

MEDICARE

MEDICARE ADVANTAGE

March 2007

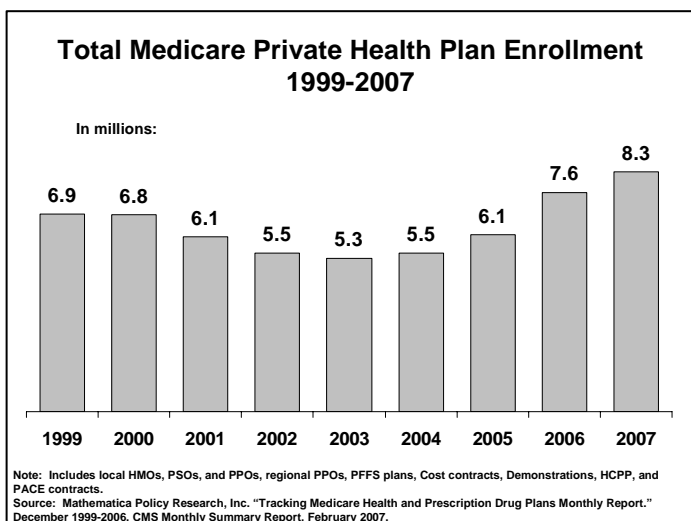
OVERVIEW

Most of the 43 million elderly and disabled people on Medicare (81%) have their health bills paid by the traditional fee-for-service program; 19% (8.3 million) receive their Medicare benefits through private health plans that receive payments from Medicare, now generally known as "Medicare Advantage" plans.

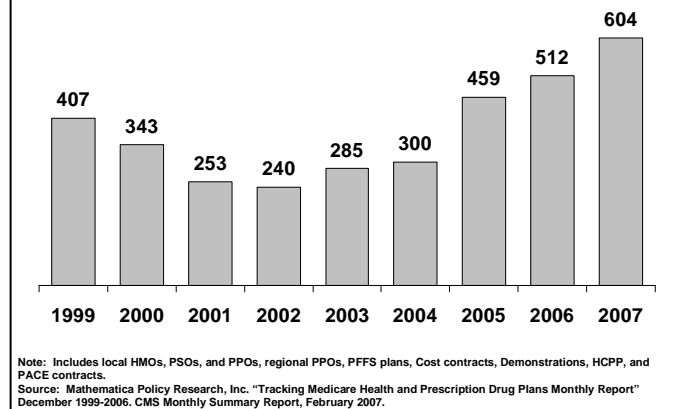
Medicare HMOs have been an option under Medicare since the 1970s. The Balanced Budget Act of 1997 authorized new Medicare plans, including preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and high deductible plans linked to Medical 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. The MMA also increased payments to plans to encourage plan participation and enrollment.

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 8.3 million (across 604 contracts) as of February 2007. The growth is largely attributed to higher plan payments and new marketing opportunities associated with the Medicare drug benefit.



Medicare Private Health Plan Contracts 1999-2007



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 2006, less than 1% of beneficiaries were enrolled in Medicare Advantage plans in 4 states (AK, ME, NH, VT), while at least 25% of beneficiaries in 8 states (AZ, CA, CO, HI, NV, OR, PA and RI) were in such plans. Nationwide, half of all Medicare Advantage enrollees lived in 5 states (AZ, CA, FL, NY, and PA) in 2006.

BENEFITS AND PREMIUMS

Medicare Advantage plans provide benefits covered under traditional Medicare; most provide additional benefits. Medicare pays plans to provide basic Medicare benefits, and plans must use any savings to reduce enrollee premiums or improve benefits (see payment section below). MA plans (excluding PFFS 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 HMOs (68%), PPOs (85%) and 100% of private FFS plans had a coverage gap (the so-called "doughnut hole") (Gold, 2006).

Average monthly premiums for Medicare Advantage plans vary widely. More than 40% of all HMOs and 20% of all PFFS plans with drug benefits offered zero-premium coverage in 2006 (Gold, 2006). Zero premium plans were common in the mid- to late-1990s, but declined in the early 2000s in response to changes in federal payment policy.

EMERGENCE OF NEW MEDICARE HEALTH PLANS

Private fee-for-service plans (PFFS) differ from Medicare HMOs and PPOs in that they are not required to establish provider networks, adopt utilization management strategies, or coordinate care like most other Medicare Advantage plans. PFFS plans account for a small share of total MA enrollment in 2007 (16%), but the rate of growth in enrollment far exceeds the rate for HMOs and PPOs (18%) between December 2005 and February 2007. During this period, PFFS enrollment increased from nearly 209,000 to 1.3 million enrollees, an increase of over 500%.

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. In 2006, total SNP enrollment reached nearly 603,000, the majority of whom were dual eligibles (nearly 492,000). The number of SNPs rose from 125 to 276 between 2005 and 2006, and to 470 in 2007 (CMS, 2006).

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 in plans offered in 2007), at which point the plan will pay for all Medicare-covered services. As of February 2007, CMS reports 2,238 beneficiaries enrolled in Medicare MSAs.

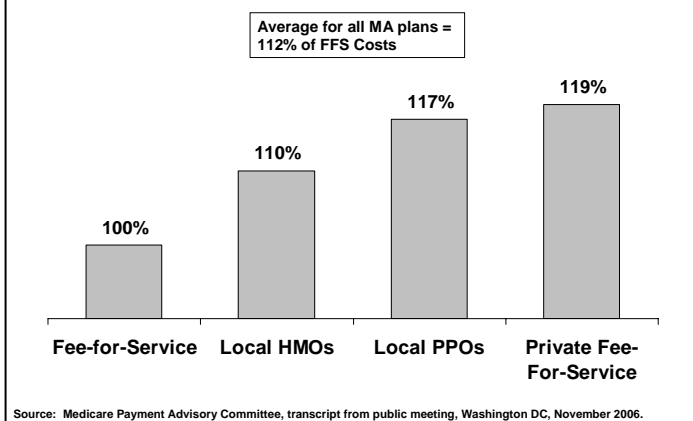
Regional PPOs were established under the MMA in an effort to provide beneficiaries in rural areas greater access to Medicare Advantage plans. The MMA included a \$10 billion stabilization fund to encourage PPOs to contract with Medicare (reduced to \$3.5 billion due to legislation passed in 2006). Medicare PPOs are available in all but five MA regions, yet enrollment remains modest at about 100,000 in 2006.

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, overall growth in Medicare payments was constrained in the late 1990s leading to limited increases in payments to plans. In the years that followed, plan participation and enrollment declined.

In 2006, Medicare began to pay plans under a bidding process. Plans 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. Payments to regional PPOs are also based on a bidding process, although the benchmarks are determined separately using a formula that incorporates the plan bids.

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



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 services to rural and other areas with benchmarks that are high relative to Medicare FFS spending because these areas were given increases in payment rates under earlier law. 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 rural areas where the benchmark rate is significantly higher than Medicare FFS costs—are paid 119% of FFS costs before adjusting for enrollee risk.

FUTURE ISSUES

Private health plans with Medicare enrollees are experiencing accelerated growth. Ongoing evaluation would help in monitoring how well these plans serve the needs of enrollees, especially the chronically ill, particularly in light of the new annual "lock in" which limits the ability of enrollees to disenroll or switch plans. Higher payments may allow plans to offer more generous benefits, but also increase Medicare expenditures over the long run and raise questions about the extent to which Medicare distributes extra benefits equitably across the Medicare population. Achieving balance between the need to control spending growth, 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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