

MEDICARE

MEDICARE ADVANTAGE

March 2004

OVERVIEW

Medicare provides health benefits to 41.7 million elderly and disabled Americans. Most (88%) have their health bills paid by the traditional fee-for-service program, while 11% are covered by managed care plans, primarily HMOs.

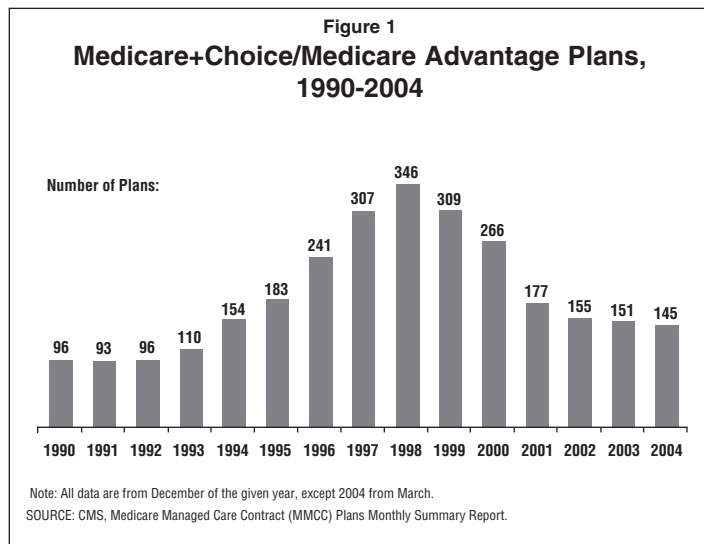
HMOs—an option under Medicare since the 1970s—were created to improve coordination of care for people on Medicare while eliminating inefficiencies to control costs. The Balanced Budget Act (BBA) of 1997 expanded the role of private plans under “Medicare+Choice” to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high-deductible insurance plans. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) renamed the program “Medicare Advantage” (MA) and created another option: regional PPOs.

Beneficiaries have historically had an option to enroll (as long as the plan is accepting new enrollees) and disenroll from a plan at any time during the year. Beginning in 2006, there will be a “lock-in”: beneficiaries will be able to disenroll or change plans only once a year and only during a six-month period; shortened to a three-month period in later years.

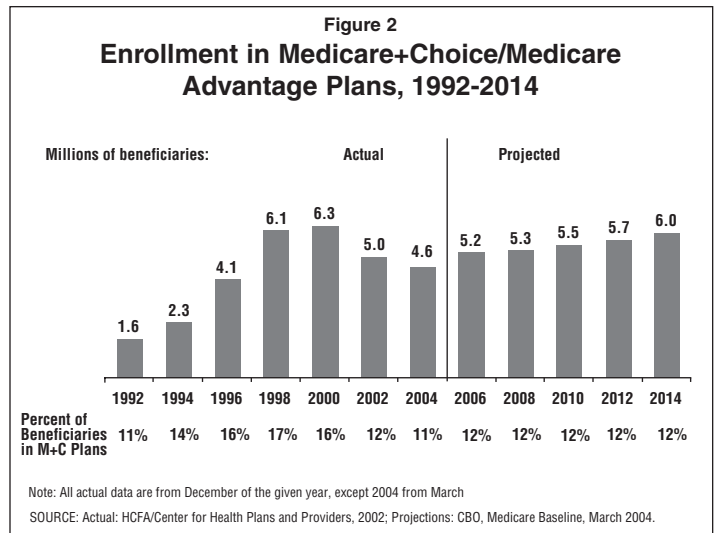
PLAN PARTICIPATION AND ENROLLMENT

Plan participation and enrollment has fluctuated over the past year. In 2004, there are:

- 145 Medicare Advantage plans, a drop from 346 in 1998.
- 4.6 million enrollees (11%), down from 6.3 million (16%) in 2000.
- 60% of beneficiaries with access to a private Medicare plan, down from 71% in 1999 (MedPAC, 2004).



The Administration estimates 31% of Medicare beneficiaries will enroll in MA plans by 2009, while CBO estimates an enrollment rate of 12% in 2009.



Plan enrollment varies widely across states. Less than 1% of Medicare beneficiaries are enrolled in plans in 18 states and D.C., while at least 25% are enrolled in CA, AZ, OR, and RI. Nationwide, more than one in four Medicare HMO enrollees live in California.

The vast majority of Medicare Advantage plans are HMOs. To encourage PPO participation, the Centers for Medicare and Medicaid Services (CMS) created a demonstration with enhanced payment and risk-sharing arrangements. As of February 2004, there were 89,000 PPO enrollees concentrated in a small number of plans. There are fewer than 29,000 Medicare beneficiaries in private fee-for-service plans nationwide.

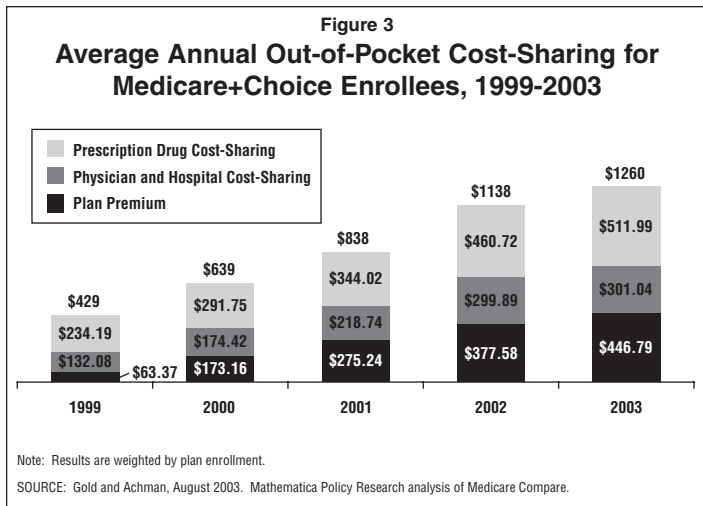
BENEFITS AND PREMIUMS

Medicare Advantage plans are generally required to provide all Medicare-covered benefits. Plans with costs below their Medicare payments must distribute savings to beneficiaries as lower plan premiums and copayments or additional benefits or contribute to a reserve fund.

Premiums. Sixty-two percent of Medicare Advantage enrollees in basic plans pay a monthly premium in addition to the Part B premium. The average monthly premium in 2003 was \$37 across all enrollees (up from \$6 in 1999), and \$60.50 among enrollees in plans that charge premiums (up from \$32.11 in 1999).

As of 2003, plans are permitted to reduce Part B premiums as an extra benefit. In February 2004, six plans offered this option, making it available to 4% of Medicare beneficiaries.

Out-of-Pocket Spending. Out-of-pocket spending for Medicare Advantage enrollees, including premiums and cost-sharing, has nearly tripled since 1999, from \$429 to \$1,260 in 2003.



Prescription Drugs. Nearly one third (31%) of Medicare Advantage enrollees are in plans that do not provide drug coverage (up from 16% in 1999). During this same time period, average annual out-of-pocket drug costs for enrollees rose from \$234 to \$512.

Enrollees in plans with drug coverage faced restrictions on these benefits in 2003: 19% of enrollees had an annual cap of \$750 or less, and 28% of enrollees were in plans that covered only generic drugs.

As part of the Medicare prescription drug benefit that begins in 2006, managed care plans (but not PFFS or MSA plans) must offer basic drug coverage to their enrollees and will receive extra payment for that coverage. Plans may also offer a second package with additional benefits.

PAYMENTS TO PLANS

Medicare pays plans to provide Part A and B benefits for each enrollee, totaling \$36.3 billion in fiscal year 2003. The level of plan payments has been a source of controversy. For many years, Medicare payments to HMOs were generally set at 95% of fee-for-service costs in a given county. Beginning in 1997, Congress made a number of changes to Medicare's payment structure, and in the years that followed, the number of participating plans dropped by more than half.

To encourage plan participation, MMA increased aggregate payments to plans by \$1.3 billion for 2004 and 2005. In 2004, Medicare pays plans the *highest* of:

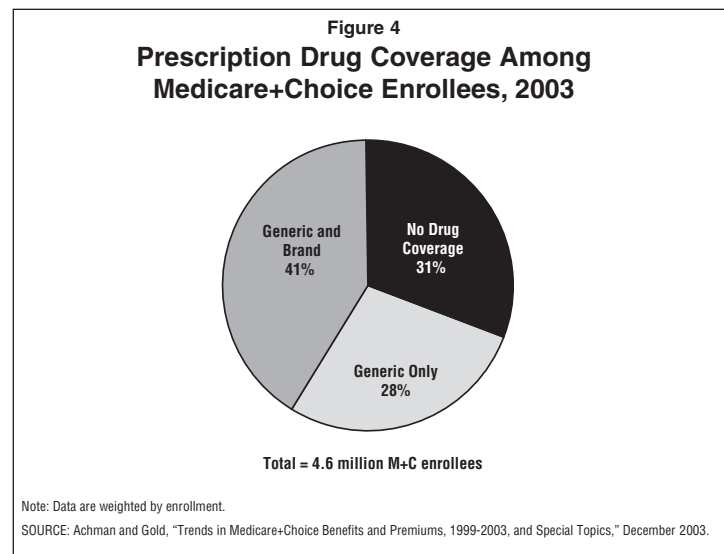
- A minimum, or "floor," for rural (\$555/month) or urban (\$614/month) counties;
- 100% of fee-for-service costs in the county;
- A minimum update over 2003 rates: 2% or the national growth rate percentage (6.3% in 2004), whichever is greater; or
- A blended payment rate update.

In 2005, plans will be paid the 2004 rate, updated by the greater of 2% or the national growth rate percentage.

This increases the average monthly payment to plans from \$620/enrollee in 2003 to \$688/enrollee in 2004, an average increase of 10.9% (weighted by plan enrollees). In some counties, the increase is more than 40% (Achman and Gold, 2004). Plans report they will spend 42% of additional funds to strengthen provider networks, 31% to lower premiums, and 17% for additional benefits (CMS, 2004).

In 2004, Medicare payments to plans are an average of 107% of the cost to cover similar beneficiaries in FFS Medicare (MedPAC, 2004). The new law guarantees plans at least 102% of FFS payments, while paying plans in certain counties, like San Francisco, CA and Clark County, WA, 132% of FFS costs. More than a quarter (26%) of managed care enrollees live in counties where payment rates are 110% or more of the average FFS costs (Achman and Gold, 2004).

A number of studies have shown that Medicare beneficiaries enrolled in managed care plans are, on average, in better health and have lower medical costs than those in the traditional program. To modify payments accordingly, Medicare began implementing a new risk-adjustment system in 2003. Today, 30% of plan payments are risk-adjusted; by 2007 all plan payments will be risk-adjusted.



Beginning in 2006, plans will be paid under a new bidding process. If a plan's bid is higher than the costs of FFS Medicare for the plan's area, the enrollee will pay the difference. If lower, 75% of the difference will go to the enrollee as extra benefits or as a rebate; the remaining 25% will be retained by the government. CBO estimates that between 2006 and 2013, plans will receive an additional \$12.9 billion as a result of the MMA changes.

FUTURE ISSUES

The role of private plans in Medicare is likely to increase in the years to come. Whether higher payments to plans and the addition of prescription drug benefits will stabilize plan participation and enrollment or improve the quality of care will be important to monitor. To date, the evidence on quality of care and satisfaction in private plans is mixed. Striking the right balance between controlling spending growth, setting payments to plans fairly, and meeting beneficiaries' health care needs will be an ongoing challenge.

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