BETTER MEDICARE
ALLIANCE

The Impact of the Medicare Advantage Benchmark Cap on Beneficiaries

WHITE PAPER OCTOBER 21, 2016

This White Paper explains the Medicare Advantage (MA) benchmark cap and highlights the consequences this policy has on MA beneficiaries.

This Paper Shows:

- The benchmark cap undermines the Quality Bonus Payment (QBP) and leads to fewer benefits for MA beneficiaries.
- Over three million MA beneficiaries in nearly 1,500 counties are impacted by the benchmark cap and may not receive the full benefits of being in a high quality plan.
- In 2016, over 2 million beneficiaries were denied additional benefits or cost sharing due to the benchmark cap.
- Better Medicare Alliance (BMA) ally organization Indiana University Health (IU HealthPlans) operates an MA plan in capped counties and beneficiaries may not receive the full complement of supplemental benefits that could be offered as a result.

The White Paper outlines the potential administrative and legislative solutions to address the benchmark cap issue.

The Department of Health & Human Services (HHS) is working to achieve goals of tying payments in Traditional Fee-For-Service (FFS) Medicare to quality and value. In Medicare Advantage (MA), payments are already tied to quality through MA's Star Rating system which rewards plans with a 4-Star rating or higher (on a 5-Star scale) with a Quality Bonus Payment (QBP). The QBP goes directly to beneficiaries, and must be applied to reducing cost sharing or increasing benefits for beneficiaries. The Star Rating system has been very effective at driving quality, in 2015 over 70% of MA enrollees were in QBP eligible plans, up from less than 20% in 2009.[1] However, due to a policy known as the benchmark cap, beneficiaries in certain counties are not able to benefit from the program. Across the country, beneficiaries in over 40% of counties are negatively impacted by this policy.[2]

The benchmark cap was implemented by the Affordable Care Act (ACA). The policy caps MA payment at the pre-ACA level (plus growth updates). The goal of the policy is to prevent benchmarks, the primary payment mechanism for MA plans, from exceeding the level of benchmarks pre-ACA. However, due to the implementation of this policy, high quality MA plans with 4+ Stars normally eligible for a QBP do not receive the quality incentive if they are in a capped county.

In 2016, over two million MA beneficiaries are negatively impacted by the benchmark cap, which means they are not receiving additional benefits for enrolling in a high quality MA plan, such as reduced cost sharing or supplemental benefits like dental or vision coverage.[3] QBPs also help enable early intervention and disease management programs and innovations like the use of telemedicine. There is broad consensus from the Administration, Congress, and MedPAC that the benchmark cap policy undermines quality and perpetuates inequality across the country for beneficiaries.[4] The impact of the benchmark cap on the Star Rating system must be addressed to preserve the goal of incentivizing quality and value in MA.

Explanation of the Benchmark Cap Policy

In MA, health care practitioners are incentivized to provide effective care in the best setting for the patient through the capitated (fixed) monthly payments, and quality is measured and publicly reported. MA plans are required to report on quality metrics and receive an annual rating using the Star Rating system, which is designed to help beneficiaries consider cost and quality in MA plans. FFS Medicare does not have an equivalent comprehensive quality accountability system.

Since the implementation of the ACA, the capitated payments using a benchmark level are set by CMS, and calculated based on FFS Medicare spending by county. MA plans submit bids based on the benchmark to determine the capitated payment amount the plan will receive to care for a beneficiary; this amount is risk adjusted for each beneficiary to account for differences in health status and other characteristics. Plans are able to receive a portion of the difference between their bid and the benchmark, called the rebate, to apply to supplemental benefits for beneficiaries.

The ACA also established the QBPs in the Star Rating system, which are awarded to plans with a 4-Star or higher rating. The QBP is a 5% higher benchmark and a larger percentage of rebate dollars that can be applied to additional benefits. Finally, the ACA placed a cap on the benchmarks to prevent them from exceeding the level of the benchmark pre-ACA, this policy is what is known as the benchmark cap.[5]

The Star Rating system QBPs are impacted by the benchmark cap because the QBPs are included in the benchmark calculation. This means if an MA plan earns 4+ Stars and earns a 5% higher benchmark, but receiving that bonus would make them exceed the cap, the plan will not be able to receive the QBP. The benchmark cap prevents over three million beneficiaries in nearly 1,500 counties from benefiting from the QBPs in the Star Rating system.[6]

How the Benchmark Cap Impacts Beneficiaries

Almost 1 in 6 MA beneficiaries in bonus-eligible 4+ Star or higher plans miss out on additional benefits due to the benchmark cap.[7] These additional benefits include vision, dental, and hearing care, lower cost-sharing and innovations like telemedicine. As Figure 1 illustrates, applying an across-the-board benchmark cap impacts over three million MA beneficiaries or nearly 18% of beneficiaries. *(See Figure 1.)* Roughly 16% of beneficiaries in plans with 4 Stars, 21% of beneficiaries in plans with 4.5 Stars, and 15% of beneficiaries in plans with 5-Star MA plans are impacted by the benchmark cap. *(See Figure 2.)*

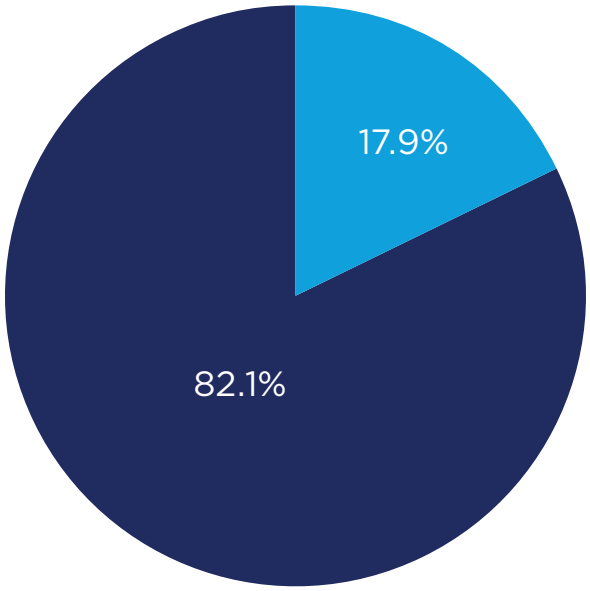
Better Medicare Alliance (BMA) ally organization Indiana University Health (IU Health) operates a Medicare Advantage plan as part of their integrated delivery system. IU HealthPlans provide insurance to Medicare beneficiaries including preventive services, chronic disease management programs, and supplemental benefits such as dental coverage.

Due to this high level of care, IU HealthPlans earned a Star Quality Rating of 4 (out of 5) stars for 2016. This high rating makes the plan eligible for Quality Bonus Payments (QBPs); however, 60% of the counties in which IU HealthPlans operate have a Benchmark Cap, preventing them from receiving QBPs in those counties.

For IU HealthPlans beneficiaries, this means fewer resources are available that could lower cost sharing or expand existing benefits like dental and vision. As long as the Benchmark Cap is in place, 6,000 IU HealthPlan beneficiaries, as well as any Medicare Advantage member in those counties with the cap, may not receive the full complement of supplemental benefits that could be offered.

FIGURE 1

Percent of MA Beneficiaries Affected by the Benchmark Cap in 2016



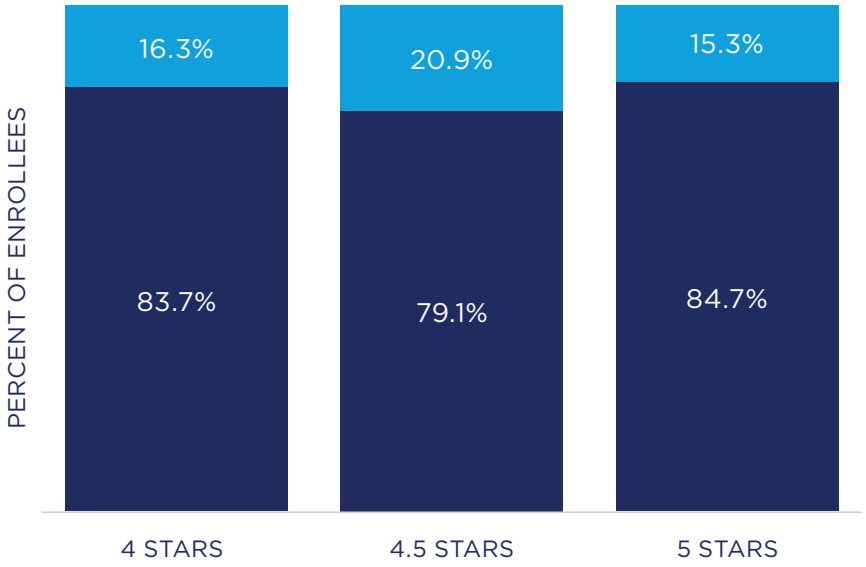
Affected by Benchmark Cap

Unaffected by Benchmark Cap

Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

FIGURE 2

Distribution of MA Beneficiaries Impacted by the Benchmark Cap in 2016



In Counties With Cap

In Counties Without Cap

Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

MA beneficiaries are impacted by the Benchmark Cap in the form of decreased benefits and increased costs. The flow chart in Figure 3 illustrates how the Benchmark Cap could impact an MA beneficiary in Tippecanoe, Indiana. The following chart shows the MA benchmark (pre-bonus) is $800. Thus, if a plan operating in that county receives a 4-star rating, it should receive a 5% bonus, which would result in a $840 benchmark. However, the Benchmark Cap in Tippecanoe is $809. Therefore, a high quality 4-star plan can only receive $809, which amounts to $20 less rebate dollars per month and $240 less rebate dollars per year that can be applied to cost sharing or additional benefits for beneficiaries. *(See Figure 3.)*

FIGURE 3

For Example, In Tippecanoe, Indiana the Benchmark Cap May Decrease Benefits or Increase Costs

When plans bid below the benchmark, they receive a percentage of the savings in the form of rebates that must be used to provide extra benefits to beneficiaries. For a 4-star plan the rebate percentage is 65%.

[1] Capped rate obtained from the 2017 MA Ratebook
[2] Assumes plan has 4-Star Rating HMO Plan. Average Plan Bid by County Obtained from 2014 Plan Payment Data
[3] Uncapped rate is estimated from 2017 MA Ratebook

Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

Geographic Distribution of Benchmark Impact

Research indicates MA plans have focused on achieving the quality measures that are the basis of QBPs.[8] The increased focus on quality has driven improvements in quality measures in MA plans for beneficiaries. CMS data show 71% of MA enrollees are now in 4+ star plans, an improvement from less than 20% in 2009.[9] However, across the country the Benchmark Cap could disincentive MA plans from achieving 4+ stars if they are not able to receive QBPs. In 2016, the Benchmark Cap will apply if a counties benchmark is projected to be more than 6.4 percent above the counties 2010 benchmark.[10] In 1,434, or 44% of counties out of over 3,000 counties in the U.S., beneficiaries in MA plans are negatively impacted by the Benchmark Cap. *(See Figure 4.)*

FIGURE 4

Number of MA Beneficiaries and Counties Impacted by the Benchmark Cap in 2016

	Affected by Benchmark Cap	Unaffected by Benchmark Cap
Number of Counties	1,434	1,814
Number of Beneficiaries	3,068,729	14,100,169

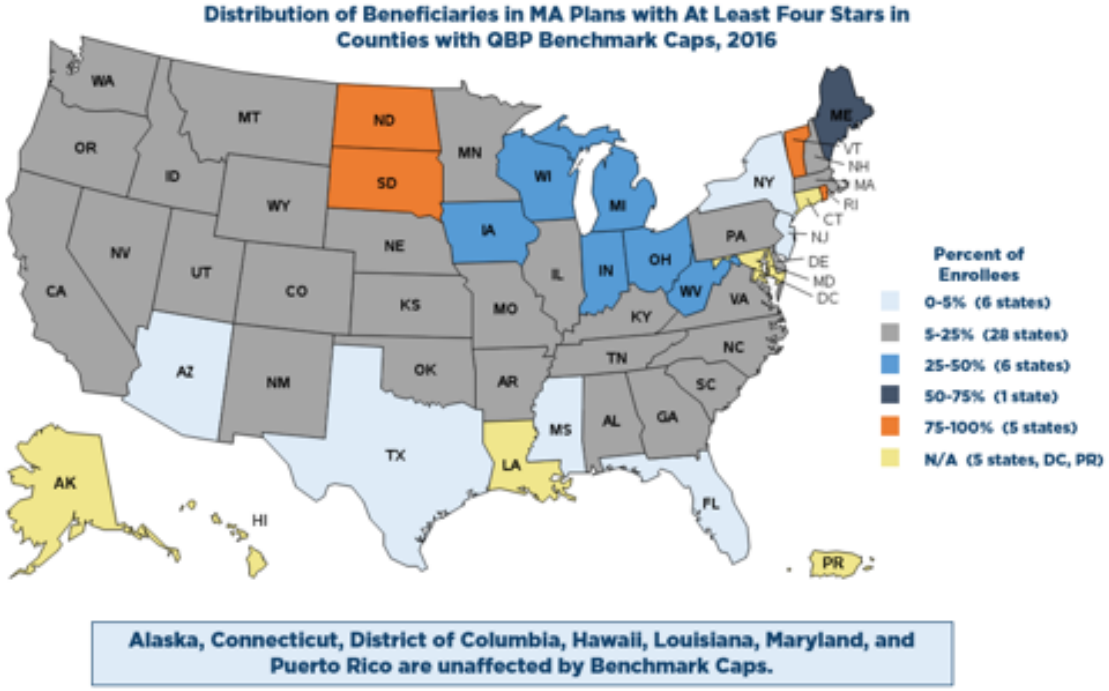
Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

Impact on the State Level

Some states are disproportionately impacted by the Benchmark Cap. In 11 states, at least 25% of beneficiaries in high quality MA plans with at least 4 stars are in capped counties. In Vermont, Rhode Island, South Dakota and North Dakota nearly all beneficiaries in high quality MA plans are impacted. In addition, MA plans in Iowa, Wisconsin, Michigan, Indiana, Ohio and West Virginia are disproportionately impacted. *(See Figure 5.)*

FIGURE 5

In 11 States, at Least 25% of Beneficiaries in at Least 4-Star MA Plans are in Capped Counties



Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

California has the most beneficiaries impacted by the Benchmark Cap with over 250,000 beneficiaries in high quality benchmark capped plans, which is 11.5% of MA beneficiaries in the state. *(See Figure 6.)* California also has three of the top ten markets affected by the Benchmark Cap. The top California markets are Sacramento, Santa Rosa and San Francisco. *(See Figure 7.)* Pennsylvania, Ohio, Michigan, and Wisconsin all have over 100,000 beneficiaries impacted. While Rhode Island has over 60,000 beneficiaries impacted, the number equates to 82.2% of the MA beneficiaries in the state. *(See Figure 6.)*

FIGURE 6

California has the Most Enrollees Impacted by the Benchmark Cap

State	Number of Enrollees in MA Plans with at Least Four Stars Where County Benchmark is Capped	Percent of Total MA Enrollees in State
CA	260,556	11.5%
PA	215,193	21.1%
OH	212,451	28.6%
MI	167,495	26.8%
WI	137,286	37.9%
NC	131,026	23.8%
IN	88,372	31.4%
TN	85,661	19.3%
IL	85,171	21.0%
RI	60,205	82.2%

Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

FIGURE 7

California has Three of the Top Ten Markets Impacted by the Benchmark Cap

Market Area	Number of Enrollees in MA Plans with at Least Four Stars Where County Benchmark is Capped	Percent of Total MA Enrollees in State
Sacramento, CA	154,601	89.1%
Providence, RI	79,059	85.8%
Milwaukee, WI	56,519	50.6%
Winston, NC	47,606	69.4%
Detroit, MI	47,007	18.9%
Santa Rosa, CA	41,896	100.0%
San Francisco, CA	41,610	13.9%
Harrisburg, PA	39,692	83.7%
Cleveland, OH	39,292	30.9%
Canton, OH	28,569	72.5%

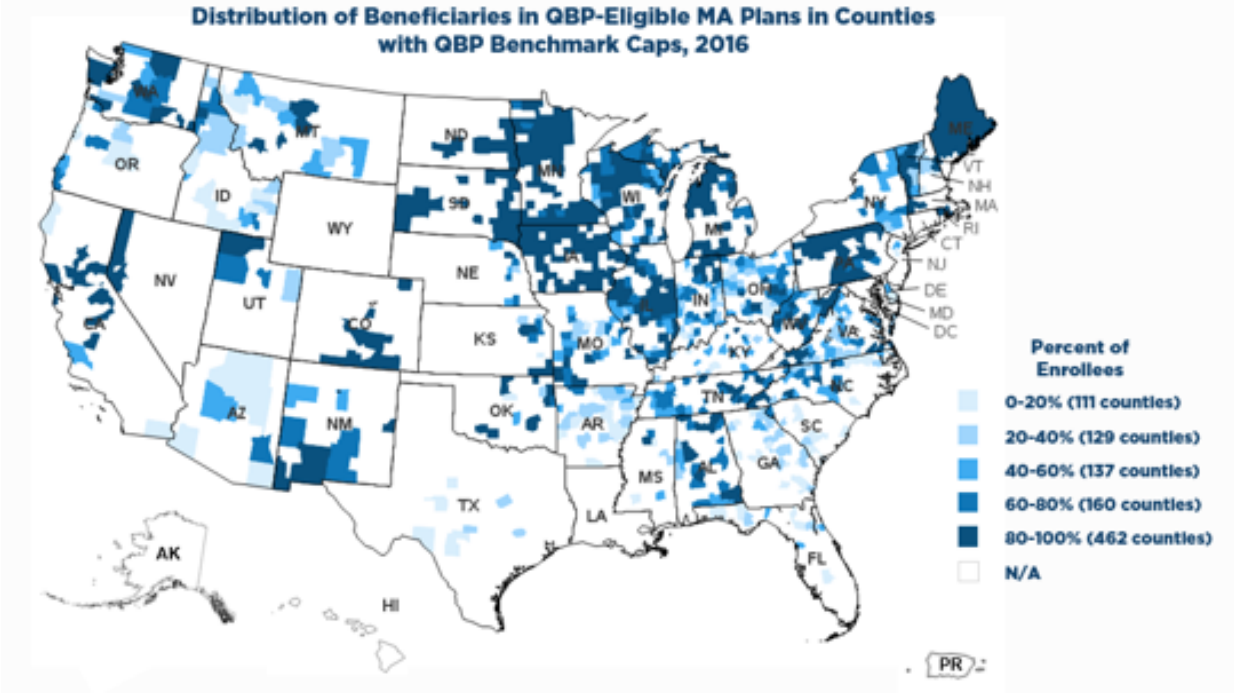
Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

Impact on the County Level

MedPAC has recommended eliminating or limiting the Benchmark Cap because the policy results in an unequal cut to quality incentive payments in some counties.[11] In nearly 500 counties across the U.S., 80% of beneficiaries in plans with 4+ stars are negatively impacted by the Benchmark Cap. In over 750 counties, 40% or more beneficiaries are negatively impacted by the Benchmark Cap. *(See Figure 8.)*

FIGURE 8

In 462 Counties, at Least 80% of Beneficiaries in MA Plans with at Least 4 Stars are Impacted by the Benchmark Cap



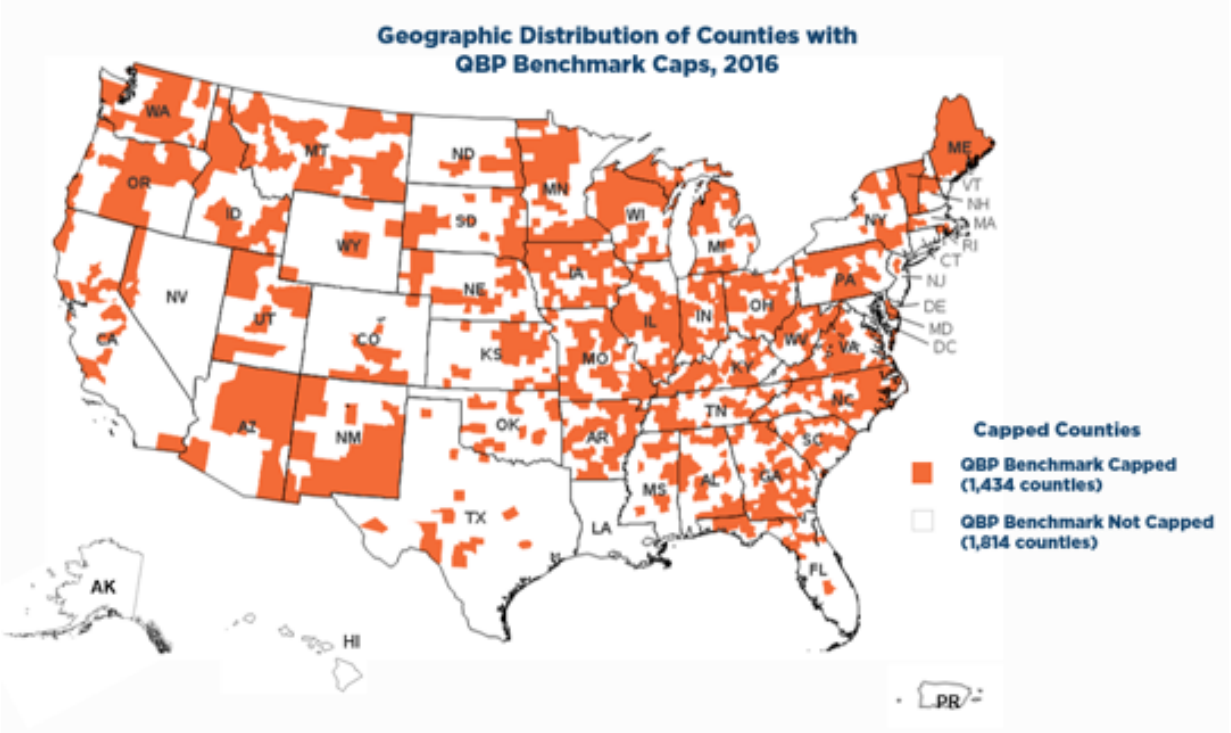
Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

In 2016, 5-star rates have been capped in about 40 percent of all counties in the U.S. Out of roughly 3,000 counties, over 1,400 counties experience the 5-star Benchmark Cap. The vast majority of states in the U.S. have 5-star contracts impacted by the Benchmark Cap. *(See Figure 9.)* Seven of the top ten counties impacted by the Benchmark Cap are in California and Ohio.

Sacramento County in California has over 100,000 beneficiaries impacted and San Mateo County, California has over 40,000 beneficiaries impacted. Additionally, in Cuyahoga County, Ohio over nearly 40,000 beneficiaries are impacted, Hamilton County, Ohio has nearly 30,000 beneficiaries impacted, and Stark County, Ohio has over 25,000 beneficiaries impacted. *(See Figure 10.)*

FIGURE 9

5 Star Rates are Capped in Roughly 40% Percent of Counties



Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

FIGURE 10

Seven of the Top Ten Counties Impacted by the Benchmark Cap are in California and Ohio

County	Number of Enrollees in MA Plans with at Least Four Stars Where County Benchmark is Capped	Percent of Total MA Enrollees in State
Sacramento, CA	107,783	94.9%
Milwaukee, WI	56,519	87.3%
Macomb, MI	47,007	90.7%
Providence, RI	41,984	100.0%
Sonoma, CA	41,896	100.0%
San Mateo, CA	41,610	96.6%
Cuyahoga, OH	39,692	52.0%
Placer, CA	35,244	100.0%
Hamilton, OH	27,900	57.6%
Stark, OH	26,677	72.2%

Source: CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

Ways to Address Benchmark Cap Issue

CMS has stated "we appreciate the concerns" about the Benchmark Cap reducing or eliminating the value of quality incentives for 4+star plans. However, despite legal arguments that CMS has the regulatory authority to address the issue, CMS has denied discretion to waive the cap based on interpretation of the ACA.[12] As long as CMS maintains the inability to overturn the current policy, the Benchmark Cap must be addressed by a change in law. Legislative attempts have been made to address this policy issue. On June 17, 2015 the House passed H.R.2570, the Strengthening Medicare Advantage through Innovation and Transparency for Seniors of 2015. The bill expressed the sense of Congress that HHS could address the Benchmark Cap issue. The bill was non-controversial and passed by voice vote.[13] Additionally, a bipartisan bill, H.R. 4275, the Medicare Advantage Quality Payment Relief Act of 2015 has been introduced in the House to disaggregate QBPs from the benchmark cap calculation.

There is broad support in the Administration, Congress, and MedPAC to address the Benchmark Cap by lifting the cap completely, and at a minimum, removing the cap for 4-star or higher rated plans to ensure they receive their QBPs.[14] The Administrations FY2017 budget supported "lifting the cap on benchmarks for plans that are entitled to receive a quality bonus payment."[15]

Support to lift or mitigate the impact of the Benchmark Cap on QBPs continues to grow. Proposals to address the issue include continuing to urge the HHS Secretary to administratively address the Benchmark Caps by removing QPBs from the benchmark calculation or waiving the cap. Congress could also continue to urge CMS to apply the QPBs without the consideration of the benchmark cap or enact a law to clarify the statute.

The Benchmark Cap undermines the goals of moving payment incentives towards quality and value in MA and the Medicare program more broadly. Over two million MA beneficiaries are negatively impacted by the Benchmark Cap in the form of increased cost-sharing and decreased benefits. The impact on beneficiaries is unequal and states like California, Pennsylvania and Ohio are disproportionately impacted. It's important that beneficiaries receive the high quality benefits and low cost sharing over 18 million beneficiaries have come to expect from MA. The negative impacts of the Benchmark Cap should be addressed to preserve the goal of incentivizing quality and value in Medicare.

Methodology

All data and figures prepared by Avalere Health for Better Medicare Alliance (September 2016) unless otherwise noted.

[1] CMS 2016 Star Rating data, 2015

[2] CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

[3] CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

[4] HHS FY 2017 Budget in Brief - CMS - Medicare. HHS.gov. Web; MedPAC, Medicare Advantage Benchmarks. Harrison, Scott. Oct. 8,2015. Web; H.R.2570, Strengthening Medicare Advantage Through Innovation and Transparency for Seniors of 2015. Web.

[5] MedPAC, Medicare Advantage Program Payment System. Oct. 2014. Web.

[6] CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

[7] CMS, Monthly Enrollment by Contract/Plan/State/County, September, 2016; CMS, Part C and D Medicare Star Ratings Data, 2016; CMS, Medicare Advantage Ratebook and Prescription Drug Rate Information, 2016

[8] MedPAC, Report to the Congress: Medicare Payment Policy. March 2016. Web.

[9] CMS, 2016 Star Rating Data, 2015. Web.

[10] MedPAC, Report to the Congress: Medicare Payment Policy. March 2016. Web.

[11] MedPAC, Medicare Advantage Benchmarks. Harrison, Scott. Oct. 8, 2015. Web.

[12] CMS 2016 Announcement, Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Final Call Letter, April 4, 2016. Page 21. Web.

[13] Strengthening Medicare Advantage Through Innovation and Transparency for Seniors of 2015. Web.

[14] HHS FY 2017 Budget in Brief - CMS - Medicare. HHS.gov. Web; MedPAC, Medicare Advantage Benchmarks. Harrison, Scott. Oct. 8,2015. Web; H.R.2570, Strengthening Medicare Advantage Through Innovation and Transparency for Seniors of 2015. Web.

[15] Fiscal Year 2017, U.S. Department of Health & Human Services, Budget in Brief. Web.