2,609
Essex	16.21%	1,369
Putnam	16.78%	2,726

Table 2: New York Counties with the Highest Number of MA Enrollees, 2014

County	Percentage of Medicare-Eligible Beneficiaries Enrolled in MA Plans	Total Number of MA Plan Enrollees
Queens	41.12%	131,079
Kings	38.24%	127,467
Erie	55.50%	101,515
Bronx	50.81%	92,620
Monroe	63.09%	87,441

¹³ Kaiser Family Foundation, <http://kff.org/medicare/state-indicator/total-enrollment-2/>.

¹⁴ Figures taken from 2014 County penetration data available on: www.cms.gov, January 2014 MA State/County penetration.

¹⁵ *Id.*

Given New York's higher-than-average MA enrollment penetration rate and high total number of MA enrollees, New York policymakers, plans, providers, beneficiaries and consumer advocates all have an interest in understanding the implications and impact of ACA-mandated MA payment reforms on the MA plan landscape. It is particularly important to understand potential impacts given that beneficiaries in particular regions of the state could be disproportionately affected because of New York's combination of high-cost urban counties and lower-cost rural areas, and related MA reimbursement rates, as explored below.

Medicare Advantage Payment Changes Leading Up to ACA Reforms

Medicare Advantage is the latest iteration of a program, initiated in 1972, that allows Medicare to contract with private insurance to administer Medicare benefits and allow beneficiaries to receive their Medicare benefits through private insurance plans.¹⁶ These plans are required to cover all the same benefits and services as Original Medicare, the fee-for-service program administered by the federal government.¹⁷ In addition, MA plans may offer other services and supports.¹⁸

The historical antecedents of the MA program demonstrate that the program has weathered a variety of legislative and policy changes through the years. The 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) first established Medicare Health Maintenance Organizations (HMOs), giving plans the opportunity to provide additional benefits and to reduce cost-sharing to attract beneficiaries,¹⁹ while attempting to generate Medicare savings by paying plans 95 percent of the estimated cost of treating an average beneficiary enrolled in Original Medicare.²⁰ Enrollment in Medicare Advantage grew to approximately six million beneficiaries by 1997,²¹ when the Balanced Budget Act of 1997 (BBA) made additional programmatic changes, allowing private insurers to offer coverage options in addition to HMOs, including Preferred Provider Organizations (PPOs), private fee-for-service plans (PPFSs), and medical savings accounts (MSAs).²² The BBA also changed the plan payment system, creating risk-adjusted payment rates based on a beneficiary's health and setting payment floors for counties with lower costs. This resulted in relatively lower plan payment rates in areas where Original Medicare spending was high and higher plan payment rates in areas where spending was low, making it less attractive for plans to serve certain geographic areas.^{23,24} Consequently, some plans exited the Medicare market: between 1998 and

¹⁶ 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 that are managed care models rather than fee-for-service.

¹⁷ Medicare Managed Care Manual, Chapter 4 Benefits and Beneficiary Protections, Section 10.2.

¹⁸ *Id.* at Section 30.

¹⁹ 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*).

²⁰ *Id.*

²¹ *Medicare + Choice Fact Sheet*, Kaiser Family Foundation, April 2003, available at: <http://www.kff.org/medicare/upload/Medicare-Choice-Fact-Sheet-Fact-Sheet.pdf>.

²² *See*, The Balanced Budget Act of 1997, Section 1851, Pub. L. No. 105-33 (1997).

²³ *Id.*

2003, the number of Medicare private plans declined from 346 to 148.²⁵ By 2003, Medicare private plan enrollment had fallen by nearly one million beneficiaries.²⁶

The ACA payment reform provisions were developed to reform those enacted by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which reversed the decline in Medicare private health plan enrollment. To achieve this end, the MMA created the Medicare Advantage program as it exists currently and offered financial relief by imposing a minimum per beneficiary payment, blending the benchmark calculation amount between national averages and county-specific costs, and providing for a minimum 2 percent increase from the previous year's payment rate.^{27,28} The MMA also restructured the way in which MA plans are paid by implementing a competitive bidding process.²⁹ After the MMA was enacted, enrollment in Medicare managed care grew from 5.1 million beneficiaries in 2003 to 11.5 million beneficiaries 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.³⁰

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.³¹ 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.³² The benchmark is a bidding target for MA plans. If a plan's bid exceeds the benchmark, the cost is absorbed by plan enrollees, who pay the difference in the form of a monthly premium. Under the MMA, if the bid fell below the benchmark, the plan received 75 percent of the difference and Medicare retained the other 25 percent.³³ It is important to note that these MA benchmarks were not tethered to Original Medicare spending, which overtime resulted in payments to plans that greatly exceeded the Original Medicare cost of coverage for beneficiaries in the same region.

This system was intended to reduce beneficiary cost-sharing, to increase plan benefits, and to lower premiums.³⁴ It was successful, in part. While many beneficiaries enrolled in MA plans did reap the benefits of increased federal reimbursement to these plans, the

²⁴ *Id.*

²⁵ *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission, March 2003 (hereinafter, 2003 Medpac Report).

²⁶ McDowell, *Payment for MA Plans*.

²⁷ *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.

²⁸ *Id.* Congress authorized a 6.3 percent payment update for 2004.

²⁹ *Id.*

³⁰ Cosgrove, James, *Medicare Advantage: Enrollment Increased from 2010 to 2011 while Premiums Decreased and Benefit Packages were Stable*, US Government Accountability Office, October 2011.

³¹ 42 U.S.C. Section 1395w-23.

³² *Id.* at Section 1395w-23(a)(1)(B).

³³ *Id.* at Section 1395w-23(a)(1)(E).

³⁴ *Id.* at Section 1395w-23(b)(1)(C).

federal government and beneficiaries in Original Medicare were paying the price. Specifically, the MA program, initially designed to provide the federal government with an average 5 percent discount for each beneficiary enrolled, cost 9 to 13 percent more per beneficiary than Original Medicare.³⁵ These higher payments had negative consequences for the federal budget, led to a more rapid exhaustion of the Medicare Part A Trust Fund, and also raised the cost of the monthly Part B premium paid by all Medicare beneficiaries.³⁶

For many years, the Medicare Payment Advisory Commission (MedPAC) had recommended that Congress align payments to MA plans with payments to Original Medicare.³⁷ Outside analysis had also reflected broad variation in MA payments compared to Original Medicare across different geographical regions and plan types, indicating the likelihood that efficiency gains in Medicare Advantage were readily attainable.³⁸

ACA Revised Benchmark Amounts and Quality Incentives

To address the overpayments to Medicare Advantage plans, the ACA reformed the MA bidding and payment process by revising MA plan benchmarks—the amount against which plan bids are evaluated—and by incorporating quality measures into plan payments. These payment changes are being phased in over nearly a decade, starting in 2010 and continuing through 2019.³⁹ The Congressional Budget Office (CBO) estimates that over this period MA plan payments will be reduced by \$136 billion.⁴⁰

The ACA adjusted the benchmark amounts for each county so that plan payments are indexed to the average amount that Original Medicare spends per beneficiary in that county. Counties were grouped in order of Original Medicare cost and divided into quartiles, with about 800 counties per quartile.⁴¹ Plans in counties that are in the top quartile of Original Medicare spending will have benchmarks set at 95 percent of Original Medicare costs for that county, while the benchmark in counties in the bottom quartile of Original Medicare spending will be 115 percent of Original Medicare costs for that county.⁴² The benchmark does not take into account quality bonus payments, which are discussed in greater detail below.

³⁵ *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission [MedPAC], March 2010 (hereinafter MedPAC 2010).

³⁶ Foster, Rick “Letter to Congressman Stark,” Office of the Actuary, CMS, June 25, 2009.

³⁷ MedPAC 2010, Chapter 4.

³⁸ Biles, Brian, Grace Arnold, and Stuart Guterman. “Medicare Advantage in the Era of Health Reform: Progress in Leveling the Playing Field.” *Issue Brief #1491. The Commonwealth Fund*, March 2011; Gold, Marsha. “Making Sense of the Change in How Medicare Advantage Plans are Paid.” *Issue Brief. The Commonwealth Fund*, May 2013.; Gold, Marsha, and Maria Cupples Hudson. “Analysis of the Variation in Efficiency of Medicare Advantage Plans.” Washington DC: *Mathematica Policy Research*, May 2013.

³⁹ See generally, ACA.

⁴⁰ *Selected CBO Publications Related to Health Care Legislation (2009-2010)*, Congressional Budget Office, December 2010.

⁴¹ MedPAC 2011.

⁴² 42 USC 1395 w-23(n).

Implementation of the new benchmarks depends on the size of the payment decrease. New benchmarks were completely phased in over two years for counties with relatively small payment decreases (“two-year counties”), and will gradually replace old benchmarks over four or six years in counties with larger payment decreases under the new formula (“four year counties” and “six-year counties”).⁴³⁴⁴ During the phase-in period, CMS uses a “blended benchmark”, combining the pre-ACA rate with the new rate based on Original Medicare costs.⁴⁵

The phased-in change to the benchmark rates has reduced plan payments, which are now approaching Original Medicare costs. In 2013, MedPAC’s report to Congress reflected that the average benchmark for payments to MA plans had dropped to 110 percent of Original Medicare spending, down 8 percent from the 2009 level, and that average payments to MA plans dropped to 104 percent.⁴⁶ Average bids—that is, what MA plans estimate it will cost them to provide Medicare Part A and Part B benefits (which were historically above 100 percent of Original Medicare costs)—have fallen to 96 percent of Original Medicare spending.⁴⁷

In addition to revised benchmarks, the ACA changed MA payment methodology by financially rewarding plans for increases in health care quality. To measure increased quality, CMS looks to its five-star rating system, which is designed to assess and reflect the quality of care provided by MA plans across several different measures.⁴⁸ The star ratings draw on a number of quality and performance measures in five broad categories: outcomes, intermediate outcomes, patient experience, access and outcomes.

Payments based on star rating are twofold. First, CMS reviews 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. CMS will allow plans with higher quality ratings to retain a greater share of the difference between the bid and benchmark.⁴⁹ Specifically, plans receiving 4.5 or 5 stars retain 70 percent of the difference between the bid and the benchmark, while plans receiving 3.5 or 4 stars retain 65 percent of the difference.⁵⁰ All other plans retain 50 percent of the difference. It is worth noting that in addition to these payments, higher star ratings can also give plans a marketing advantage because 5-star plans are able to market to beneficiaries year-round, while others may only market during the Fall Open

⁴³ 42 U.S.C. 1395w-23(n)(3).

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Report to the Congress: Medicare Payment Policy*. Medicare Payment Advisory Commission. Chapter 13, “The Medicare Advantage Program: Status Report.” Washington, DC: March 2013.

⁴⁷ *Id.*

⁴⁸ Jacobson, Gretchen, Anthony Damico, et. al. *Reaching for the Stars: Quality Rating of Medicare Advantage Plans*, The Kaiser Family Foundation, February 2011.

⁴⁹ 42 U.S.C. 1395w-23(o)(4)(A).

⁵⁰ *Id.*

Enrollment period from October 15 –December 7,⁵¹ and because a plan’s star rating has been shown to have an effect on beneficiary choice.⁵²

In addition to the above, star ratings determine the supplemental or bonus payments received by MA plans. Initially, the ACA provided for bonus payments of 1.5 percent to plans that are awarded four or more stars.⁵³ CMS’ 2012 call letter, however, provided for an even more generous three-year demonstration, during which any 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 bonus payments for plans with higher star ratings.⁵⁴ The demonstration was criticized by the Government Accountability Office (GAO) for its more than \$8.3 billion cost over the course of 10 years. Much of the criticism stems from the fact that 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.⁵⁵ The demonstration ended in 2014, subsequently, only 4- and 5- star plans will receive bonus payments, as outlined in the ACA.⁵⁶

Further, pursuant to the ACA, star-based bonus payments are doubled for plans that are offered in counties with all of the following characteristics: 1) lower than average Original Medicare costs, 2) a Medicare Advantage penetration rate of 25 percent or more as of December 2009, and 3) a designated urban floor benchmark in 2004. In 2012, Medicare Advantage plans in 210 counties qualified for double bonus payments.⁵⁷

Finally, starting in 2014, the ACA imposed a requirement that most Medicare Advantage plans have to meet a minimum Medical Loss Ratio (MLR) of 85 percent.⁵⁸ A plan’s MLR reflects the percentage of premium dollars that are spent on clinical services and activities to improve health care quality.⁵⁹ An MLR requirement therefore limits the amount that a Medicare Advantage plan can spend on marketing, overhead and other costs, and in general, the higher a plan’s MLR, the more value the consumer is

⁵¹ Beneficiaries have a once-per year Special Enrollment Period that allows them to enroll into a five-star MA plan.

⁵² Reid, Rachel O., Partha Deb, Benjamin L. Howell, William H. Shrank, “Association Between Medicare Advantage Plan Star Ratings and Enrollment” *JAMA*. 2013; 309(3) :267-274.

⁵³ 42 U.S.C. 1395w-23(o)(1).

⁵⁴ *Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, CMS, April 4, 2011.

⁵⁵ *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings*, GAO, March 2011 (hereinafter, GAO March 2011).

⁵⁶ *Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter*, CMS, Feb. 21, 2014. Available at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvSpecRateStats/Downloads/Advance2015.pdf> (Hereinafter 2015 Call letter).

⁵⁷ Jacobson, Gretchen, Tricia Neuman, Anthony Damico and Jennifer Huang, “*Medicare Advantage Plan Star Ratings and Bonus Payments in 2012*” Kaiser Family Foundation Data Brief. November 2011. *Under 15 of these counties are in New York*.

⁵⁸ See §1103, Health Care Reconciliation Act (P.L. 111-152).

⁵⁹ Centers for Medicare & Medicaid Services, “Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs: Final Rule,” Federal Register, May 23, 2013. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf>.

getting.⁶⁰ The ACA also required commercial policies in the exchanges to meet minimum MLR requirements.

In addition to all of these ACA-related payment changes aimed at bringing Medicare Advantage plan payments into closer alignment with costs under Original Medicare, MA plans have faced payment reductions as a result of broader economic and political circumstances. Specifically, in April 2013 the Budget Control Act of 2011—also known as sequestration— took effect, instituting a 2 percent cut in Medicare payments to Medicare Advantage plans.⁶¹

Implications for New York State

In New York State, Medicare Advantage costs tend to be higher and more divergent from Original Medicare costs in downstate counties— particularly the counties that comprise 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 as discussed in the previous section these larger reductions take place over a longer period of time. Plans operating in four- and six-year counties, described above, will not be fully transitioned to new benchmarks until 2015 or 2017.⁶²

Bonus payments will also undoubtedly affect New York’s MA plan landscape. Although New York has not had a 5-star MA plan, overall star ratings have improved consistently in recent years: in 2014, 38 percent of New York MA plans with drug coverage achieved a score of 4 stars or higher, compared to 24 percent in 2012.^{63,64} Further, because of the CMS bonus payment demonstration, discussed above, which allowed for bonus payments to plans with lower star ratings, insurers with 3 and 3.5 star-rated plans, which make up the bulk of the New York plan market, have seen bonus payments increased well above what they would have been under the ACA alone.⁶⁵ As these bonuses are eliminated, increased effects may be seen.

⁶⁰ Kirchhoff, Suzanne M., “Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress.” *CRS Report for Congress*, Prepared for Members and Committees of Congress. August 9, 2013. Available at: <http://www.healthreformgps.org/wp-content/uploads/med-loss-ratio-crs-report-8.9.2013.pdf>.

⁶¹ P.L. 112-25.

⁶² 2015 Call letter. Note that rate changes effective in 2015 are discussed in the 2015 call letter, released in early 2014.

⁶³ Figures from CMS MA Landscape Source files available at: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn>.

⁶⁴ 2014 Star Ratings CMS, Fact Sheet, available at: http://aishealth.com/sites/all/files/2014_star_ratings_factsheet_092713.pdf.

⁶⁵ 2014 Report to the Congress, Medicare Payment Advisory Commission [MedPAC] “Medicare Payment Policy” Chapter 13 p. 339, March 2014. (Hereinafter MedPAC 2014).

The 2011-2014 Medicare Advantage Plan Landscape in New York State

Research Methodology

Our earlier work compared MA benefit packages from 2011 and 2012 to determine the impact of ACA-related payment changes on New York beneficiaries.⁶⁶ In this update, we analyze subsequent changes in plan benefits and expanded our focus by including two additional plans. Project research consisted of two tracks: 1) analyzing and comparing plan evidence of coverage (EOC) documents for 2011, 2012, 2013 and 2014; and 2) conducting interviews with insurers.⁶⁷ 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 2011, 2012, 2013, 2014 and 2015 plan year call letters issued by CMS, which contain further details about ACA payment changes affecting MA plans.⁶⁸

Medicare Rights examined one MA plan offering from each of seven insurers of the 26 insurers that offer Medicare plans in New York State: Humana, EmblemHealth, Excellus BCBS, Empire BCBS, UnitedHealthcare (AARP), Liberty Health Plan, and the Capital District Physicians' Health Plan (CDPHP). To ensure a representative picture of the state's MA market, insurers and plans were selected based on several considerations, including 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. For the additional plans added to this new analysis, we also selected plans with different star ratings.

⁶⁶ Goggin-Callahan, Doug, "New York's Medicare Marketplace: Examining New York's Medicare Advantage Plan Landscape in Light of Payment Reform," available at: <http://www.uhfny.org/publications/880842>.

⁶⁷ EOCs outline covered services and costs in an MA plan.

⁶⁸ HIICAPs comprise New York's State Health Insurance Information and Assistance Program (SHIP) network.

Table 3: Factors for selecting insurers and plans for this analysis

<p>Insurer Market Share</p>	<p>Examining MA insurers with large shares of the market in New York helped ensure that plans analyzed were those 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 at the time of selection were EmblemHealth and UnitedHealthcare.⁶⁹ Medicare Rights selected one plan offering from each of these insurers”: EmblemHealth VIP HMO and AARP Medicare Complete HMO.</p>
<p>National Presence</p>	<p>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—trends could be observed that might be emerging in the national MA market.</p>
<p>Number of Calls to Medicare Rights’ National Helpline</p>	<p>Each year Medicare Rights’ helpline provides nearly 15,000 counseling sessions to consumers and professionals, and roughly 40 percent of these sessions are for New Yorkers. A typical question from callers is how plan coverage has changed from year to year, And by selecting plans most often mentioned during calls, Medicare Rights could better understand the state’s plan landscape and its own clients. Plan selections include BlueCrossBlueShield (BCBS) Empire MediBlue Freedom I PPO and Excellus BCBS Medicare Blue PPO Plan ONE.⁷⁰</p>
<p>State geographic presence</p>	<p>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 51 of the 62 counties in New York.⁷¹</p>

⁶⁹ Gold, Marsha et al., *Medicare Advantage 2010 Data Spotlight: Plan Enrollment Patterns and Trends* Kaiser Family Foundation (June 2010).

⁷⁰The Excellus BCBS Medicare Blue PPO Plan One, which we compared in 2011-2012, was not offered in 2013. In 2011 and 2012, Excellus had four PPO offerings in Broome, Chemung, Chenango, Schuyler, Steuben, Tioga, Cayuga, Cortland, Jefferson, Lewis, Onondaga, Oswego, St. Lawrence, and Tompkins Counties. These plans were called “Medicare Blue PPO Plan ONE” “Medicare Blue PPO – TWO” “Medicare Blue PPO – THREE” and “Medicare Blue PPO Plan FOUR.” In 2013 in those counties, Excellus’s four plan offerings were called “Medicare BlueSecure PPO” “Medicare BlueEnhanced PPO,” “Medicare BlueClassic PPO” and “Medicare BlueBasic PPO.” Medicare Rights reviewed the plan options and found that, in premium and benefit design, the Medicare BlueClassic PPO was very similar to PPO Plan ONE, and compared that plan’s EOCs to the Plan ONE benefits from 2011 and 2012.

⁷¹ Plan service areas included the following counties in the initial five plan comparison: Allegany, Broome, Bronx, Cattaraugus, Chautauqua, Chemung, Chenango, Columbia, Cortland, Cayuga, Delaware, Dutchess, Greene, Jefferson, Kings, Lewis, Nassau, New York, Onondaga, Orange, Oswego, Putnam, Queens, Richmond, Rockland, Schuyler, Seneca, St. Lawrence, Stuben, Sullivan, Suffolk, Tioga, Tompkins, Ulster, Westchester, and Yates. The (footnote continued)

Type of Insurance Offering	To further diversify the study, Medicare Rights selected two health maintenance organizations (HMOs) and three preferred provider organizations (PPOs). In New York, there is a higher rate of HMO enrollment among beneficiaries, but recent years have seen increased enrollment into PPOs. ⁷²
Star Ratings	The two new plans for this analysis—the Capitol District Physicians’ Health Plan (CDPHP) Choice Rx HMO and Liberty Health (Liberty) Advantage Preferred Choice HMO—were chosen in part because of their historic star rating performance. CDPHP has consistently received a 4.5-star rating for every year since 2011, while Liberty scored a below-average 2.5 stars in 2011 and 2012, and 3 stars in 2013 and 2014.

In addition to reviewing EOCs and CMS call letters for the above plans, Medicare Rights gained further insight by conducting hour-long interviews with plan staff members who oversee Medicare products, structuring the conversations around a set of questions provided to the interviewees in advance (Appendix 1). Although we reached out to all plans to give them the opportunity to participate, plan representatives were less willing to discuss payment rate changes than they were in 2011 and 2012, when we spoke with them for our previous report. During the interviews, representatives were more reserved than they had been in the past, and several plans required anonymity as a condition for proceeding with the conversation. We conducted interviews with three plans.

Questions centered on plan benefit and cost changes, these changes’ relation to ACA-mandated payment reforms, and anticipated adaptation to future changes in payment.

2011-12 Medicare Advantage Landscape

As noted in our previous report, despite plan payment methodology changes that took effect in 2011 and some dire industry predictions, Medicare Advantage premiums and benefit packages were stable in 2011 and 2012.^{73,74} National MA plan enrollment increased by approximately 6 percent between 2010 and 2011 and by 10 percent in 2012.^{75,76} Further, MA plan premiums fell on average by 7 percent in 2012.⁷⁷ The number of plan offerings did decrease from 2,307 in 2010 to 1,964 in 2011. However, this change was caused primarily by a CMS initiative to eliminate plan offerings with low

two additional plans also serve: Albany, Essex, Fulton, Hamilton, Herkimer, Madison, Montgomery, Oneida, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

⁷² 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>.

⁷³ Cosgrove, *Medicare Advantage: Enrollment Increased from 2010 to 2011 while Premiums Decreased and Benefit Packages were Stable*.

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ Bunis, Dena, *Medicare Advantage Premiums Down, Enrollment Up*, CQ HealthBeat News, February 1, 2012.

⁷⁷ *Id.*

enrollment or those that were duplicative of other plan offerings from the same insurer.⁷⁸ Interestingly, reducing plan offerings in counties with a high number of plans may have helped to increase MA plan enrollment in 2011 by simplifying an overly complex landscape.^{79,80}

In 2011-12, New York followed the national trend: the state MA plan landscape remained relatively stable in 2011 and the state MA enrollment rate increased by approximately 4 percent. Furthermore, 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.

2013 Medicare Advantage Landscape

Nationally, the Medicare Advantage landscape remained healthy in 2013. Indeed, enrollment increased by nearly 10 percent—to 14.4 million—and premiums shifted little from 2012 levels.⁸¹ There was a slight increase in the total number of plans offered in 2013 compared to 2012—2,074.⁸² The average beneficiary had the same number of plans—20—available to them during open enrollment, with 10 of these likely to be HMOs, four local PPOs, two regional PPOs, and two PFFS plans.⁸³ All told, 87 percent of beneficiaries had access to a zero-premium plan, where the beneficiary is responsible for only the Part B premium and no additional monthly payment to the plan.⁸⁴ Although other cost sharing can be higher in these zero-premium plans, and they tend to be HMO plans with more limited networks, these plans are popular with lower-income beneficiaries.

New York continued to be representative of national trends. In 2013, 1.04 million New Yorkers were enrolled in a Medicare Advantage plan, up from 992,699 in 2012.⁸⁵ In January of 2013, 33 percent of eligible New Yorkers were enrolled in an MA plan, up from 30 percent in 2012.⁸⁶ There was a slight reduction in the number of plans offered in New York, from 180 in 2012 to 176 in 2013, but all New Yorkers maintained access to at least one MA offering.⁸⁷

⁷⁸ Gold, Marsha, Gretchen Jacobson, et al., *Medicare Advantage 2011 Data Spotlight*, Kaiser Family Foundation, October 2011.

⁷⁹ 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.

⁸⁰ *Id.*

⁸¹ Gold, Marsha, Gretchen Jacobson, et al., *Medicare Advantage 2013 Data Spotlight*, “Enrollment Market Update” Kaiser Family Foundation, June 2013.

⁸² Gold, Marsha, G. Jacobson, A. Damico, and T. Neuman. “Medicare Advantage 2013 Spotlight: Plan Availability and Premiums” Kaiser Family Foundation, December 2012.

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Kaiser Family Foundation Enrollment Tracker, at <http://kff.org/medicare/state-indicator/total-enrollment-2/>

⁸⁶ Data taken from County level MA penetration data available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/MA-State-County-Penetration.html>, January 2012.

⁸⁷ Kaiser Family Foundation Enrollment Tracker, at <http://kff.org/medicare/state-indicator/total-enrollment-2/>

2014 Medicare Advantage Landscape

The national Medicare Advantage plan landscape experienced a net change of only 60 plan products from 2013 to 2014, with a total of 2,014 MA plans available this year.⁸⁸ While 350 plans were discontinued between 2013 and 2014, more than half of these were PFFS plans, a category that has been steadily declining in availability and popularity.⁸⁹ The other 117 plans were discontinued as a result of plan consolidation and organizational mergers, a trend, described above, intended to eliminate under-performing and duplicative products.^{90,91} Also, because new plan offerings entered the marketplace at the same time that other products were discontinued, the impact on beneficiary choice is likely to be minimal.⁹² Indeed, enrollment in Medicare Advantage has continued to rise nationally, with 15.7 million beneficiaries enrolled in MA plans in 2014, and premiums have remained stable, though some plans have increased out-of-pocket maximums between 2013 and 2014.⁹³

New York's MA marketplace was similarly steady in 2014. Enrollment into MA plans grew to 1.14 million enrollees, or 35 percent of eligible beneficiaries.⁹⁴ The number of plans offered increased to over 200.⁹⁵ These modest changes are also reflected in Medicare Rights' analysis of EOCs in New York. While some benefits were scaled back or eliminated, other benefits were added or improved.

As discussed in more detail below, we saw more shifting and adjustments within plan benefits, year-to-year, rather than a steady, multi-year trend toward less generous overall plan packages. For example, in one plan, outpatient rehab copays decreased if the service was provided in an office setting, but increased if the service was provided in a hospital setting.

Overall, we found that plan benefits have not changed substantially over the last four years. To the extent that costs changed, we saw both increases and decreases in beneficiary costs over different years. Although most changes were minimal, we found that the PPO plans changed a bit more than HMO plans. Many of these changes affected cost sharing for out-of-network services. We also found that higher star-rated plans tended to change slightly less than some of the lower rated plans. These changes

⁸⁸ Gold, Marsha, G. Jacobson, A. Damico, and T. Neuman. "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums" *Kaiser Family Foundation*, December 2013.

⁸⁹Id.

⁹⁰ Id.

⁹¹2013 Call Letter.

⁹² Gold, "Medicare Advantage 2014 Spotlight"

⁹³ Id.; Marsha Gold, [Gretchen Jacobson](#), [Anthony Damico](#) and [Tricia Neuman](#), "Medicare Advantage 2014: Enrollment Market Update," May 1, 2014.

⁹⁴ Data taken from County level MA penetration data available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/MA-State-County-Penetration.html>, January 2013.

⁹⁵ Fact Sheet, CMS, Sept. 19, 2013. Available at <http://www.cms.gov/Center/Special-Topic/Open-Enrollment/Downloads/2014-Health-and-Drug-State-Fact-Sheets.pdf>.

are explored in more detail in the section that follows and are summarized in table 4 below.

Table 4: Plan changes among 2011 and 2014 plan years

	AARP	CDPHP	Emblem	Empire	Excelsus	Humana	Liberty
Premium	Same	Decrease	Same in some counties, increase in others	Increase	Decrease	Slight increase	Same
Cost Sharing	Slight increase overall	Decrease	Decrease	Fluctuated, no net trend	Slight increase	Increase	Increase on a few services
Out-of-Pocket Maximum	Same	Decrease	Decrease	Increase	Increase in-network, decrease total	Increase	Same
Utilization Management	Decrease	Fluctuated, no net trend	Slight increase	Slight increase	Decrease	Decrease	Same
Supplemental Benefits	Decrease	Increase	Increase	Decrease	Same	Fluctuate	Slight increase

Detailed Assessment of Plan Changes

The following summaries synthesize key changes within the targeted plans. As noted above, this analysis revealed no major changes within 2014 plan costs or benefits design; the following sections describe the more granular changes implemented by plans from year to year. For each plan, we highlight the star rating, key costs (including significant changes to premiums and copayments), and key benefits (including potentially noteworthy changes to preventive care, prescriptions, and other services—as well as preauthorization requirements, which can impede beneficiary access to care). Some benefit changes, like increased zero cost coverage of certain preventative services, were mandated by the ACA and guidance from CMS. Although some plans offered these benefits before the mandate, we did not focus on coverage changes that were required of all plans.

Humana HumanaChoice PPO, Southern Tier New York

Star Rating: 3.5 stars in 2013 and 2014

Costs: The premium is higher in 2014—\$24—than it was in 2011 (\$21), 2012 (\$19), or 2013 (\$22) but only modestly so. There was also an overall slight increase in copayments between 2011 and 2014. In 2012, there was a reduction in copayments and coinsurance for many out-of-network services, but these changes were largely reversed in 2013 and the reversal was maintained in 2014. The increases to cost-sharing were largely focused on out-of-network benefits, with a general trend toward increasing the use of coinsurances rather than copayments for out-of-network benefits.

Some copayments, including those for dialysis equipment, advanced imaging, and some services received in outpatient hospital settings, decreased.

Benefits: Benefits were expanded through the addition of coverage for over-the-counter drugs and supplies, and a supplemental hearing benefit. Benefits were reduced, however, in that a dental supplemental benefit was removed and the supplemental vision benefit became more limited. Cardiovascular disease testing was also limited to once every five years, consistent with coverage of this preventive service under Original Medicare. Prior authorization requirements shifted: fewer durable medical equipment services require prior authorization than in 2011, but prior authorization requirements were added to two specific outpatient surgical services in 2013.

EmblemHealth VIP HMO

Star Rating: 3 stars in 2012, 3.5 stars in 2013, 3.5 stars in 2014

Costs: Overall consumer costs decreased from 2011 to 2012 but have now risen slightly. Plan premiums vary by county: in Bronx, Kings, Queens, New York, and Richmond counties, premiums have remained \$0 since 2011, while in Nassau, Suffolk, and Westchester counties, premiums have increased by roughly \$50 since 2011. Out-of-pocket maximums have decreased significantly since 2011, from \$6,700 to \$3,400 in 2012 and thereafter. From 2011 to 2012, the majority of the plan's copayments decreased or stayed the same, and copayments remained stable overall in 2013 and 2014.

Benefits: Dental services have been removed from the supplementary benefits offered by the plan, but there have been simultaneous expansions of vision coverage, hearing services and health and wellness programs. Since 2011, prior authorization has been reduced for some benefits and increased for others: as a whole it appears that the plan has increased prior authorization slightly, and has moved toward higher-cost sharing for outpatient care.

Excellus BlueCross BlueShield Medicare Blue PPO Plan ONE⁹⁶

Star Rating: 4.5 stars in 2013 and 2014

Costs: Premiums were eliminated in 2012. Other costs, however, including in-network out-of-pocket maximums, have increased slightly. The out-of-pocket maximum was \$4,000 in network and \$10,000 combined in 2011 and 2012. The combined maximum was reduced in 2013 and 2014, but the in-network maximum was increased. Copayments were increased between 2011 and 2014 for ambulance services,

⁹⁶ Plans Compared: We compared the Excellus Medicare Blue PPO Plan One in 2011 and 2012. In 2013, the plan was canceled. We compared the Excellus Medicare BlueClassic plan in 2013 and 2014 because it appeared to be most similar to Excellus Medicare Blue PPO Plan One.

emergency care, urgent care, outpatient rehabilitation services, some inpatient care and other services, but the increases were generally modest, for example from \$43 in 2013 to \$45 in 2014 for outpatient rehabilitation. Ambulance services increased more, from \$100 to \$175. Outpatient surgery cost sharing changed from a 20 percent coinsurance to a \$250 copayment per visit, and this and similar coinsurance-to-copayment changes could have differing impact on beneficiary costs, depending on the price of a service. In-network x-ray cost sharing was reduced from \$40 to \$20 between 2011 and 2014. Notably, outpatient mental health coinsurance was reduced to 20 percent in 2014, down from 45 percent in 2011. Coinsurances for in-network partial hospitalization services and for in-network substance abuse services were also reduced from 50 percent to 20 percent.

Benefits: Benefit changes to this plan were slight and largely brought its benefits in line with those offered under Original Medicare. The fitness benefit was restructured in a way that might increase reimbursement for some beneficiaries and decrease it for others. A once-per-year limit on hearing screenings was removed, and a prior authorization requirement for coverage of some inpatient services was removed in 2014.

Empire BlueCross BlueShield MediBlue Freedom I (PPO)

Star Rating: 3.5 stars in 2013 and 2014

Costs: The plan premium has increased significantly since 2011 and 2012 when it was zero, to \$30 per month in 2013 and is \$50 in 2014. The out-of-pocket maximum has remained the same since 2012: \$4,500, which is \$1,000 more than in 2011. This plan has changed its copayments each year, but the changes are very mixed.

Benefits: Decreased use of prior authorization in 2013 was reversed in 2014, but overall mirrors the standards in place in 2011. There have been some improvements to benefit access beyond prior authorization, including removal of a post-hospitalization notification requirement, the removal of the lifetime limit on inpatient mental health care, the re-introduction of coverage for emergency care outside the United States, and expansion of coverage for diabetic self management, including shoes. Fitness and wellness benefits, however, have been reduced.

AARP MedicareComplete Essential (HMO), insured through UnitedHealthcare

Star Rating: 3 stars in 2013 and 2014

Costs: Premiums and out-of-pocket maximums are unchanged since 2011, at \$0, and \$5,900, respectively. The plan increased the majority of its copayments in 2014, with only a few cost-sharing reductions. Many of the increases were small, but ambulance transportation copayments increased by \$125 per trip.

Benefits: The majority of the plan's benefit changes occurred in 2012. For instance, the plan dramatically decreased prior authorization for many services, and has maintained that reduction. In 2012, frequency limits were added to a number of services, and the medical nutrition therapy benefit was reduced. Since 2012 the benefit package has been quite stable. Small changes include the addition of frequency limitations for screening services, often bringing them in line with Original Medicare schedules.

Liberty Preferred Choice HMO

Star Rating: 2.5 stars in 2011 and 2012, 3 stars in 2013 and 2014

Costs: The premium has remained \$0 since 2011. In 2012, the out-of-pocket maximum declined from the highest allowable amount—\$6,700—to \$3,400, but increased to \$5,000 in 2014. Copayments have remained at \$0 for most services. Increases to cost sharing were narrowly targeted: only a small number of services had cost sharing increases, but these increases tended to be costly. The most substantial change in copayments between 2011 and 2014 was the increase in cost for inpatient mental health care from \$0 to \$900. In 2014, other inpatient hospital care increased in cost from a \$0 copayment to a \$75 copayment for the first seven days of care. SNF care costs have also risen, with days 1-20 now costing \$25 each.

Benefits: The plan requires prior authorization for most services. Since 2011, some additional services have been added to the prior authorization list, including acupuncture, medical nutritional therapy, podiatry services, diabetes self-management services, and outpatient rehabilitation services. In 2013, the plan expanded the DME benefit, and in 2011, additional telehealth services were made available to people living in all locations. Coverage for transportation services has also increased. Some benefits have been reduced: plasma glucose tests and fasting glucose tests are now only covered if certain risk factors are present, and the number of acupuncture treatments is limited.

CDPHP Choice Rx (HMO)

Star Rating: 4.5 stars in 2011, 2012, 2013, and 2014

Costs: The premium is lower in 2014 than it was in 2011. In 2012 the premium was reduced from \$83 to \$75. Since then, the premium has increased each year and is \$81 in 2014.

In 2012, there was a significant reduction in the out-of-pocket maximum, from \$4,000 to \$2,500, and this amount remains stable. Overall, copayments have decreased between 2011 and 2014. For example, copayments were reduced or eliminated for ambulance services, cardiac rehabilitation services, Part B prescription drugs and pulmonary rehabilitation. Copayments for health and wellness counseling have increased since 2011. The most significant increase and overall fluctuation over the years has taken place in partial hospitalization copayments: in 2011, the copayment for this service was

\$20. The copayment was increased to \$275 in 2012 and then decreased to \$110 in 2013 and to \$55 in 2014.

Benefits: Prior authorization is no longer required for cardiac rehabilitation services, pulmonary rehabilitation and outpatient rehabilitation services. A prior authorization requirement was added to repairs, adjustments and replacements of DME. Overall, there have not been a great number of changes in benefits between 2011 and 2014. Two exceptions are the implementation of limits on certain cardiovascular therapy. Specifically, intensive cardiac rehabilitation services were limited to 72 visits in 2012 and 2014 but not in 2013; and cardiovascular disease testing did not have a frequency limit in 2011 but beginning in 2012 is limited to once every five years.

*Insurer Interviews*⁹⁷

Medicare Rights Center contacted six of this analysis' seven insurers to participate in an hour-long interview to gather additional information about the plans, the broader New York market, and potential insurer responses to payment changes in the outer years of ACA implementation. Staff who oversee Medicare products for three of the insurers participated in these interviews and informed Medicare Rights that:

- Payment changes in 2012, 2013 and 2014—including the sequester cuts described above and reductions in payments as a result of slowed health care cost growth—can either be passed along to consumers or absorbed by the plans.
- 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.
- Insurers who offer zero-premium plans are very reluctant to introduce premiums and prefer to utilize other methods of cost control.
- Network size reductions are one means of reducing costs and increasing efficiency within the plan.
- Insurers must engage beneficiaries to better understand their plan experiences, and engagement should take place through a variety of media, including online tools.

During interviews, selected insurers expressed concerns regarding benefits and plan choice in the years beyond 2014. Overall, there was a sense that the payment changes thus far were absorbed by the insurance companies and not passed onto beneficiaries in the form of reduced benefits or higher cost-sharing, but there were concerns about insurers' ongoing abilities to shoulder these costs.

Several insurers referred to the cumulative nature of the reductions and noted that a combination of factors could hurt plans in 2015 and beyond. These factors include the

⁹⁷ Appendix 1: "Sample Memo and Question Set Sent to Insurers" included at the end of the report.

ACA benchmark recalculation and reductions, the sequester, the potential that the Sustainable Growth Rate (SGR) formula, the statutorily dictated mechanism for setting provider payment rates, which has been routinely put off to avoid dramatic cuts to physician payments, would not be altered by Congress,⁹⁸ and potential reduced payments based on lower Original Medicare costs. These concerns echo industry responses to the payment rate proposals in both the 2014 and 2015 proposed call letters, which have been subsequently adjusted to more modest reductions than initially proposed. CMS states that it remains committed to the ACA's model, "however, for 2015, given the number of changes in other payment factors, we believe that providing a longer timeframe for full implementation is appropriate."⁹⁹

Despite anticipated reductions in payments, all insurers expressed reluctance to tinker with the benefit package, and two expressed that low or zero premiums remained a priority. All insurers mentioned, as an alternative belt-tightening strategy, creating smaller, more efficient networks. While some insurers were concerned and expressed reservations about beneficiary access and the extent of CMS oversight in their competitor's networks that have been reduced recently, others expressed hope that savings could be achieved through working with doctors who have an interest in participating fully with the plan. Specifically, insurers described efficiencies that can be obtained when all providers within the plan network are committed to sharing information with other network doctors, obtaining feedback and information from the plan about the treatment that members are getting, and investing in technologies that facilitate easy and secure communications. Insurers also talked about how to prioritize some of the increased costs that had to be passed onto beneficiaries. One insurer mentioned that the plan tried to first reduce costs for preventive services, then services that are widely used, and to increase cost sharing for services with low utilization as a final cost savings mechanism.

All of the insurers commented about how vital it is for them to obtain high star ratings and described efforts that they are engaged in to increase scores across various metrics. For instance, several insurers engage in active outreach through nurses or case managers to encourage beneficiaries to obtain needed screenings, tests and medications. Others are more focused on the customer satisfaction scores and have engaged in strategies, including "over informing," or providing more notice and information than is required by CMS, to beneficiaries about any change in their benefits, network and/or cost-sharing. As they are working to improve their plans' star ratings, however, insurers continue to express some concerns about the star rating metrics, particularly since these ratings do not take into account differences in populations served by various plans.

⁹⁸ The SGR payment reduction was delayed in April 2014. Protecting Access to Medicare Act of 2014 (H.R. 4302; Pub.L. 113-93).

⁹⁹ Hollander, Catherine "CMS to Increase Medicare Advantage Pay Rate by 0.4%" *Modern Healthcare*, April 7, 2014. Available at: <http://www.modernhealthcare.com/article/20140407/NEWS/304079938/cms-to-increase-medicare-advantage-pay-rate-by-0-4>

The need for increased communication with members was a 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 services, and satisfaction surveying. Insurers want beneficiaries to be fully informed of the range of services—particularly preventive services—available to them for low or no cost. Additionally, online tools—particularly as baby boomers age into Medicare—are a priority for many insurers.

Conclusion

The Affordable Care Act and other recent policies aim to bring Medicare Advantage payments in line with the cost of providing the same care under Original Medicare. While across-the-board cuts to Medicare Advantage have been instituted, this report finds that cuts to New York State MA plans have had minimal effect on the state's MA market or on beneficiaries themselves. Additionally, there now exist an array of opportunities for high-performance plans to secure increases to their payments, most notably through the CMS star rating system.

Benefit structure and costs have remained quite stable in the four years since the passage of the ACA, and MA enrollment has continued to increase. While individual plans have made year-to-year changes in their cost structure and benefits, they often reverse course in subsequent years, pointing to a tendency for plans to make small adjustments to costs and benefits rather than shift the cost of payment reductions onto beneficiaries.

For now, MA plans are not dramatically changing their cost and benefit structures. At the same time, plan adjustments—however small—underline the ongoing importance of beneficiaries examining their plan choices on an annual basis. In order to obtain coverage that is right for them and ensure the efficient operation of the plan marketplace, beneficiaries should be equipped to evaluate their plan's annual changes against other options available to them.

Appendix 1

Sample Memo and Question Set Sent To Insurers

Project background

The Medicare Rights Center has received a grant from the United Hospital Fund (UHF) to conduct a second analysis of Medicare Advantage (MA) plan benefits between the 2011 and 2014 plan years. The following survey will examine plan offerings from several insurance companies in New York State, including: UnitedHealth, Excellus, BlueCross, Emblem, Capitol District Community Health Plan, Liberty, and Humana.

The genesis of the UHF grant was concern over potential changes in the scope of plan benefits and beneficiary cost sharing owing to implementation of payment reductions to MA plans under the Affordable Care Act. Medicare Rights and UHF wanted to explore how payment reductions—and related incentives— could affect both the benefit structure and the focus of diverse insurance products. Medicare Rights' analysis last year of the New York State MA landscape found that plan offerings remained relatively consistent despite implementation of aspects of the ACA. Results from this analysis can be found here: <http://www.medicarerights.org/policy/priorities/new-yorks-medicare-marketplace-june-2012/>.

Now, Medicare Rights, undertaking its second analysis of New York State's MA landscape, is comparing plan evidences of coverage (EOCs) and related materials from 2011 to 2014. We are also conducting interviews with representatives of the seven targeted companies to determine the anticipated and actual effects of payment changes—on a specific MA plan and on their MA plan offerings in general—and how companies are adapting to these changes. This year's conversations follow up on five insurer interviews conducted in 2012.

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

The product of the research collected here and elsewhere will be a second report released in late spring that summarizes the findings of plan comparisons and interviews and makes predictions about the MA plan landscape in New York in future years.

Call Questions

- 1) What are the major plan-specific benefit or structural changes you would highlight over the past two years? New benefits? Changed benefits? Changes in premiums, deductibles, copayments?
- 2) What company-wide MA-related changes would you highlight over the same period? –For instance, describe any changes in the balance of your MA portfolio among different plan types.

- 3) What was the impetus for any changes described above? ACA regulations? Actuarial findings? Member utilization? Other?
 - a. How would you weight the various factors?
- 4) What is the expected effect of future payment reform changes on this plan? On other plans your company offers?
- 5) Describe any changes in this plan's provider network over the past two years. What do you think are the causes for these changes?
- 6) How does your plan/company currently engage beneficiaries to learn about their plan experiences? What percentage of your MA customers would you estimate you currently engage about their plan experiences?
- 7) What, if any, new initiatives is your company considering to assist beneficiaries in understanding their insurance and how to manage their care? For instance, are you...[provide a few examples to stimulate conversation]
- 8) With new payment mechanisms providing additional funding to 4- and 5-star plans, what, if any, initiatives is your company pursuing to increase plan ratings?