



# HEALTH CARE REFORM update



BlueCross BlueShield  
of Kansas City

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## Summary of Medicare Advantage and Part D Provisions

On March 23, 2010, President Obama signed into law the “Patient Protection and Affordable Care Act” (PPACA). A reconciliation bill making changes to the Act was signed by the President on March 30, 2010. The PPACA as amended by the reconciliation bill is collectively referred to as the Act in this summary. This summary provides an overview of the Medicare provisions.<sup>1</sup>

### *Funding Cuts*

The reform bill is funded in large part by cuts in Medicare Advantage (MA). Over the next 10 years the government will cut funding for MA by about \$131 billion directly and an additional \$70 billion from interactions with cuts in Fee for Services (FFS) Medicare. Congress is working on legislation outside of the reform bill to address doctor payments - the doc fix - which will also impact prices and/or benefits (§ 1102 of the Reconciliation bill).

- For 2011, rates are frozen at 2010 levels.
- For 2012 and future years, rates are phased down. In 2012, the base amount reflects ½ the current benchmark and ½ the modified benchmark. In 2013, the base amount is 100% of the modified benchmark. Longer phase-in schedules are allowed: if the MA organization would face a reduction between \$30-\$50 dollars then the phase-in runs for four years and if more than \$50 dollars then the phase-in runs for five years. The modified benchmark is based on the county’s relative FFS costs. Counties in the highest-quartile of FFS spending would have modified benchmarks of 95% of the FFS costs, the second-highest are 100%, the third highest are 107.5%, and the lowest-cost counties have a modified benchmark of 115%.
- Also beginning in 2012, plans will be eligible for quality performance bonuses. All four and five star plans would receive a 5% increase, phased in over three years (1.5% in 2012, 3% in 2013, and 5% in 2014). The increase is doubled for qualifying plans in qualifying areas: historical urban floor, at least 25% MA penetration, and below average FFS spending.
- Beginning in 2012 and phased in through 2014, the calculation of the amounts by which the MA organization’s bid is less than the benchmark – the “beneficiary rebates” – are increasingly a product of the plan’s star ranking rather than a plan retaining a flat 75% of the difference. By 2014, plans with 4.5 or more stars will retain 70% of the beneficiary rebate amounts, and those with less than 3.5 stars only 50%. The permitted usage of the beneficiary rebates is also changed, as described below.

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<sup>1</sup> PPACA: [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h3590enr.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf)  
Reconciliation: [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h4872pcs.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872pcs.txt.pdf)



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## ***Benefit Design & Bid Requirements (§ 3202 of the Act regarding benefits and §3209 on bids)***

- For plan years beginning in 2011, cost-sharing in MA cannot be greater than it is in original Medicare fee-for-service for three identified services - chemotherapy, renal dialysis, skilled nursing care - or for other services CMS determines.
- For plan years beginning in 2012, the Act limits how plans may use the beneficiary rebates (as described above) and bonuses. Plans must use most of the funds to reduce cost sharing for any of the benefits under original Medicare fee-for-service parts A, B, and D (and not to reduce or eliminate the Part B premium) and any reduction in out-of-pocket spending limits would be required to apply to all Part A and B benefits. The second and third priorities are to add preventative and wellness benefits and to add non-covered benefits (such as dental benefits).
- *For bids submitted for contract years beginning in 2011, an MA or Part D Plan (PDP) bid may be rejected if it proposes significant increases in cost-sharing or decreases in benefits offered under the plan.*

## ***Medical Loss Ratio***

- Beginning in contract year 2014, Medicare Advantage plans will be required to spend at least 85% of premiums on care and care-related activities or else pay a refund to the government of the amount over that threshold. If the plan doesn't meet that standard for three years then it will be barred from taking new enrollees and after five years its MA contract would be terminated. (§ 1103 of the Reconciliation bill).

## ***Member Elections (§3204 of the Act)***

- Enrollment – With respect to 2012, the annual enrollment period for MA and PDPs will be October 15 – December 7.
- Disenrollment – Beginning in 2011, enrollees in an MA plan will have a disenrollment period, January 1 – February 15, during which beneficiaries may disenroll and return to original Medicare fee-for-service and elect qualified prescription drug coverage.

*Open issue:* this disenrollment period only appears to apply with respect to MA and not for a Part D plan.

## ***Changes Specific to Part D (MA-PD and PDP plans)***

- *Closing the coverage gap or donut-hole.*
  - In 2010, beneficiaries who reached the gap would have received a \$250 rebate from the government. The rebate amount will be distributed by the government, by the 15th day of the third month following the end of quarter in which the beneficiary reached the gap (§1101(a) of the Reconciliation bill).
  - Beginning in 2011, coinsurance for generic drugs in the gap is 93% and is lowered by 7% each succeeding year, such that the coinsurance for generic drugs is 25% by 2020. (§1101(b) of the Reconciliation bill)



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- Beginning in 2013, coinsurance for brand name drugs in the gap are progressively lowered until 2020 at which time it is 75% (§1101(b) of the Reconciliation bill).
- Beginning in 2011, brand name drug manufacturers agreed to provide discounts of 50% off the negotiated price (§3301 of the PPACA). CMS will issue guidance and administer this program. The combination of the 50% discounts and 75% coinsurance results in the beneficiary paying 25% of the cost of the drug.
- Beginning in 2014, the annual growth rate applied to the Part D catastrophic threshold is reduced.
- **TrOOP (True Out-of-Pocket Costs).** Calculations toward the annual out-of-pocket threshold are to include:
  - Beginning in 2011, costs incurred in providing prescription drugs by AIDS drug assistance programs, state pharmaceutical assistance programs (SPAPS), and the Indian Health Service (§3314 of PPACA).
  - The negotiated price for brand-name drugs provided at a discount as described above, and not the discounted price. (§3301(c) of PPACA).
- The **Low-Income Subsidy (LIS)** program.
  - Beginning in 2011, the LIS benchmark amounts are calculated without including the beneficiary rebates or bonus payments described above (§3302 of PPACA).
  - Beginning in 2011, plans that bid a nominal amount above the regional LIS benchmark can choose to absorb the cost of the small difference between their bid and the LIS benchmark. CMS will define the “de minimus” threshold. If the plan waives the premium, then new beneficiaries may be auto-enrolled in the plan and existing enrollees will not be reassigned (§3303 of PPACA).
  - Beginning not later than 2011, an LIS beneficiary who is reassigned will be provided with information on formulary differences with respect to the individual’s drug regimens within 30 days of the reassignment (§3305 of PPACA).

*Open Issue:* The initial plan likely will be required to provide drug utilization data to either CMS or the beneficiary; the process is not clear.

- **Formularies.** For plan years beginning in 2011, CMS is given authority to identify classes of clinical concern (without criteria), with six classes of clinical concerns codified now until rules are issued. The classes are: Anticonvulsants, Antidepressants, Antineoplastics, Antipsychotics, Antiretrovirals, and Immunosuppressants for the treatment of transplant rejection. A plan is required to include all covered part D drugs in these classes. CMS may establish exceptions or to otherwise limit access including through prior authorizations or utilization management (§3307 of PPACA).
- **High-income beneficiaries.** Beginning in 2011, the premium subsidy is reduced for beneficiaries with modified adjusted gross income amounts exceeding the Part B threshold (§3308 of PPACA).
- **Complaints.** A uniform complaint system is to be developed to collect and maintain complaints on MA-PD and PDP plans that are received through any channel (the plan or any of the various governmental agencies) along with a resolution date (§3311 of PPACA).



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- **Uniform Exceptions and Appeals.** For exceptions and appeals on or after January 1, 2012, each PDP and MA-PD plan is to use a uniform process for coverage determinations (HHS may develop a model form). The sponsor is also to provide instant access to the process through a toll-free number and Internet website (§3312 of PPACA).
- **Medication Therapy Management Programs:** Establishes new requirements for Medication Therapy Management Programs, for plan years beginning on or after March 23, 2012 (§10328 of PPACA).
  - Requires such programs to include annual comprehensive medication reviews provided person-to-person or via telehealth by a licensed pharmacist or other qualified provider, resulting in an action plan and a summary of the results of the reviewer. Regulations will define the relevant telehealth technologies and formats for the action plan and summary.
  - Mandates that such programs perform assessments on at least a quarterly basis of the medication use of at-risk individuals who are not enrolled in such programs.
  - Requires such programs have processes to automatically enroll at-risk individuals with an opt out.
- **Medigap.** The National Association of Insurance Commissioners (NAIC) is to create new model plans for benefit packages C and F that include nominal cost sharing. The new models C and F are to be available in 2015 (§3210 of PPACA).

*This summary is provided for informational purposes only and is not intended as legal advice. This summary does not reflect any guidance or federal regulations that may have been issued after the passage of PPACA. Please consult your legal advisor for additional information.*