THE FUTURE OF PRIVATE PLANS UNDER THE MEDICARE PROGRAM

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Vicki Gottlich, Esq.
Center for Medicare Advocacy, Inc.

Medicare Part C: Medicare Advantage (MA)

- Provides for alternative delivery systems
  - Coverage criteria are required to be the same as those in traditional Medicare
- Must cover the same “package” of services as traditional Medicare
  - But actuarially equivalent benefit structure
  - Some but not all provide prescription drug coverage
- Use overpayments to provide additional services

Medicare Advantage General Description

- Types of Plans:
  - Coordinated Care plans
    - Health Maintenance Organizations (HMOs)
    - Preferred Provider Organizations (PPOs)
      - Local and regional
    - Special Needs Plans (SNPs)
  - Private fee-for-service plans (PFFS)
  - Medicare Medical Savings Accounts (MSAs)

Key an Eye On:

Special Needs Plans

- Fastest growing coordinated care plans
  - Coordinated care plan that exclusively or disproportionately enrolls special needs individuals
  - Must provide Part D benefits to all enrollees.
  - Special needs individual are
    - Institutionalized,
    - Dually eligible, or
    - Has a severe or disabling chronic conditions

Changes to Medicare Advantage Plans

- Changes to private plans are occurring as a result of:
  - MIPPA 2008
  - Changes in administrative policies
  - Health care reform legislation
- Despite everything, private plans are here to stay

MIPAA Changes to Special Needs Plans

- New requirements for 2010 for all SNPs
  - Evidence-based model of care with appropriate networks of providers and specialists
  - Initial assessment and annual reassessment of individual’s physical, psychosocial and functional needs and
  - Development of care plan with individual’s participation as feasible

MIPPA Changes to Special Needs Plans

- New requirements (con't)
  - Data collection and reporting relating to compliance with new plan requirements. Must be done at the plan, rather than sponsor, level.
  - All plans must enroll only those who meet the statutory definition of special needs individual for that type of SNP.

MIPPA Changes to Special Needs Plans

- New requirement for I-SNPs
  - If enrolling individuals from the community but needing an institutional level of care, must use a state assessment tool and must have the assessment performed by an entity other than the plan sponsor

MIPPA Changes to Special Needs Plans

- New requirements for D-SNPs
  - Must provide each prospective enrollee with information about their state Medicaid benefits and cost-sharing protections and which, if any, of those is available under the plan
  - Must have contract with State Medicaid agency to provide or arrange for provision of state Medicaid benefits; if plan does not have such a contract, it cannot expand service area

Medicare Advantage Special Needs Plans

- New requirements for D-SNPs (con't)
  - Prohibits D-SNPs from imposing cost-sharing on dual eligibles and Qualified Medicare Beneficiaries that is more than would be required under their State Medicaid plan

MIPPA Changes to Special Needs Plans

- New requirement for C-SNPs
  - Enrollees must have "one or more [co-morbid] and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care."

MIPPA Changes to Private Fee-For-Service Plans

- PFFS plans
  - No care coordination
  - Providers can accept on case by case basis
- 2010 - must have quality improvement program and report quality data
- 2011 most must have a network of providers
  - Many plans have left or will leave Medicare

Administrative Changes to Medicare Advantage Plans

- Biggest change is in oversight and enforcement
  - Ex., January 2010 letter re SNPs
- Changes to MA Payment policy
  - Reduce “up-coding”
  - Reduce increases in payments
  - Cost-sharing for clinical trials

Administrative Changes to Medicare Advantage Plans

- Changes through the Call Letter
  - Suggested reduction in number of plan offerings
  - On-going clarification of non-discrimination in benefit package
  - Application and filing processes
- New final regulations to be issued in the next few months

Health Care Reform

- Changes to payment structure
  - Based on benchmarks
    - Big cities the biggest losers
  - Bonuses for quality
  - Extends “upcoding” prohibition
  - Reconciliation bill requires 85% Medical Loss Ration

Health Care Reform

- Beneficiary- related changes
  - 2011 – can’t have cost-sharing higher than original Medicare for some services
    - **BUT** – can charge cost-sharing when original Medicare doesn’t charge cost-sharing
  - Any OOP cap must apply to all A/B services
  - 2012 – rebates go first to reducing cost-sharing, then adding wellness/prevention, then non-A/B benefits
  - Extension of SNPs to 2013, with additional requirements

Health Care Reform

- Beneficiary-related changes
  - Secretary to categorize plans based on benefit structures, medical loss ratio
  - 2012- changes to the enrollment periods
    - October 15 – December 7
    - Eliminate Open Enrollment (Jan – March)
      - 45 days to leave MA and return to traditional Medicare
  - Improved complaint tracking and monitoring

CENTER FOR MEDICARE ADVOCACY, INC.

Call on us

202-293-5760 (DC office)
860-456-7790 (CT office)

www.medicareadvocacy.org

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