

MEDICARE

MEDICARE ADVANTAGE

April 2009

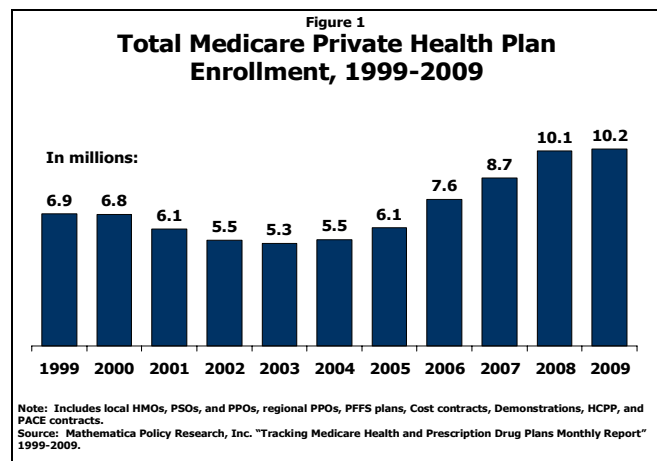
Since the 1970s, Medicare beneficiaries have had the option to receive their Medicare benefits through private health plans, mainly Medicare health maintenance organizations (HMOs), as an alternative to the fee-for-service (FFS) Medicare program. Between 1997 and 2008, Congress made several policy changes to encourage private plan participation in Medicare and enrollment growth. Recently, attention has focused on concerns that Medicare pays more for beneficiaries in Medicare Advantage plans than for those in the FFS program, contributing to fiscal challenges facing Medicare's future.

The Balanced Budget Act of 1997 (BBA) expanded private plan options under Medicare 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). The BBA also established a payment floor, applicable almost exclusively to rural counties. The Benefits Improvement and Protection Act of 2000 (BIPA) enhanced payments by creating payment floors for urban areas and increasing the floor for rural areas. 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 payments to encourage plan participation.

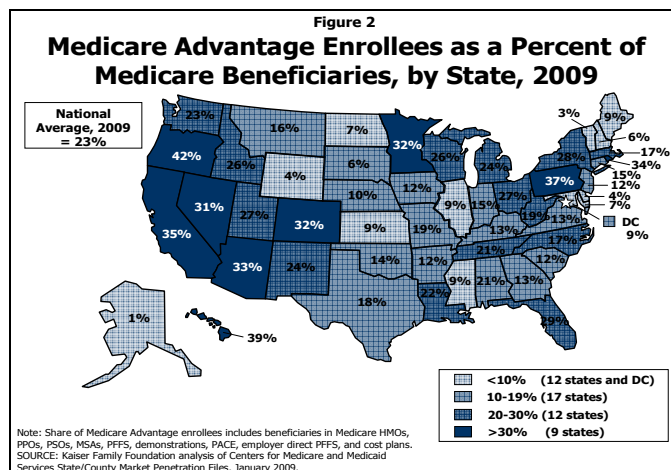
The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 included changes in payments to plans, and added beneficiary protections, focusing on marketing practices.

MEDICARE ADVANTAGE ENROLLMENT

In 2009, the majority of the 45 million people on Medicare are in the FFS program, with 22 percent now enrolled in a private Medicare Advantage plan. Since 2003, the number of Medicare beneficiaries enrolled in private plans has nearly doubled from 5.3 million in 2003 to the current level of 10.2 million (as of March 2009) (Figure 1).



Enrollment rates are substantially higher in urban (25%) than in rural (13%) counties (MedPAC, 2009). Enrollment in Medicare Advantage varies widely by state, with less than 10% of beneficiaries enrolled in Medicare Advantage plans in 12 states and DC, and more than 30% are enrolled in Medicare Advantage plans in 9 states (Figure 2).



MEDICARE ADVANTAGE PLANS

Medicare beneficiaries currently have access to several different types of Medicare Advantage plans.

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

Private Fee-for-Service plans (PFFS) are not currently required to establish networks, report quality measures, or have Medicare review and negotiate premiums. However, MIPPA requires PFFS plans to comply with new quality reporting requirements and, beginning in 2011, form provider networks in certain counties. Since July 2006, PFFS enrollment has nearly tripled from 765,000 enrollees to 2.3 million.

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 chronic conditions. Since 2006, the number of SNP enrollees has increased from 0.5 million to 1.3 million enrollees, mainly dual eligibles. MIPPA reauthorized SNPs through 2010, but prohibits the entry of new SNPs until 2011.

Regional PPOs were established under the MMA to provide rural beneficiaries greater access to Medicare Advantage plans, with a \$10 billion "stabilization fund" to encourage entry of regional PPOs. This fund was virtually eliminated under the MIPPA. In 2009, regional PPOs account for only 3% of all Medicare Advantage 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 \$2,700 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.

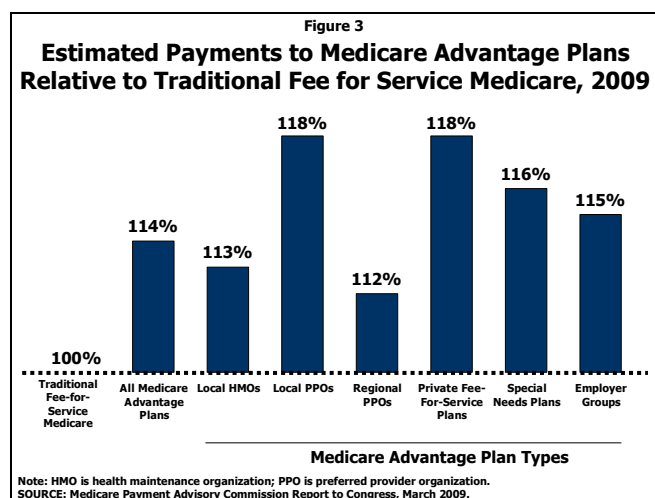
Other plans (e.g., cost, HCPP, PACE contracts, demonstrations and pilots) account for 3% of Medicare Advantage enrollment.

PAYMENTS TO MEDICARE PRIVATE PLANS

Medicare 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 \$110 billion in 2009 (CBO, 2009). 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 because HMOs were thought to be able to provide care more efficiently than FFS.

In 2006, Medicare began to pay plans under a bidding process. Plans (other than regional PPOs) bid against county-level benchmarks. 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 and the plan receives 75% as a rebate, which must be returned to enrollees in the form of additional benefits or reduced premiums. Plan payments from Medicare are then adjusted based on enrollees' risk profiles. Local HMOs are the only type of Medicare Advantage plan with average bids below FFS (98% of FFS in 2009).

Medicare Advantage plans are currently paid more, on average, than FFS costs in their area. According to MedPAC, payments to Medicare Advantage plans per enrollee in 2009 will average 114% of FFS costs for the counties where Medicare Advantage enrollees reside (Figure 3).



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 reduced cost sharing or premiums. An analysis by MedPAC indicates reduced cost-sharing is the most common benefit enhancement but that for 2009 Medicare pays \$1.30 in subsidies to the plans for each \$1 provided in extra benefits. Companies that offer Medicare Advantage plans (excluding PFFS, MSA, and cost plans) 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.

2010 PAYMENT AND POLICIES

For 2010, Medicare county benchmarks will increase by 0.81% - 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.

Each year, the Centers for Medicare and Medicaid Services (CMS) issues a Call Letter to help Medicare organizations that sponsor Medicare Advantage Part D plans prepare their bids for the following contract year. Among other changes, the Call Letter for 2010 urged elimination of duplicative Medicare Advantage plans or plans with little or no enrollment; announced the consideration of a rule that would limit the number of plan benefit designs; imposed restrictions on cost sharing for certain Medicare services; and provided additional guidance regarding the relationship between a plan's annual limit on out-of-pocket expenses and the extent of scrutiny by CMS of plan cost sharing levels for Medicare covered services.

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. 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 (#2052-12) is available on the Kaiser Family Foundation's website at www.kff.org.