SECTION 10

Medicare Advantage

Chart 10-1. Access to MA plans available to all Medicare beneficiaries

	CCPs					
	HMO or local PPO	Regional PPO	Any CCP	PFFS	Any MA plan	Average plan offerings per county
2005	67%	N/A	67%	45%	84%	5
2006	80	87	98	80	100	12
2007	82	87	99	100	100	20
2008	85	87	99	100	100	35

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process. That is, special needs plans, cost-based plans, employer-only plans, and certain demonstration plans are excluded.

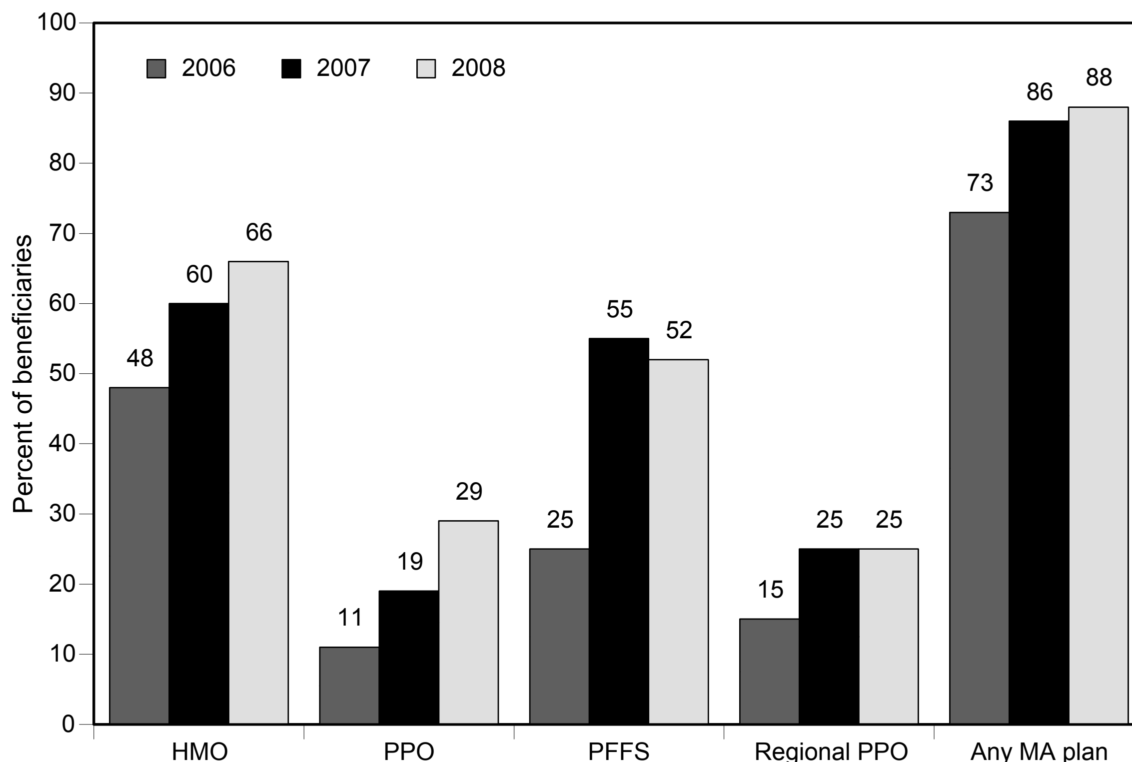
Source: MedPAC analysis of plan finder data from CMS.

- Local coordinated care plans (CCPs) are local preferred provider organizations (PPOs) and health maintenance organizations (HMOs), which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional CCPs (regional plans are required by statute to be PPOs) cover entire state-based regions and have networks that may be looser than the ones required of local PPOs. Regional PPOs were only available beginning in 2006. Another type of Medicare Advantage (MA) plan is a private fee-for-service (PFFS) plan. PFFS plans are not required to have networks and members may go to any willing Medicare provider.

- Local CCPs are available to 85 percent of Medicare beneficiaries in 2008—up from 67 percent in 2005. Regional PPOs are available to 87 percent of beneficiaries. Virtually all beneficiaries live in a county where MA PFFS plans are available in 2008—up from 45 percent in 2005. For the past three years, 100 percent of Medicare beneficiaries have had MA plans available, up from 84 percent in 2005.

- The number of plans from which beneficiaries may choose has increased. In 2008, beneficiaries can choose from an average of 35 plans operating in their counties, up from a choice of 20 plans in 2007 and 5 plans in 2005.

Chart 10-2. Access to zero-premium plans with MA drug coverage, 2006, 2007, and 2008



Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

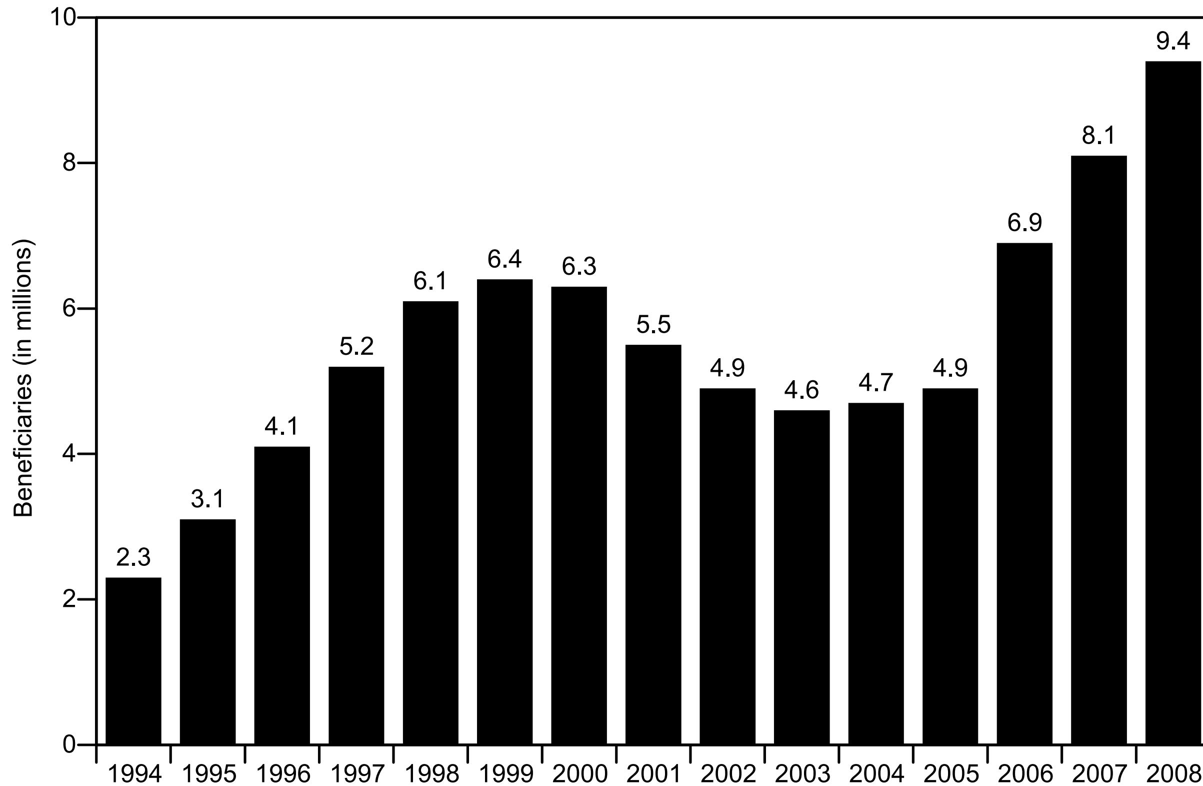
Source: MedPAC analysis of bid and plan finder data from CMS.

- Across all plan types, in 2008 there is increased availability of "zero-premium" plans—plans with no premium payments other than the Medicare Part B premium. More beneficiaries can obtain an MA plan with Part D drug coverage (an MA–PD plan) for which the enrollee pays no premium for either the drug coverage or the coverage of Medicare Part A and Part B services. In 2008, 88 percent of Medicare beneficiaries have access to at least one MA–PD plan with no premium (beyond the Medicare Part B premium) for the combined coverage (and no premium for any non-Medicare-covered benefits included in the benefit package), compared with 73 percent in 2006 and 86 percent in 2007.

- Sixty-six percent of beneficiaries have zero-premium MA–PD HMOs available, while MA–PD PPOs without premiums are much less widely available. Particularly noteworthy is the increased availability of private fee-for-service (PFFS) plans offering zero premiums. In 2006, 25 percent of beneficiaries had access to a PFFS plan with no plan premium for Part C and Part D coverage—a figure that grew to 52 percent in 2008.

- In most cases, enrollees of MA plans continue paying their Medicare Part B premium, but some MA–PD plans use rebate dollars to reduce or eliminate their enrollees' Part B premium obligation.

Chart 10-3. Enrollment in MA plans, 1994–2008



Note: MA (Medicare Advantage).

Source: Medicare managed care contract (MMCC) reports and monthly summary reports, CMS.

- Medicare enrollment in private health plans paid on an at-risk capitated basis is at an all-time high at 9.4 million enrollees (21 percent of all Medicare beneficiaries). Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999, and declined steadily to a low of 4.6 million enrollees in 2003.

Chart 10-4. Enrollment in local coordinated care plans grew slower than in other major plan types

Plan type	Total enrollees (in thousands)			Percentage change 2007–2008
	July 2006	February 2007	February 2008	
Local CCPs	5,480	6,065	6,830	13%
Regional PPOs	82	121	257	112
PFFS	774	1,328	2,057	55

Note: CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). Local CCPs include health maintenance organizations and local PPOs.

Source: CMS health plan monthly summary reports.

- Growth in enrollment in local coordinated care plans (CCPs) was slower than growth in regional preferred provider organizations (PPOs) or private fee-for-service (PFFS) plans over the past year. Combined enrollment in the three types of plans grew by 22 percent from February 2007 to February 2008.
- While still the dominant form of enrollment, local CCP enrollment grew 13 percent over the past year, while enrollment in regional PPOs grew by 112 percent and PFFS enrollment grew by 55 percent.
- Almost half of the growth in regional PPOs from February 2007 to February 2008 can be attributed to regional special needs plans (SNPs). As of February 2008, 30 percent of regional PPO enrollees are enrolled in SNPs.

Chart 10-5. MA enrollment by state and type of plan, 2008

State	Medicare eligibles (in thousands)	Distribution (in percent) of MA enrollees by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
Alabama	787	11%	3%	0%	3%	0%	16%
Alaska	57	0	0	0	0	0	1
Arizona	821	31	1	1	4	0	37
Arkansas	495	2	0	2	7	0	11
California	4,360	32	0	1	1	0	34
Colorado	556	23	1	0	4	4	32
Connecticut	536	11	1	0	1	0	13
Delaware	135	1	0	0	2	0	3
District of Columbia	74	1	0	0	1	6	9
Florida	3,099	22	1	2	2	0	27
Georgia	1,108	2	1	2	7	0	12
Hawaii	189	12	2	1	1	20	37
Idaho	206	9	3	0	11	1	24
Illinois	1,739	4	1	0	3	0	9
Indiana	939	0	1	1	8	2	12
Iowa	499	1	0	1	7	1	11
Kansas	410	2	2	0	4	1	9
Kentucky	709	3	1	1	8	1	13
Louisiana	637	15	0	0	4	0	20
Maine	246	1	1	0	3	0	5
Maryland	723	3	1	0	1	2	7
Massachusetts	996	14	1	0	3	0	18
Michigan	1,536	4	0	0	16	0	20
Minnesota	730	11	0	2	9	11	33
Mississippi	468	1	0	0	6	0	8
Missouri	944	11	2	1	4	0	18
Montana	156	0	1	0	12	0	14
Nebraska	267	3	0	1	6	1	11
Nevada	316	28	0	1	2	0	31
New Hampshire	198	0	0	0	4	0	4
New Jersey	1,257	9	1	0	0	0	10
New Mexico	284	16	3	0	3	0	23
New York	2,832	22	2	0	1	0	26
North Carolina	1,351	7	0	0	9	0	16
North Dakota	105	0	0	0	6	1	7
Ohio	1,800	12	1	1	10	1	25
Oklahoma	561	9	1	0	3	0	13
Oregon	565	23	13	0	4	1	40
Pennsylvania	2,176	26	4	0	3	0	34
Puerto Rico	605	54	6	0	0	0	60
Rhode Island	175	34	1	0	1	0	36
South Carolina	692	1	0	3	9	0	12
South Dakota	129	3	0	1	4	0	9
Tennessee	970	14	0	0	5	0	20
Texas	2,692	11	1	1	3	1	17
Utah	253	3	9	0	13	1	26
Vermont	102	0	0	0	2	0	3
Virginia	1,042	1	0	0	9	1	11
Washington	870	14	2	0	5	0	22
West Virginia	366	1	2	0	14	4	22
Wisconsin	854	6	1	0	14	1	23
Wyoming	74	0	0	0	3	1	5
U.S. Total	43,688	14	1	1	5	1	22

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Totals may not sum due to rounding.

Source: CMS enrollment and population data, 2008.

- Medicare private plans attract more beneficiaries in some areas than in others. At the state level, private plans attract only 1 percent of beneficiaries in Alaska. The highest penetrations of Medicare private plans are in Oregon and Puerto Rico, with 40 percent and 60 percent of beneficiaries, respectively, enrolled in plans.
- The popularity of different types of plans varies as well. For example, some states have all their plan enrollment in private fee-for-service (PFFS) plans, while other states have none of their enrollment in PFFS plans.

Chart 10-6. Different requirements and provisions apply to different types of MA plans

	PFFS	MSA	HMO/Local PPO	Regional PPO	SNP
Must build networks of providers			✓	✓	✓
Must report quality measures			✓	✓	✓
Must have CMS review and approve bids and premiums			✓	✓	✓
Must return to the Trust Funds 25 percent of the difference between bid and benchmark	✓		✓	✓	✓
Must offer individual MA plan if offering employer group plan*			✓	✓	✓
Must offer Part D coverage			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures		✓		✓	
Can limit enrollment to targeted beneficiaries					✓

Note: MA (Medicare Advantage), PFFS (private fee-for-service), MSA (medical savings account), HMO (health maintenance organization), PPO (preferred provider organization), SNP (special needs plan).
*Effective as of 2008 contract year; requirement does not apply to PFFS and MSA plans.

Source: MedPAC analysis of MA statutory and regulatory requirements.

- Different requirements apply to different plan types in Medicare Advantage (MA). Private fee-for-service (PFFS) plans and medical savings account (MSA) plans are exempt from many requirements that apply to coordinated care plans (CCPs). PFFS and MSA plans are not required to build networks, report on all CCP-required quality measures, offer the Part D drug benefit, or have the level of their premiums approved by CMS. Also, beginning in 2008, non-network PFFS plans and MSA plans will not be subject to the requirement that they offer nongroup MA plans if they offer employer group MA plans.

- MSA plans have a payment advantage over other types of MA plans (though currently only three MSA plans are in operation). When an MSA plan bids below the benchmark, its enrollees retain the full difference in their accounts, while non-MSA plans receive only 75 percent of the difference between the bid and benchmark to provide extra benefits to their enrollees. In non-MSA plans, the Medicare program retains the other 25 percent of the difference.

- Only regional preferred provider organizations and MSA plans are required to have benefit structures that include an out-of-pocket limit on enrollee expenditures. The plans are allowed to determine their own level of the out-of-pocket limits. Special needs plans are allowed to limit their enrollment to one of three special populations: Medicare/Medicaid dual eligibles, institutionalized beneficiaries, and beneficiaries with chronic or disabling conditions.

Chart 10-7. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2008

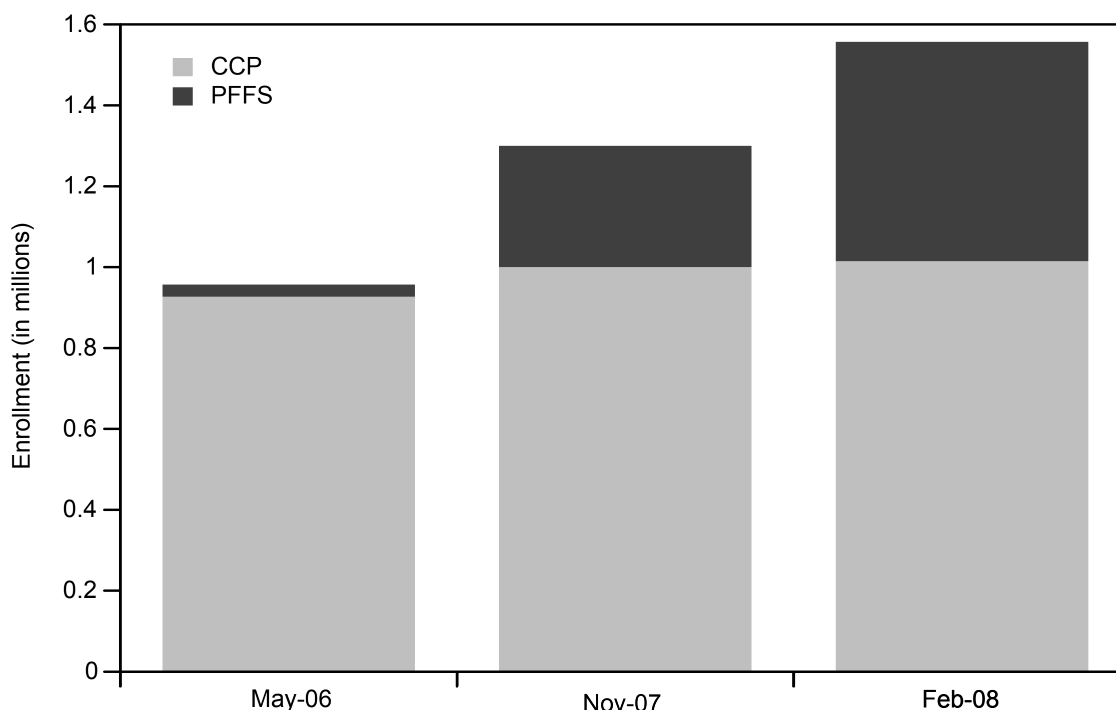
	All Plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	118%	117%	122%	115%	120%
Bids/FFS	101	99	108	103	108
Payments/FFS	113	112	119	112	117

Note: MA (Medicare Advantage), FFS (fee-for-service), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of plan bid data from CMS, November 2007.

- Since 2006, plan bids have partially determined the Medicare payments they receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is handled separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.
- The benchmark is an administratively determined bidding target. Legislation in 1997 established benchmarks in each county, which included a floor—a minimum amount below which no county benchmarks could go. By design, the floor rate exceeded fee-for-service (FFS) spending in many counties. Benchmarks are updated yearly by the national growth in FFS spending.
- If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid, plus a "rebate," defined by law as 75 percent of the difference between the plan's bid and its benchmark. The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.
- We estimate that Medicare Advantage (MA) benchmarks average 118 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type, because different types of plans tend to draw enrollment from different types of areas.
- Plans' enrollment-weighted bids average 101 percent of FFS spending. We estimate that HMOs bid an average of 99 percent of FFS spending, while bids from other plan types average at least 103 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS, while other plan types tend to charge more.
- We project that 2008 MA payments will be 113 percent of FFS spending. That means that in 2008 the Medicare program is paying about $10 billion more for the 21 percent of beneficiaries enrolled in MA plans than if they remained in FFS Medicare.
- The ratio of payments relative to FFS spending varies by the type of MA plan. HMOs and regional preferred provider organization (PPO) payments are estimated to be 112 percent of FFS, while payments to PFFS and local PPOs will average at least 117 percent.

Chart 10-8. Enrollment in employer group MA plans, 2006–2008



Note: MA (Medicare Advantage), CCP (coordinated care plans), PFFS (private fee-for-service).

Source: CMS enrollment data.

- While most Medicare Advantage (MA) plans are available to any Medicare beneficiary, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.

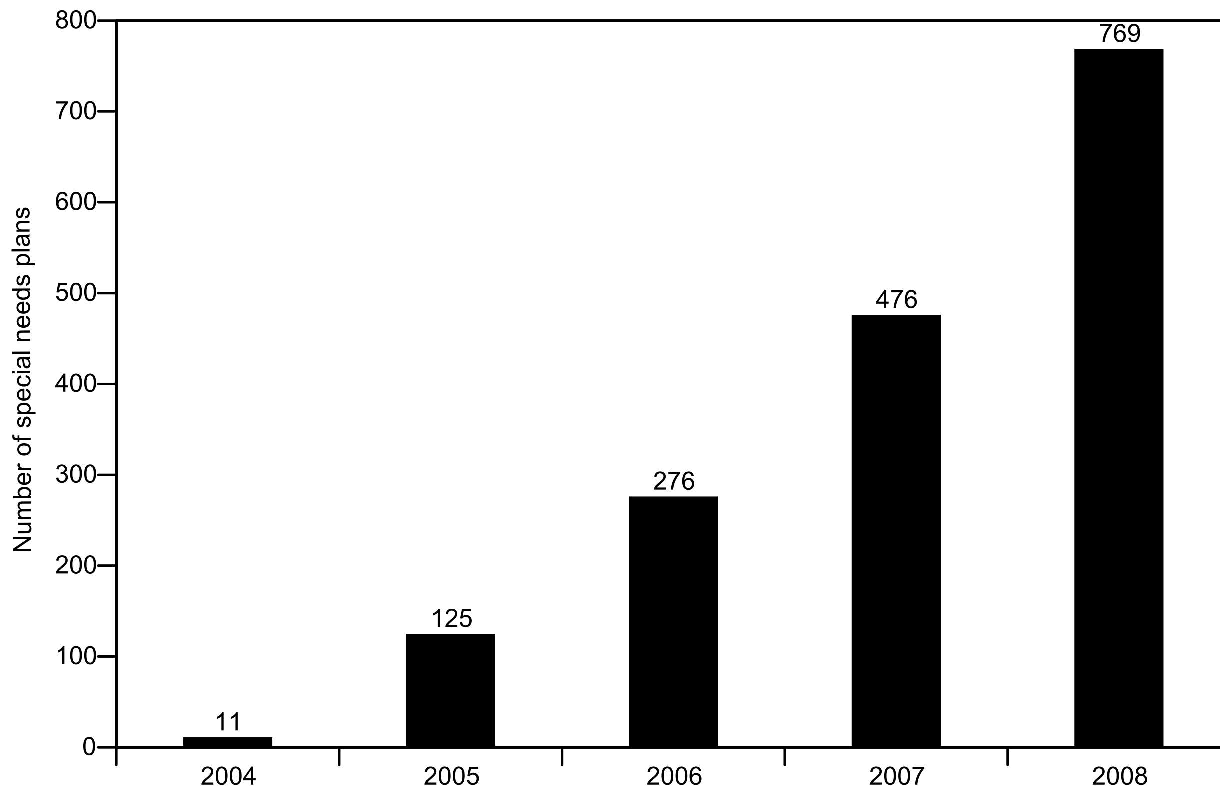
- In the last 2 years, enrollment in employer group plans has grown by more than 60 percent, while overall MA enrollment grew by about 20 percent. As of February 2008, there were about 1.55 million enrollees in employer group plans compared with about 7.5 million enrollees in individual MA plans. Thus, about 17 percent of all enrollees in MA plans were employer group enrollees.

- As in the individual MA market, the growth has been concentrated in private fee-for-service (PFFS) plans. Over 80 percent of the growth in employer group enrollment over the past two years, and virtually all of the growth over the past year, has come from private fee-for-service enrollment. There are now more than half-a-million enrollees in employer group PFFS plans. PFFS plans now have about one-third of the enrollment in the MA employer group market, and employer group enrollment is now about a quarter of all PFFS enrollment.

- Our analysis of MA bid data shows that employer group plans on average have bids that are higher relative to fee-for-service (FFS) spending than individual plans, meaning that group plans appear less efficient than individual market MA plans. Employer group plans bid an average of 109 percent of FFS, compared with 99 percent of FFS for individual plans.

- We estimate that Medicare pays employer group plans 116 percent of average FFS Medicare spending, compared with 113 percent of FFS for individual market MA plans.

Chart 10-9. Special needs plans have grown quickly



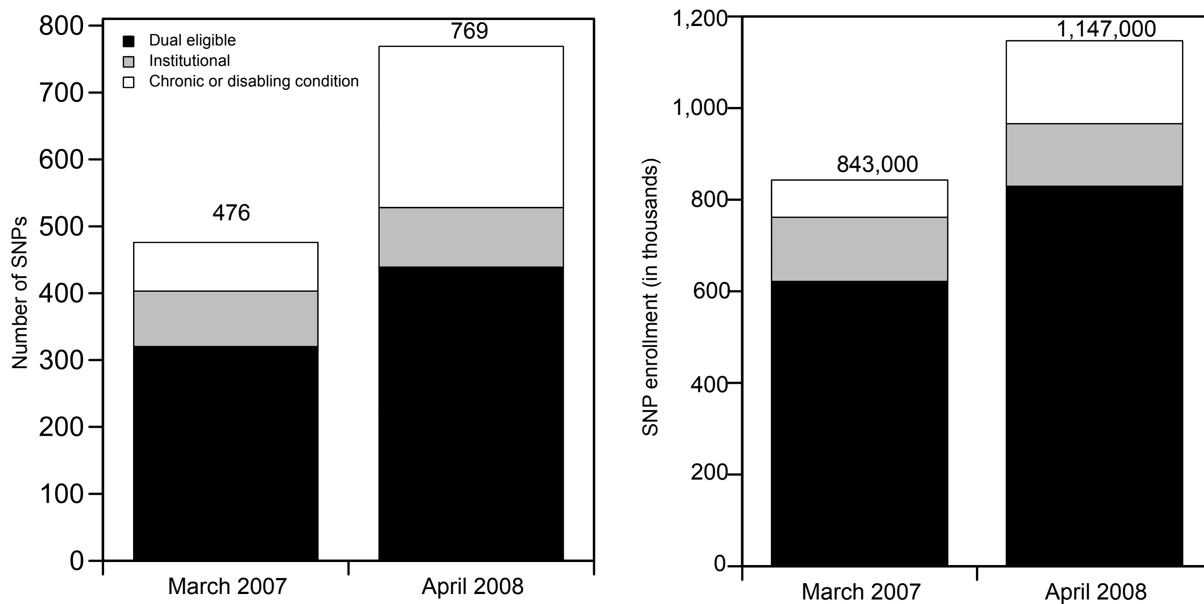
Source: CMS special needs plans fact sheet and data summary, February 14, 2006 and CMS special needs plans comprehensive reports, March 21, 2007, and April 2008.

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.

- In 2008, there are 769 SNPs, a 62 percent increase over 2007 and a 179 percent increase over 2006.

- SNPs were originally authorized for five years. The Medicare, Medicaid, and SCHIP Extension Act of 2007 extended SNP authority for an additional year while placing a moratorium on new plans and service area expansions for existing plans. Absent additional congressional action, SNP authority will expire at the end of 2009.

Chart 10-10. The number of SNPs and SNP enrollment increased from 2007 to 2008



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, March 21, 2007, and April 2008.

- In 2008, most special needs plans (SNPs) (57 percent) are for dual-eligible beneficiaries, while 31 percent are for beneficiaries with chronic conditions, and 12 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need).
- This is a change from 2007 when 67 percent of SNPs were for dual eligibles.
- Enrollment in SNPs has grown quickly from 843,000 in March 2007 to 1,147,000 in April 2008, a 36 percent increase.
- The rate of enrollment growth was especially rapid for chronic condition SNPs (55 percent). (For more information, see Chapter 3 of MedPAC's March 2008 Report to the Congress at http://medpac.gov/chapters/Mar08_Ch03.pdf.)
- Most beneficiaries (95 percent) live in an area served by a SNP. Eighty-nine percent of beneficiaries live in an area served by a chronic condition SNP, 77 percent in areas with dual-eligible SNPs, and 54 percent in areas with institutional SNPs.

Web links. Medicare Advantage

- Chapter 3 of MedPAC's March 2008 Report to the Congress provides information on Medicare Advantage plans.

  http://medpac.gov/chapters/Mar08_Ch03.pdf

- Chapter 3 of MedPAC's June 2007 Report to the Congress provides information on Medicare Advantage plans.

  http://medpac.gov/chapters/Jun07_Ch03.pdf

- More information on the Medicare Advantage program payment system can be found in MedPAC's Medicare Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_07_MA.pdf

- CMS provides information on Medicare Advantage and other Medicare managed care plans.

  http://www.cms.hhs.gov/HealthPlansGenInfo/

- The official Medicare website provides information on plans available in specific areas and the benefits they offer.

  http://www.medicare.gov/Default.asp