

MEDICARE

MEDICARE ADVANTAGE

June 2007

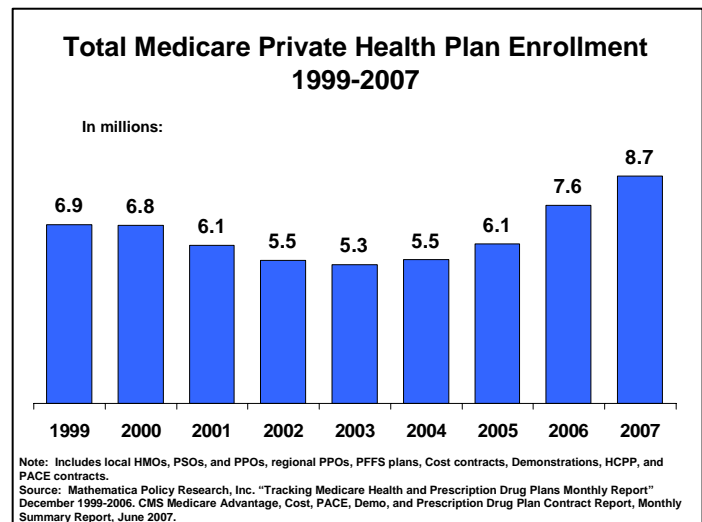
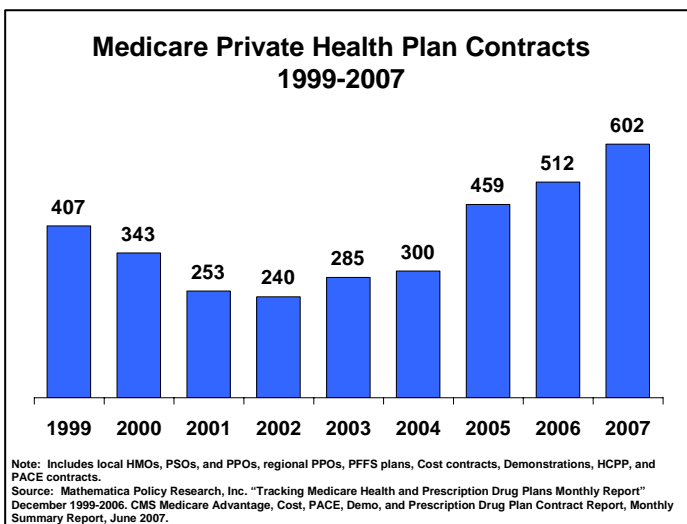
OVERVIEW

Most of the 44 million elderly and disabled people on Medicare (80%) have their health bills paid by the traditional fee-for-service program; 20% (8.7 million) get their Medicare benefits through private health plans that receive payments from Medicare, now called "Medicare Advantage" plans.

Medicare HMOs have been an option under Medicare since the 1970s. The Balanced Budget Act of 1997 authorized new Medicare plans, including preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and high deductible plans linked to Medical Savings Accounts (MSAs). The Medicare Modernization Act of 2003 (MMA) created new regional PPOs and Special Needs Plans (SNPs) for dual eligibles and other vulnerable populations.

PLAN PARTICIPATION AND ENROLLMENT

Plan participation and enrollment have fluctuated over the past decade. After a precipitous drop between 1999 and 2002, the program has seen a rapid rise in both the number of plans and enrollees. The number of Medicare enrollees in private health plans increased from 5.3 million (across 285 contracts) in 2003 to 8.7 million (across 602 contracts) as of June 2007. The growth is largely attributed to higher plan payments.



Virtually all Medicare beneficiaries have access to a private plan, mainly due to the emergence of PFFS plans and regional PPOs in rural areas. However, enrollment rates vary widely across states. In 2007, less than 3% of beneficiaries are enrolled in Medicare Advantage plans in 4 states (AK, ME, NH, VT), while at least 30% of beneficiaries are in such plans in 8 states (AZ, CA, CO, HI, NV, OR, PA, and RI). Nationwide, over half of all Medicare Advantage enrollees live in 6 states (CA, FL, NY, OH, PA, and TX). In general, Medicare Advantage enrollees tend to be in better health than their counterparts in traditional Medicare. Plans also enroll a smaller share of beneficiaries under age 65 with permanent disabilities.

SUPPLEMENTAL BENEFITS AND PREMIUMS

Medicare pays plans to provide basic Medicare benefits, and plans must use any savings to provide additional benefits, reduce cost-sharing, or reduce Part B or supplemental premiums (see payments to plans). Examples of additional benefits include limits on out-of-pocket spending, vision care, and preventive dental services. MA plans (excluding PFFS, MSA, and cost plans) are required to offer at least one plan that includes the basic Medicare drug benefit or a plan with enhanced alternative drug coverage. In 2006, the majority of MA plans provided drug coverage, and most enrollees were in a plan with a coverage gap (i.e., "doughnut hole").

TYPES OF MEDICARE ADVANTAGE PLANS

Local HMOs, PPOs, and PSO plans, collectively referred to as local coordinated care plans, cover Medicare Parts A, B, and often Part D services within provider networks. As of June 2007, 6.2 million beneficiaries were enrolled in such plans with the vast majority (92%) in HMO plans.

Private fee-for-service plans (PFFS) account for a small share of total MA enrollment in 2007 (18%), but the rate of growth in enrollment far exceeds the rate for HMOs and PPOs (7%) between July 2006 and June 2007. During this period, PFFS enrollment more than doubled from nearly 765,000 to 1.6 million enrollees. PFFS plans differ from Medicare HMOs and PPOs in that they are not required to establish provider networks, report quality measures, or have CMS review and negotiate bids.

Special needs plans (SNPs) enrollment is restricted to beneficiaries who are dually eligible for Medicare and Medicaid, the institutionalized, and those with certain severe and disabling conditions. The number of SNPs rose from 125 in 2005 to 478 in 2007. As of June 2007, SNPs enrolled over 930,000 beneficiaries, the majority of whom are dual eligibles. SNPs are scheduled to sunset in 2009 unless they are reauthorized.

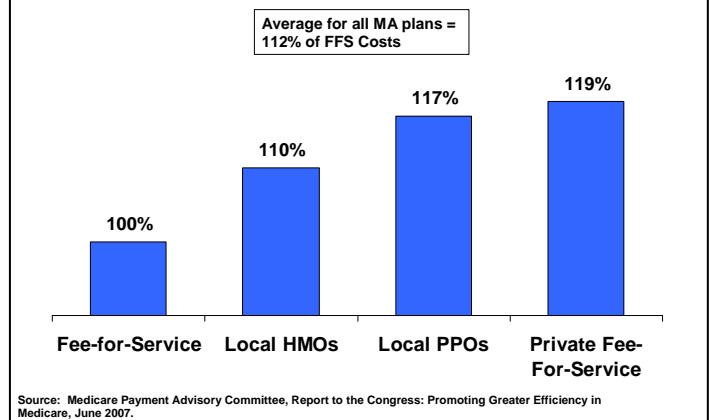
MSAs. Medical savings accounts linked to high deductible MA plans are available in 38 states and DC, as of 2007. Medicare makes an annual deposit into an interest-bearing account on behalf of enrollees who may use these funds to pay for qualified health care expenses until they meet the deductible (between \$2,500 and \$4,500 for plans in 2007), at which point the plan will pay for all Medicare-covered services. As of June 2007, 2,249 beneficiaries were enrolled in Medicare MSAs.

Regional PPOs were established under the MMA in an effort to provide beneficiaries in rural areas greater access to Medicare Advantage plans. The MMA included a \$10 billion stabilization fund to encourage PPOs to contract with Medicare (reduced to \$3.5 billion due to legislation passed in 2006). Medicare PPOs are available in all but five MA regions, yet enrollment remains modest at around 150,000 in June 2007.

PAYMENTS TO PLANS

Medicare pays plans a capitated rate to provide Part A and B benefits to enrollees, totaling a projected \$67 billion in 2007 (CBO, 2006). For many years, payments to HMOs were generally set at 95% of FFS costs in each county. As part of a broader effort to reduce deficits, growth in Medicare payments was constrained in the late 1990s leading to limited increases in payments to plans. In the years that followed, the number of plans declined. Payments to plans were increased by law a number of times to stabilize the program and expand participation.

Payments to Medicare Advantage Plans as a Share of Medicare Fee-for-Service Costs, 2006



In 2006, Medicare began to pay plans under a bidding process. Plans (other than regional PPOs) bid against county level benchmarks established by CMS based on the prior year's MA county payment rate, increased by the projected national growth rate in per capita Medicare spending. If a plan's bid is higher than the benchmark, enrollees pay the difference in the form of a monthly premium. If the bid is lower than the benchmark, the Medicare program retains 25% of the savings and the plan gets the other 75% as a rebate, which must be returned to enrollees in the form of supplemental benefits or lower premiums. As of 2007, all plan payments are adjusted based on their enrollees' risk profiles.

Recent studies have shown that MA plans are paid more than the average FFS costs in their area. Many plans have expanded their services to areas with benchmarks that are high relative to Medicare FFS spending. MedPAC analysis based on July 2006 enrollment data shows that Medicare payments to private health plans on behalf of enrollees average 112% of FFS costs for the counties where MA enrollees reside. PFFS plans—prevalent in areas where the benchmark is significantly higher than Medicare FFS costs—are paid 119% of FFS costs before adjusting for enrollee risk.

FUTURE ISSUES

The proliferation of Medicare Advantage plans raises a number of key issues. Generous payments allow plans to offer extra benefits to enrollees, but raises questions about the extent to which Medicare distributes extra benefits equitably across the Medicare population. The current payment system also increases Medicare expenditures over the long run, cuts short the life of the Part A trust fund by two years, and increases Part B premiums by \$2 per person per month. Achieving balance among competing goals including keeping Medicare fiscally strong, setting adequate payments to plans, and meeting beneficiaries' health care service needs will remain critical issues for policymakers.

Additional data about Medicare private plan participation, enrollment, and benefits are available on the Medicare Health Plan Tracker at www.kff.org/medicare/healthplantracker/

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