



FACT SHEET

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Strengthening Medicare Advantage

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The policies in the 2015 Medicare Advantage and Part D Rate Announcement and final Call Letter continue the successful implementation of the Affordable Care Act's reforms that improve quality and provide greater protections for beneficiaries and value for taxpayers. Here are the facts:

Since the Affordable Care Act was passed in 2010:

- Medicare Advantage premiums have fallen by nearly 10 percent.
- Medicare Advantage enrollment has increased by 38 percent to an all-time high of more than 15 million beneficiaries, with nearly 30 percent of Medicare beneficiaries enrolled in a Medicare Advantage plan.
- Medicare Advantage enrollees are benefiting from greater quality with over half of enrollees now in plans with 4 or more stars, a significant increase from 37 percent of enrollees in such plans in 2013.
- Access to the Medicare Advantage program remains nearly universal, with 99.1 percent of beneficiaries having access to a plan in their area.
- The average number of plan choices remains consistent in 2014 compared to 2013 and access to supplemental benefits such as dental and vision benefits remains stable
- Over 90 percent of Medicare beneficiaries have access to a \$0 premium Medicare Advantage plan.
- Approximately 80 percent of Medicare beneficiaries have access to a Medicare Advantage plan with Part D drug coverage with a yearly maximum out-of-pocket limit of \$3,400 or less. All Medicare Advantage enrollees are in plans that will have a maximum out-of-pocket limit for all Medicare covered services of \$6,700 or lower.
- 100 percent of Medicare beneficiaries – including Medicare Advantage enrollees – have access to Medicare-covered preventive services at zero cost sharing.

- CMS has taken other steps to strengthen the Medicare Advantage program that include:
 - Allowing Medicare beneficiaries to a one-time opportunity to switch to a 5-star MA plan or Part D plan in their area anytime during the year.
 - Continuing the inclusion of a low performing icon  to the Medicare.gov website so beneficiaries know which plans are not performing well.
 - Requiring that all Medicare Advantage plans spend at least 85 percent of premiums on quality and care and not overhead, profit or administrative costs as required by the Affordable Care Act.

Improving Consumer Protections

CMS intends to again use its authority, provided by the health care law, to protect Medicare Advantage enrollees from significant increases in costs or cuts in benefits, and, for the 2015 contract year, finalizing the permissible amount of increase in total beneficiary cost to \$32 per member per month (down from \$34 per member per month for the 2014 contract year). CMS will maintain existing limits on beneficiaries' maximum out-of-pocket spending, but expand existing guidance by encouraging Medicare Advantage organizations to allow enrollees' dollar contributions towards these limits to be transferable when they move to any plan, regardless of plan type, offered by the same organization instead of starting over in the new plan. CMS also continues to require plans to refine their offerings so that beneficiaries can easily identify the differences between their options.

The final Call letter also requires plans to provide to CMS with 90 days notice of any significant changes to their provider networks in order to ensure help compliance with provider access requirements. The Call letter also establishes best practices for Medicare Advantage Organizations to follow when they make significant changes to their provider networks. Furthermore, in response to comments from beneficiary advocates and some professional associations, CMS is establishing a policy to allow enrollees to switch plans when they are affected by significant mid-year provider network terminations initiated by their Medicare Advantage Organization without cause.

Medicare Advantage – Net Payment Impacts Based on Final Estimates Released on April 7, 2014

The Rate Announcement and final Call Letter continue implementation of changes under the Affordable Care Act to reduce overpayments and improve quality, by phasing in alignment of Medicare Advantage benchmarks with Medicare fee-for-service (FFS) costs. Before the Affordable Care Act, Medicare Advantage plans were paid more than 10 percent more compared to traditional Medicare, costing the program more than \$1,000 per person each year, while quality and health outcomes were similar to those enrolled in traditional Medicare. The changes

underway revise payments to Medicare Advantage plans to be more consistent with costs in traditional Medicare, while incentivizing quality improvements by basing part of Medicare Advantage payment on plan quality performance. The Rate Announcement and final Call Letter also make other non-Affordable Care Act changes to increase payment accuracy such as updating the methodology to calculate risk adjustment normalization factors.

Although payments will vary by plan based on its location and star rating, overall, CMS estimates the net change to plan payments between 2014 and 2015 to be +0.4 percent. Last year, plans instituted modest premium changes and overall enrollment grew by greater than 5 percent.

CMS received over 1,300 comments on the Advance Notice and draft Call Letter that was released on February 21, 2014. Based on those comments, several changes were made for the Rate Announcement and final Call Letter. Key changes include:

- **Modified phase-in schedule for the new risk adjustment model that began in CY2014.** We will blend the risk scores calculated using the 2013 CMS-HCC and 2014 CMS-HCC models at 67 percent and 33 percent, respectively. We are committed to the new 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. In addition, **CMS will not finalize the proposal to exclude diagnoses from enrollee risk assessments.** CMS will continue to analyze the data on home risk assessments we began collecting and may reconsider this proposal to exclude home-based diagnoses for payment purposes in a future plan year.
- **Delayed implementation of new Part D Risk Adjustment Model,** continue using current model.
- **Refined the risk adjustment methodology to account for the impact of baby boomers.** We have calculated the normalization factors for 2015 in order to better account for the effect of baby boomer enrollment.
- **Delayed changes to the Star Ratings.** We are not proceeding with the proposed changes to reduce the Adherence measure weights or any of the proposed “Data Integrity” changes at this time.
- **Enhanced Alternative (EA) Plans.** We are not finalizing the proposal to require plans to provide additional coverage in the gap for generic and brand drugs.

The chart below outlines the year to year percentage change in payment from CY2014 to CY2015.

Year-to-Year Percentage Change in Payment

Impact	Advance Notice Impact	Final Announcement Impact
Growth rate	-1.9%	-3.4%
Benchmark updates	-5.0%	-4.4%
Calibration of the risk model to account for demographic changes (Baby Boom Adjustment)	+3.2%	+4.3%
Other risk adjustment updates	+1.8%	+3.9%
Total	-1.9%	+0.4%

The final Medicare Advantage capitation rates and payment policies for 2015 were released on April 7, 2014. As done each year, Medicare Advantage plans will submit bids in June and all Medicare Advantage plan options for 2015 will be made available to the public as part of the CMS annual landscape announcement, which is prior to the 2015 Medicare Open Enrollment set to begin on October 15, 2014.

Technical Factors Underlying Payment Changes

As part of CMS' Medicare Advantage and Part D 2015 Rate Announcement and final Call Letter release, CMS indicated the final estimate of the combined effect of the Medicare Advantage growth percentage and the fee-for-service (FFS) growth percentage was -3.4 percent (described further below). This historically low growth in Medicare per-capita spending is attributed, in part, to successful initiatives undertaken to promote value over volume and help curb fraud, waste, and abuse in the Medicare fee-for-service program in recent years. It is important to note that this figure is the combined effect of the Medicare Advantage growth percentage and the fee-for-service growth percentage.

As required by the Affordable Care Act, CMS established a new methodology for calculating each Medicare Advantage county rate as a percentage of FFS spending in each respective county. The Affordable Care Act provides for a transitional period during which each county rate is calculated as a blend of the pre-Affordable Care Act rate set under the law (known as the "applicable amount") and the new FFS-based Affordable Care Act rate (known as the "specified amount"). For 2015, most counties will be fully transitioned to the new rate methodology, while others will continue to be based on a blended rate. The Social Security Act requires that the blended benchmark (which is increased by quality bonus payment percentages where applicable) be capped at the level of the applicable amount.

As outlined in the Rate Announcement, the final estimate of the change in the national per capita Medicare Advantage growth percentage for aged and disabled enrollees combined in CY 2015 is

-4.0 percent. The Rate Announcement also includes the final estimate of the FFS growth percentage. The Affordable Care Act requires that the specified amount be calculated as a percentage of the county FFS amounts. For 2015, the final estimate of the change in the Aged/Disabled FFS United States per capita cost (USPCC), which will be used for the county FFS portion of the benchmark is -3.3 percent. The combined impact both of these estimates is -3.4 percent.

Consistent with the 2014 Rate Announcement, the basis for the final growth percentages reflects an assumption that Congress will act to prevent the projected reduction in Medicare physician payment rates from occurring on April 1, 2015. The statute provides the Secretary with the discretion to base the Medicare Advantage Growth Percentage on a current law basis or to base the estimate on what is likely to occur to the physician fee schedule based on recent history. CMS is using this assumption based on the grounds that it is a more reasonable expectation than the reduction required under the statutory “sustainable growth rate” (SGR) formula.

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