

MA Plans Prepare For Final Countdown

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HEADLINE: Medicare Advantage plans prepare for the final countdown

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HIGHLIGHT:

A major growth center for health insurers in recent years is about to become a lot less profitable.

It's been a nice run for Medicare Advantage plans, created by the 2003 Medicare Modernization Act that also created the Part D prescription drug benefit. But the countdown to their ultimate transformation - from highly profitable drivers of fee-for-service growth to a relatively low-margin managed care business - has now officially begun.

The clock started shortly after President Barack Obama signed the landmark health care reform bill March 23, when the Senate voted 56-40 to begin 20 hours of debate on a final reconciliation package. The chamber used up about seven of those hours before adjourning about 10:30 p.m. ET, and the Democratic leadership still hopes to get a vote on the bill - which requires only a simple majority to pass - before breaking for recess March 26.

Before the health care reform bills, enrollment in Medicare Advantage plans had been projected by the nonpartisan Congressional Budget Office to grow from 10.6 million in 2009 to 13.9 million in 2019. But CBO now projects changes in the reform bills will cause enrollment to drop to 9.1 million in 2019, as the reconciliation bill cuts \$135.6 billion from the program from 2010 through 2019, \$17.5 billion more in cuts than under the bill signed by the president. The cuts starts with \$1.8 billion in 2011, add up to \$30.3 billion through the first five years and hit \$25.0 billion in 2019.

Medicare Advantage plans use federal payments in excess of plan bids - which averaged \$87 per member per month in 2009 and were expected to grow to \$135 per member per month in 2019 - to fund additional benefits not covered by traditional Medicare, such as vision, dental, out-of-pocket costs for Medicare Part B or Part D premiums and cost-sharing for Medicare-covered benefits.

The subsidies that plans receive to provide those benefits come out of a formula that calculates the difference between a plan's bid and locally determined benchmarks, which are set at between 100% and 150% of per-capita spending in the local fee-for-service sector. Plans receive rebates equal to 75% of the difference between their bid and the local benchmark.

Under the reform plans, the benchmarks would be reduced significantly. Counties will now be divided into one of four quartiles: a 95% benchmark in those counties with the highest fee-for-service costs; 100% and 107.5% benchmarks in counties with roughly average fee-for-service costs; and a 115% benchmark in counties with the lowest fee-for-service costs. Plans that submit bids above the local benchmark would be required to charge the difference to their enrollees. Plans also will no longer be permitted to use rebates to subsidize Part B or Part D premiums.

For smaller niche players like HealthSpring Inc. that specialize in the Medicare market, the impact could be significant. According to SNL data, HealthSpring subsidiaries that filed health insurer statements with the NAIC reported \$1.9 billion of direct written premiums in the Medicare line of business in 2008, finishing the year with roughly 162,100 members. According to Chairman and CEO Herbert Fritch, the company closed out 2009 with 189,000 Medicare Advantage members.

"Unfortunately, what we found and I think what a lot of the industry finds is the vast majority of our counties fall in the first quartile," Fritch said March 23, referring to those with the highest fee-for-service costs and lowest benchmark. "So instead of going to 100%, we're actually headed to 95% in most counties. We do have several in the second quartile and less than 1% in the third and fourth quartiles. And that really reflects the fact that most urban counties are in your higher cost areas where people have access to a lot of specialty and hospital care. And as a natural consequence, there's more opportunities for managed care plans to save money in those markets and more competitiveness amongst providers as you build networks."

Some larger writers like Humana Inc. already saw the writing on the wall and have been working to shift Medicare Advantage enrollees from private fee-for-service plans into HMO and PPO networks. According to Humana CFO James Bloem, the company had been preparing for parity between Medicare Advantage reimbursements and private fee-for-service since at least 2006, which is why the insurer "reinvested the money that we made; we strived to get a 5% operating pretax margin."

"There will be some benefit reductions and it will disproportionately impact small players. That's why we're ... continuing to go after market share, to meet consumers and particularly seniors where they are and show them all the options they have," Bloem said March 24. Humana reported \$6.7 billion of 2008 direct written premiums in the Medicare line of business through subsidiaries that filed the NAIC's health statement, as well writing \$10.4 billion of Medicare business - including stand-alone Part D plans - through subsidiaries that were life filers.

Other major writers include WellPoint Inc., which had \$2.9 billion of 2008 direct written premiums from its health filers and \$1.6 billion from its life filers, and UnitedHealth Group Inc., which reported \$10.5 billion from its health filers and \$7.0 billion from its life filers. UnitedHealth's PacifiCare of California unit - which, like many California-domiciled managed care writers, does not file with the NAIC - also showed \$3.9 billion in revenues related to Medicare in 2008.

Coventry Health Care Inc., which reported \$2.0 billion of 2008 Medicare direct written premiums from its health filers and \$2.3 billion from its life filers, has been working to balance its exposure to government business so that about a third of its revenues come from Medicare, according to interim CFO John Stelben, as the company moved last year to exit smaller expansion markets and certain special needs plans, losing about 13,000 members in the process.

"This has never been an easy business; it's always been a business of two inches forward, one [inch] backwards every day, but we have always found a way to move forward," Stelben said March 23.

"While this is not going to get any easier in reform, we do think we're going to be able to compete."

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