THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

MEDICARE ADVANTAGE

September 2010

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 Medicare program. The Balanced Budget Act (BBA) of 1997 named Medicare's managed care program "Medicare+Choice" and the Medicare Modernization Act (MMA) of 2003 renamed it "Medicare Advantage." Medicare payments to plans are estimated to total $116 billion in 2010, accounting for 22% of total Medicare spending (CBO August 2010 Medicare Baseline).

Over the course of the past several decades, Medicare payment policy for plans has shifted from one that produced savings to one that focused more on expanding access to private plans under Medicare and providing extra benefits to Medicare private plan enrollees. These policy changes resulted in Medicare paying private plans more per enrollee than the cost of care for beneficiaries in the fee-for-service program, on average. According to MedPAC, payments to Medicare Advantage plans per enrollee average 109% of fee-for-service costs in 2010.

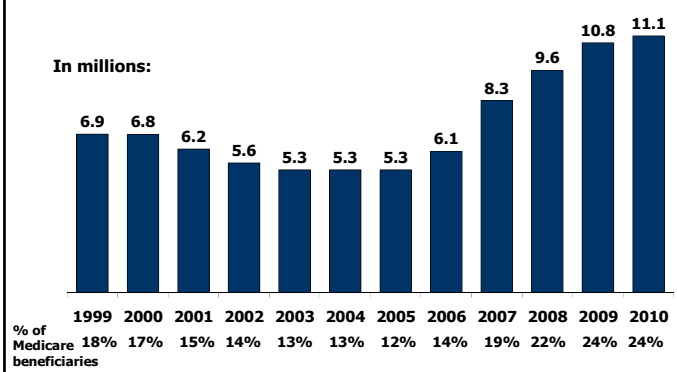
The 2010 health reform law reduces federal payments to Medicare Advantage plans over time, bringing them closer to the average costs of care under the fee-for-service Medicare program. The law also provides new quality bonus payments to plans, beginning in 2012, and beginning in 2014, will require plans to maintain a medical loss ratio of at least 85%, restricting the share of premiums that Medicare Advantage firms can use for administrative expenses and profits.

MEDICARE ADVANTAGE ENROLLMENT

In 2010, the majority of the 47 million people on Medicare are in the fee-for-service Medicare program, with 24% enrolled in a Medicare Advantage plan **(Figure 1)**. Since 2005, the number of beneficiaries enrolled in private plans has more than doubled from 5.3 million to 11.1 million in 2010.

Figure 1

Total Medicare Private Health Plan Enrollment, 1999-2010

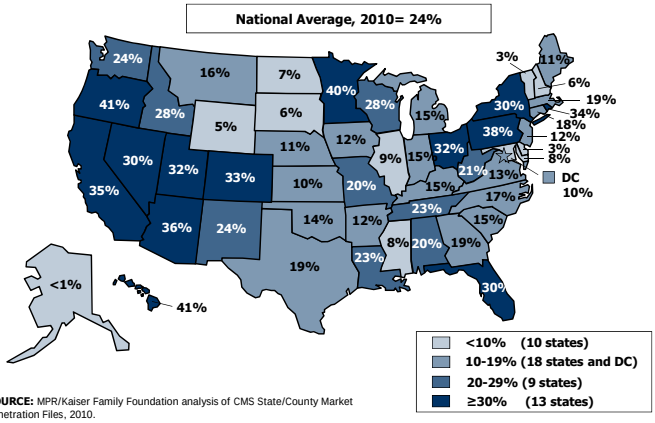


Note: Includes local HMOs, PSOs, and PPOs, regional PPOs, PFFS plans, 1876 cost plans, demonstrations, HCPP, and PACE plans.
Source: Mathematica Policy Research,"Tracking Medicare Health and Prescription Drug Plans Monthly Report," February 1999-2010

Medicare Advantage enrollment rates vary by state, ranging from 41% in Oregon and Hawaii to less than 1% in Alaska **(Figure 2)**. Enrollment rates vary by county, and are higher in urban (26%) than in rural (15%) counties (MedPAC, 2010).

Figure 2

Medicare Advantage Enrollees as a Percent of Medicare Beneficiaries, by State, 2010



SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2010.

MEDICARE ADVANTAGE PLAN TYPES

Medicare now contracts with insurers to offer the following different types of health plans:

Local HMOs and PPOs contract with provider networks to deliver Medicare benefits. HMOs account for the majority (65%) of total Medicare Advantage enrollment in 2010; local PPOs, account for 12% of all Medicare Advantage enrollees.

Private Fee-for-Service plans (PFFS), as authorized in 1997, were not required to establish networks, but beginning in 2011, will generally be required to do so. PFFS enrollment increased ten-fold from 0.2 million enrollees in 2005 to 2.3 million 2009, but declined to 1.5 million enrollees in 2010.

Special Needs Plans (SNPs), typically HMOs, are restricted to beneficiaries who: (1) are dually eligible for Medicare and Medicaid; (2) live in long-term care institutions (or would otherwise require an institutional level of care); or (3) have certain chronic conditions. Since 2006, the number of SNP enrollees has increased from 0.5 million to 1.3 million enrollees in 2010; of this total, 69 percent are 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 7% of all Medicare Advantage enrollees in 2010.

Other types of private plans (e.g., cost plans, HCPP, PACE plans, medical savings accounts, demonstrations and pilots) account for 3% of Medicare Advantage enrollment. In 2010, one in six Medicare Advantage enrollees is in a group health plan, such as an employer-sponsored plan (Gold, M et al.).

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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. In addition, Medicare makes a separate payment to plans for providing prescription drug benefits under Medicare Part D. For many years, Medicare paid plans 95% of average Medicare fee-for-service costs in each county because HMOs were thought to be able to provide care more efficiently than could be provided in fee-for-service Medicare. These payments were not adjusted for health status, and HMOs typically enrolled beneficiaries who were healthier than average.

Over the past several years, Congress has revised the payment formula to raise payments in order to attract more plans throughout the country, particularly in 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. The MMA of 2003 increased payments across all areas.

Since 2006, Medicare has paid plans under a bidding process, whereby plans submit "bids" based on estimated 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). The benchmarks are the maximum amount Medicare will pay a plan in a given area. If a plan's bid is higher than the benchmark, enrollees pay the difference between the benchmark and the bid 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.

The health reform law of 2010 revises the methodology for paying plans by reducing the benchmarks (excluding IME payments). The benchmarks will range from 95% of Medicare fee-for-service costs in the top quartile of counties with relatively high per capita Medicare costs (e.g., Miami-Dade), to 115% of fee-for-service costs in the bottom quartile of counties with relatively low Medicare costs (e.g., Boise). For 2011, the benchmarks are frozen at 2010 levels, with reductions phasing in beginning in 2012, over 3 to 6 years. The law also reduces the share plans are permitted to keep when bids are below the benchmark (from 75% to 50% for plans receiving 3 or fewer stars out of 5), with changes fully phased-in by 2014. Plans with high quality ratings will receive bonus payments and larger rebates, if their bids are below the benchmark.

SUPPLEMENTAL AND PRESCRIPTION DRUG BENEFITS

Medicare Advantage plans are paid to provide all of Medicare's basic benefits. In addition, if they receive rebates, they are required to use these payments to provide additional benefits, such as eyeglasses, or reduce premiums or cost sharing for covered benefits. Reduced cost-sharing is the most common benefit enhancement in 2010, according to MedPAC. Between 2008 and 2010, average cost-sharing increased for both inpatient and outpatient services (Gold, M et al.).

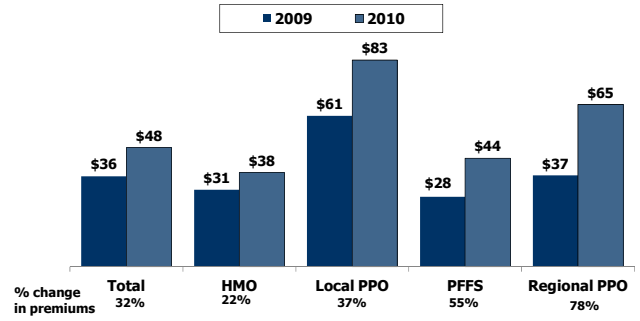
Medicare Advantage plans are generally required to offer at least one plan that covers the Part D drug benefit. In 2010, 79% of Medicare Advantage plans offered prescription drug coverage, and 49% provided some coverage in the gap (Gold, M et al.).

MEDICARE ADVANTAGE PREMIUMS

The average premium for enrollees of Medicare Advantage Prescription Drug plans was $48 per month in 2010, weighted by enrollment. This reflects a 32% increase in premiums since 2009. Premium increases were higher for PPOs and PFFS plans than for HMOs **(Figure 3)**.

Figure 3

Weighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, Total and by Plan Type, 2009-2010



NOTES: Excludes SNPs, demonstrations, HCPPs, PACE plans, employer-sponsored (i.e., group) plans, plans for special populations (e.g. Mennonites) and plans that do not offer Part D benefits. The total includes cost plans, which are not shown separately. Weighted average monthly premiums are based on MA-PDs available in 2009 and 2010, weighted for the respective year of enrollment.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Landscape Files for 2009 and 2010 and CMS 2010 Part C and D Crosswalk file.

FUTURE ISSUES

Historically, Congress has enacted a number of changes that affect the role of private plans under Medicare, including adding new types of plans to the program, increasing or decreasing Medicare payments to plans, tightening the rules governing the marketing of the plans, and even changing the name of the program (from "Medicare+Choice" to "Medicare Advantage"). The health reform law of 2010 makes a number of additional changes to the Medicare Advantage program, driven largely by concerns about the payment system and its effect on Medicare spending. These changes are projected to reduce Medicare spending by $136 billion over 10 years. They also may reduce the plans' profitability and the extent to which supplemental benefits are offered. The share of Medicare beneficiaries enrolled in Medicare Advantage is expected to decrease from 24% in 2010 to 14% in 2020 (CBO August 2010 Medicare Baseline).

Companies offering Medicare Advantage plans may respond to payment changes in several different ways, depending on the circumstances of the company, the location of their plans, their historical commitment to the Medicare market, and their ability to leverage efficiencies in the delivery of care to enrollees. For example, some companies may decide to raise beneficiaries' premiums and/or cost-sharing requirements, reduce their network of providers, reduce extra benefits, or make improvements to obtain quality-based payments. Some may choose to withdraw from the market entirely. Others may not make dramatic changes. Decisions made by these firms could have implications for beneficiaries' decisions with respect to Medicare Advantage enrollment and choice of plans, out-of-pocket costs, and access to providers.

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 continue to be a critical issue 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 (#2052-14) is available on the Kaiser Family Foundation's website at www.kff.org.