

# MEDICARE

## MEDICARE ADVANTAGE

September 2008

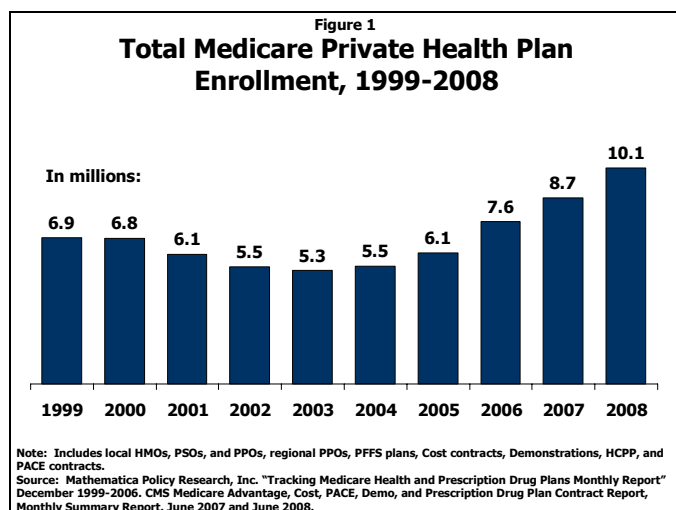
### THE HISTORY OF MEDICARE PRIVATE PLANS

Since the 1970s, many Medicare beneficiaries have had the option to receive their Medicare benefits through private health plans, mainly Medicare health maintenance organizations (HMOs), as an alternative to original fee-for-service (FFS) Medicare. Over the past decade, Congress has made several policy changes to encourage private plan participation in Medicare and enrollment growth.

The Balanced Budget Act of 1997 (BBA) expanded private plan options through the newly-established "Medicare+Choice" program, authorizing local preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and medical savings account plans (MSAs), while also modifying payments to plans which led to fewer plans and reductions in enrollment. The Benefits Improvement and Protection Act of 2000 (BIPA) enhanced payments by creating payment floors for urban areas. The Medicare Modernization Act of 2003 (MMA) revitalized the role of private plans in Medicare by renaming the program "Medicare Advantage", authorizing two additional plan types (regional PPOs and special needs plans), and boosting payments to encourage plan participation. In 2008, Congress made further changes as part of the Medicare Improvements for Patients and Providers Act (MIPPA).

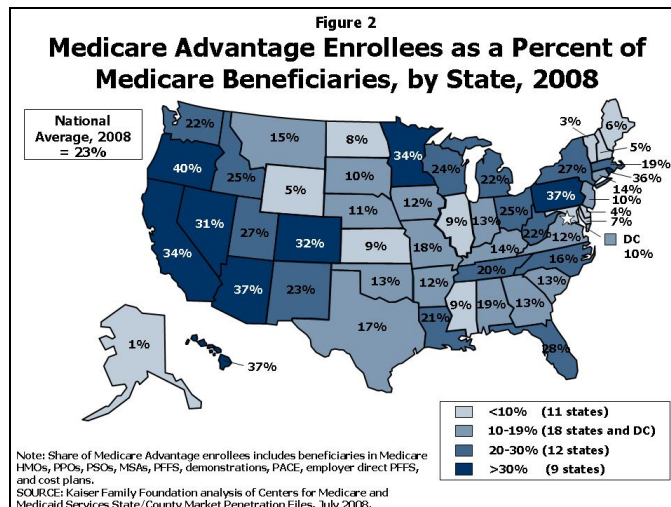
### PLAN PARTICIPATION AND ENROLLMENT

In 2008, nearly a quarter (23%) of the nearly 45 million people on Medicare are enrolled in a private Medicare Advantage plan, while most (77%) are covered under FFS Medicare. After annual declines in enrollment between 1999 and 2003, the number of Medicare beneficiaries enrolled in private plans nearly doubled from 5.3 million in 2003 to the current level of 10.1 million (as of July 2008) (Figure 1).



Currently, all beneficiaries have access to at least one Medicare private plan, mainly due to the emergence of PFFS plans and regional PPOs in rural areas; 87% of beneficiaries have a

choice of 6 or more private plans (Gold, 2008). Enrollment in Medicare Advantage varies widely by state, with less than 10% of beneficiaries enrolled in MA plans in 11 states and more than 30% enrolled in MA plans in 9 states (Figure 2). Nationwide, more than half of all MA plan enrollees live in 6 states (CA, FL, NY, OH, PA, and TX).



### AN OVERVIEW OF MEDICARE ADVANTAGE PLAN TYPES

**Local HMOs and local PPOs** contract with provider networks to deliver Medicare benefits; in 2008, 68% of all HMO and local PPO plans also offer the Part D drug benefit. These plans account for 64% and 7% of total MA enrollment, respectively.

**Private Fee-for-Service plans (PFFS)**, similar to FFS Medicare, are designed to allow open access to providers; PFFS plans are not required to establish networks, report quality measures, or have Medicare review and negotiate bids. However, the MIPPA requires PFFS plans to comply with new quality reporting requirements and, beginning in 2011, to form provider networks in certain counties. From July 2006 to July 2008, PFFS enrollment nearly tripled from 765,000 enrollees to 2.3 million (22% of total MA enrollment).

**Special Needs Plans (SNPs)**, mainly HMOs, are restricted to beneficiaries who are dually eligible for Medicare and Medicaid, live in long-term care institutions, or have certain severe and disabling conditions. The number of SNPs increased from 125 in 2005 to 769 in 2008, with 1.2 million enrollees as of July 2008, mainly dual eligibles. The MIPPA reauthorized SNPs through 2010, but prohibits the entry of new SNPs until then.

**Regional PPOs** were established under the MMA to provide rural beneficiaries greater access to MA plans, with a \$10 billion "stabilization fund" to encourage entry of regional PPOs. This fund was virtually eliminated under the MIPPA. In 2008, regional PPOs are available in all but five of the 26 MA regions but account for only 3% of all MA enrollees.

**Medical savings account plans (MSAs)** combine a high deductible health plan with an MSA into which Medicare makes annual deposits on behalf of enrollees. Beneficiaries draw from these funds to pay for qualified health care expenses until they meet a deductible (ranging from \$2,500 to \$5,100 in 2008), at which point the plan pays for all Medicare-covered services. In 2008, MSA plans have only 3,529 MA enrollees.

**Other plan types**, including cost, HCPP, PACE contracts, demonstrations and pilots, account for 4% of MA enrollment.

### PAYMENTS TO MEDICARE PRIVATE PLANS

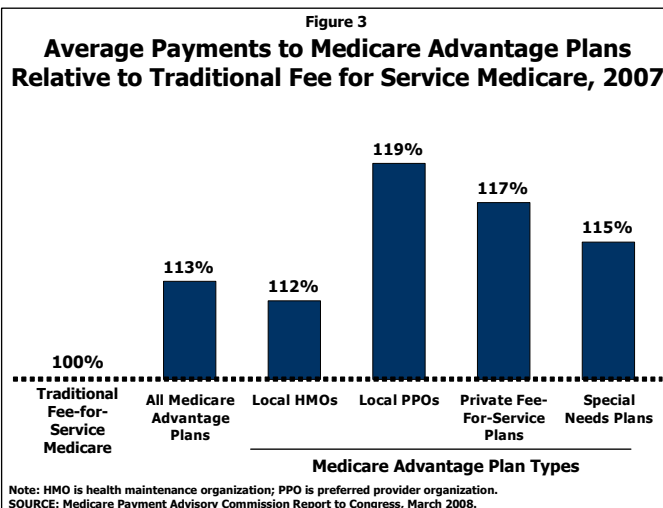
Medicare Advantage plans receive a capitated (per enrollee) rate from Medicare to provide Part A and B benefits to their enrollees. These payments are projected to total \$94 billion in 2008 (CBO, 2008). For many years, payments to Medicare HMOs were generally set on a county-by-county basis at 95% of Medicare FFS costs in each county. Provisions of the BBA constrained the growth in Medicare payments to plans as part of a broader effort to reduce the federal budget deficit, which resulted in fewer plan offerings in the following years. Congress subsequently modified the payment methodology to encourage plan participation throughout the country.

In 2006, Medicare began to pay plans under a bidding process. Plans (other than regional PPOs) bid against county-level benchmarks established by Medicare based on the prior year's MA county payment rate and 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 difference as savings and the plan receives 75% as a rebate, which must be returned to enrollees in the form of additional benefits or reduced premiums. As of 2007, plan payments are adjusted based on enrollees' risk profiles.

Analysis by MedPAC and CBO indicates that MA plans are currently paid more, on average, than FFS costs in their area, effectively increasing Medicare program costs. MedPAC estimates that Medicare payments to MA plans in 2008 average 113% of FFS costs for the counties where MA enrollees reside and as much as 117% for PFFS plans on average before adjusting for enrollee risk (Figure 3). According to Medicare actuaries, the current payment system increases Medicare expenditures, reduces the solvency of the Part A trust fund by 18 months, and increases Part B premiums paid by all beneficiaries by \$3 per month. However, a provision in the recently-enacted MIPPA adjusts MA plan payments by phasing out the cost of indirect medical education beginning in 2010, which, along with other changes in the law, is projected to slow enrollment growth and reduce spending on MA by \$48.7 billion between 2008 and 2018 (CBO, 2008).

### SUPPLEMENTAL BENEFITS AND PREMIUMS

Medicare Advantage plans are paid to provide all of Medicare's basic benefits, and are required to use any rebates they might receive by bidding below the benchmark to offer extra benefits such as vision or hearing, or reduce cost sharing or premiums. Companies that offer MA plans (excluding PFFS, MSA, and cost



plans) are required to offer at least one plan that covers the Part D drug benefit. In 2008, the majority of MA plans provide drug coverage, and 88% of beneficiaries have access to a MA drug plan with no premiums in addition to the Medicare Part B premium (MedPAC, 2008). Most MA enrollees are in plans offering limited or no coverage for drug costs in the coverage gap (the "doughnut hole").

### CHARACTERISTICS OF MEDICARE ADVANTAGE ENROLLEES

Compared to those in FFS Medicare, MA enrollees are more likely to reside in urban areas and to have incomes between \$10,000 and \$30,000. MA enrollees are less likely to report being in poor health than beneficiaries in FFS Medicare (6% vs. 10%), less likely to have a cognitive or mental impairment (25% vs. 31%), and less likely to be under 65 and disabled (11% vs. 17%). Hispanics account for a larger share of the MA population than the FFS population (14% vs. 6%), while non-Hispanic white beneficiaries comprise a smaller share of MA enrollment (71% vs. 80%) and African Americans comprise a similar share of both MA and FFS Medicare (KFF, 2008).

### FUTURE ISSUES

The relatively generous payment system for Medicare Advantage has encouraged greater plan participation in recent years, significantly expanding the number of private plans offered throughout the country and making extra benefits available to more beneficiaries. However, many policymakers have expressed concern about the current payment system in light of Medicare's overall fiscal challenges, as well as equity concerns, with only a subset of beneficiaries receiving extra benefits through MA plans. Monitoring access and use of services by enrollees is important to assess the performance of MA plans, but difficult since plans are not required to report utilization data to Medicare. Achieving a reasonable balance among multiple goals for the Medicare program—including keeping Medicare fiscally strong, setting adequate payments to private plans, and meeting beneficiaries' health care needs—will be critical issues for policymakers in the future.

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