

MEDICARE

MEDICARE ADVANTAGE

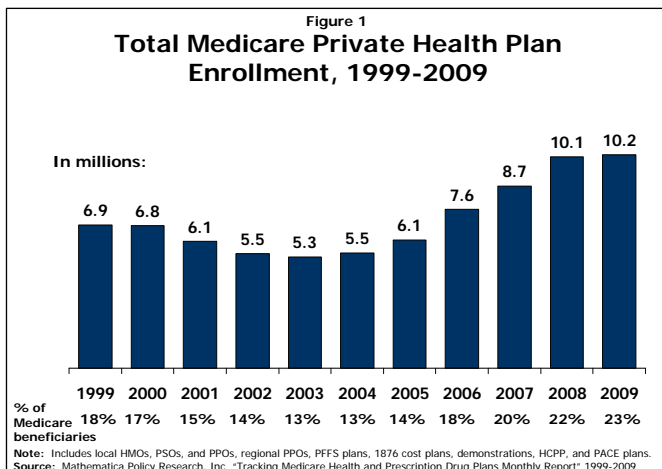
November 2009

Since the 1970s, Medicare beneficiaries have had the option to receive their Medicare benefits through private health plans, mainly health maintenance organizations (HMOs), as an alternative to the federally administered fee-for-service (FFS) Medicare program. Between 1997 and 2008, Congress made several policy changes to encourage companies to offer private Medicare plans, and encourage beneficiaries to enroll in them. These policy changes included paying private plans more than the cost of care for beneficiaries in the FFS program, in most parts of the country. In recent years, these so-called "overpayments" have been of concern because they contribute to fiscal challenges facing Medicare's future.

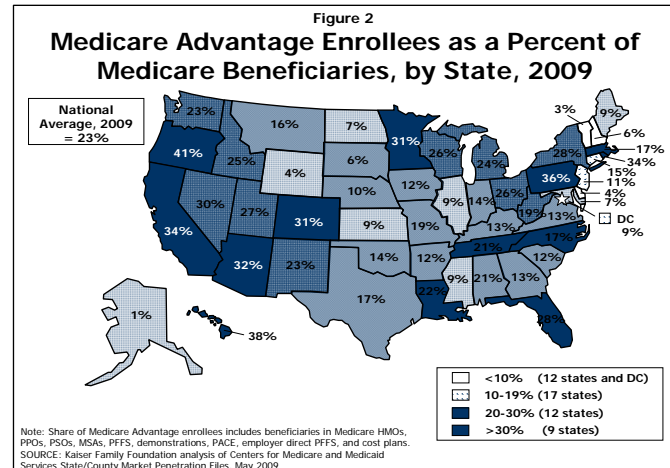
The Balanced Budget Act (BBA) of 1997 renamed the Medicare private plan options "Medicare+Choice", and authorized Medicare to contract with local preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and medical savings account (MSA) plans. The Medicare Modernization Act of 2003 (MMA) renamed the program "Medicare Advantage", authorized two additional plan types (regional PPOs and special needs plans), and boosted federal payments to plans to encourage plan participation. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 added consumer protections, focusing on marketing practices. Over the course of the past several decades, Medicare payment policy for plans has shifted from one that produced savings to one that focuses more on expanding access to private plans under Medicare and providing extra benefits to Medicare private plan enrollees. This shift in policy increased costs to the program, an issue that has emerged as key in the health policy debate.

MEDICARE ADVANTAGE ENROLLMENT

In 2009, the majority of the 45 million people on Medicare are in the FFS program, with 23 percent now enrolled in a private Medicare Advantage plan (Figure 1). Since 2003, the number of Medicare beneficiaries enrolled in private plans has nearly doubled from 5.3 million to 10.2 million in 2009.



Advantage enrollment rates also vary by state, ranging from 41 percent (Oregon) to less than 1 percent (Alaska) (Figure 2).



MEDICARE ADVANTAGE PLAN TYPES

Local HMOs and PPOs contract with provider networks to deliver Medicare benefits. HMOs account for nearly half of all plans and two thirds (63%) of Medicare Advantage enrollment; 8% of all Medicare Advantage enrollees are in a local PPO.

Private Fee-for-Service plans (PFFS) unlike other plans, are not currently required to establish networks, but beginning in 2011, will be required to form provider networks in certain counties, as a result of MIPPA. Since 2006, PFFS enrollment has tripled from 765,000 enrollees to 2.3 million, with substantial growth among retirees in employer-sponsored retiree plans.

Special Needs Plans (SNPs) are restricted to beneficiaries who are dually eligible for Medicare and Medicaid, live in long-term care institutions, or have certain chronic conditions. Since 2006, the number of SNP enrollees has increased from 0.5 million to 1.3 million enrollees, mostly dual eligibles.

Regional PPOs were established to provide rural beneficiaries greater access to Medicare Advantage plans, and cover entire statewide or multi-state regions. Regional PPOs account for 3% of all Medicare Advantage enrollees in 2009.

Medical savings account plans (MSAs) combine a high deductible health plan with a 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 \$2,700 to \$4,000 in 2009), at which point the plan pays for all Medicare-covered services. In 2009, MSA plans have only 1,866 enrollees.

Other plans (e.g. cost, HCPP, PACE contracts, demonstrations and pilots) account for 3% of Medicare Advantage enrollment.

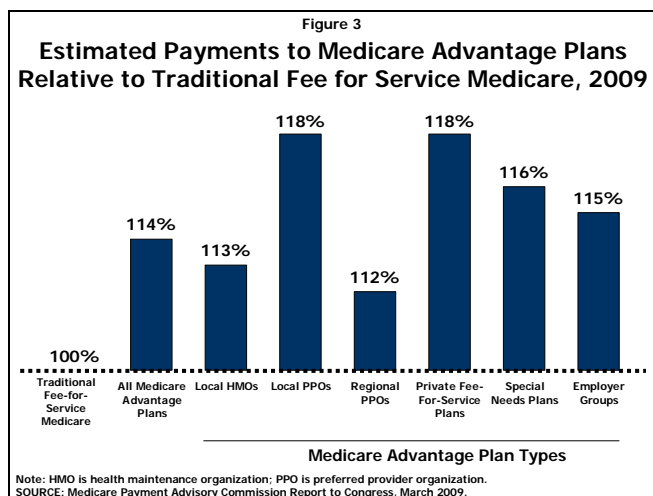
PAYMENTS TO MEDICARE PRIVATE PLANS

Medicare pays Medicare Advantage plans a capitated (per enrollee) amount to provide all Part A and B benefits to their enrollees. Plans may also provide prescription drug benefits under Medicare Part D. Initially, the government spent less, on average, for beneficiaries who enrolled in HMOs than on beneficiaries in the traditional FFS Medicare program. For many years, payments to Medicare HMOs were generally set at 95% of Medicare FFS costs in each county (and not adjusted for beneficiaries' risk profiles) because HMOs were thought to be able to provide care more efficiently than FFS. Medicare payments to plans have increased over the years and are projected to total \$110 billion in 2009 (CBO, 2009).

Over time, Congress has revised the payment formula to raise payments in order to attract more plans to rural and certain urban areas. The BBA of 1997 established a payment floor, applicable almost exclusively to rural counties. The Benefits Improvement and Protection Act (BIPA) of 2000 created payment floors for urban areas and increased the floor for rural areas, with a subsequent boost in payment, across all areas, authorized by the MMA of 2003.

Since 2006, Medicare has paid plans under a bidding process, whereby plans submit "bids" that estimate the plans' costs per enrollee for services covered under Parts A and B of Medicare; all bids that meet the necessary requirements are accepted. The bids are not compared to other bids, but rather are compared to benchmark amounts that are set by a formula established in statute and vary by county (or region in the case of regional PPOs). If a plan's bid is higher than the benchmark, enrollees pay the difference in the form of a monthly premium, in addition to the Medicare Part B premium. If the bid is lower than the benchmark, the plan receives 75% of the difference (Medicare keeps the other 25%), which is known as a "rebate" that plans must use to provide supplemental benefits. Medicare payments to plans are then adjusted based on enrollees' risk profiles.

According to MedPAC, payments to Medicare Advantage plans per enrollee average 114% of FFS costs in 2009 (Figure 3).



Medicare county benchmarks will increase by 0.81% in 2010, less than the roughly 4% increase plans had received in recent years. As required by statute, this is based on the projected national growth rate, adjusted for past projection errors; it also assumes the current law 21% cut in Medicare reimbursement to physicians scheduled to go into effect in 2010, and makes adjustments for coding intensity.

SUPPLEMENTAL AND PRESCRIPTION DRUG BENEFITS

Medicare Advantage plans are paid to provide all of Medicare's basic benefits, and, as is required, use any rebates they might receive to provide additional benefits, such as cover eyeglasses, or reduce cost sharing or premiums for all covered benefits, including those covered under Part D. Reduced cost-sharing is the most common benefit enhancement in 2009, according to MedPAC.

Companies that offer Medicare Advantage plans (excluding PFFS, MSA, and cost plans), in addition to providing all Medicare benefits, are required to offer at least one plan that covers the Part D drug benefit. In 2009, 84% of beneficiaries enrolled in Medicare Advantage are in a plan that covers the Part D drug benefit.

CHANGES IN POLICIES FOR 2010

Medicare beneficiaries will continue to be able to choose from many Medicare Advantage plans, as well as traditional fee-for-service Medicare, in 2010. Beneficiaries may notice some change in the number of Medicare Advantage plans offered due in part to strategic decisions firms have made in response to current and anticipated policy changes, such as network requirements for PFFS plans, and market consolidations driven by CMS efforts to eliminate duplicative and small Medicare Advantage plans. In 2010, the average Medicare beneficiary will have the option to choose from among 33 Medicare Advantage plans in addition to the traditional Medicare program, and some can choose from as many as 73 Medicare Advantage plans.

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 Medicare Advantage plans. Furthermore, all beneficiaries pay higher Part B premiums to help pay for higher Medicare payments to Medicare Advantage plans. 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/.

This publication (#2052-13) is available on the Kaiser Family Foundation's website at www.kff.org.