

CHAPTER

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**The Medicare Advantage  
program: Availability, benefits,  
and special needs plans**

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# The Medicare Advantage program: Availability, benefits, and special needs plans

## Chapter summary

This year brings several important changes for the Medicare Advantage (MA) program. First, Medicare payments to plans are determined differently. Plans now submit formal bids, then CMS compares the bids with benchmarks to determine payment. Also, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allows new plan types, including regional preferred provider organizations (PPOs) that are required to serve entire regions. Another change is the introduction of Medicare's Part D prescription drug benefit. MA plans usually include the Part D benefit and receive a separate payment for providing it. These changes and the introduction of stand-alone prescription drug plans to the marketplace affect the competitive environment for MA plans.

Medicare beneficiaries have more MA plans to choose from in 2006, and almost all beneficiaries have access to plans. In 2006, nearly 100 percent of beneficiaries will have MA plans available to them, up from 84 percent of beneficiaries in 2005. Overall, an average of 12 MA plans are offered in each county, ranging to as high as 63. Half of all

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beneficiaries are able to choose from among 16 or more MA plans, and 5 percent of beneficiaries are able to choose from over 40 plans. The increase is due to the participation of new plans and to the expansion of service areas by existing plans.

Regional PPOs are available to 88 percent of beneficiaries. While expanding choices, their availability does not appreciably increase beneficiaries' access to MA plans; 99 percent of beneficiaries have access to local MA plans.

About 95 percent of plans bid under their benchmarks, thus almost all plans had funds to rebate in the form of lower Medicare cost sharing, lower Part B or Part D premiums, or non-Medicare supplemental benefits. As a result, for example, zero-premium MA plans—plans that charge no premium in addition to the Part B premium—are available to 84 percent of Medicare beneficiaries in 2006, up from about 58 percent of beneficiaries in 2005. Almost 70 percent of beneficiaries have access to zero-premium MA plans that also include the Part D benefit. Health maintenance organizations (HMOs) tended to bid further below the benchmarks than other types of plans and thus had larger rebates and greater ability to offer enhanced benefits.

Virtually all Medicare beneficiaries have an available MA plan, regardless of whether they live in urban or rural areas. However, urban beneficiaries are much more likely to have local HMOs and local PPOs available than those in rural areas while private fee-for-service (PFFS) plans are much more likely to be available in rural areas. Because local HMOs and local PPOs tended to bid further below the benchmarks and thus had more rebate dollars to return to beneficiaries than regional PPOs or PFFS plans, additional benefits are more widely available in urban areas than in rural areas.

In future work, we will examine some of the broader questions about the value of private plans to the Medicare program. Such questions may focus on quality, efficiency, and payment issues.

## **Special needs plans**

The Congress created special needs plans (SNPs) to provide a common framework for many of the existing plans for special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans. These special plans include Social Health Maintenance Organizations, Evercare, and various demonstration plans.

2006 marked a significant increase in the number of SNPs available to beneficiaries. In 2004, there were just 11 SNPs. By 2005, that number had grown to 125. In 2006, the total number of SNPs has more than doubled to 276. Organizations with experience partnering with Medicaid and serving special needs populations entered the SNP market, but so did MA organizations with little or no experience serving these populations.

The Commission has sought creative ways to deliver high-quality health care to special needs beneficiaries, particularly dual eligibles. The policy and practical issues we described in the June 2004 report on dual-eligible beneficiaries might be addressed through special needs plans (MedPAC 2004b). Theoretically, SNPs may improve care coordination for dual eligibles and other special needs beneficiaries through unique benefit design and delivery systems.

However, we are concerned that many SNPs are not designed to better coordinate care for special needs beneficiaries. SNPs, even dual-eligible SNPs, are not required to contract with states to provide Medicaid benefits, and many appear not to do so. SNPs that do not integrate Medicare and Medicaid services may not coordinate the two programs. ■



The Medicare Advantage (MA) program allows Medicare beneficiaries to receive their Medicare benefits from private plans rather than from the traditional fee-for-service (FFS) program. There are several important changes for the MA program in 2006. First, Medicare payments to plans are determined differently. CMS no longer determines MA plan payments based solely on administratively set payment rates. Plans now submit formal bids, then CMS compares the bids with benchmarks (derived from the old rates) to determine payment (see text box on page 204). Also, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allows new plan types, including regional preferred provider organizations (PPOs) that are required to serve entire regions rather than the local plan service areas, which can be limited to a single county.<sup>1</sup>

Another key change relates to the introduction of Medicare's Part D prescription drug benefit. Organizations that sponsor MA plans must include the Part D benefit, or an actuarially equivalent or enhanced drug benefit, in at least one of their plan offerings. (In the Commission's terminology, a "plan" is a specific set of benefits offered in a specific service area by a sponsoring organization. A sponsoring organization can offer multiple plans in an area.) Past studies have shown that the availability of prescription drug benefits in many MA plans attracted significant enrollment. Medicare now makes separate Part D payments to the MA plans that include the Part D benefits—Medicare Advantage—Prescription Drug plans (MA-PDs)—as if they were stand-alone prescription drug plans (PDPs). Because many MA plans already offered drug benefits without receiving Medicare reimbursement for them, the Part D payments represent a new stream of funding. Plans that offered drug benefits that did not reach the actuarial value of the Part D benefit were required to improve their drug coverage. Plans also had to meet new formulary and data requirements. Managing the full spectrum of care may allow some plans to operate more efficiently than stand-alone drug plans.

This chapter discusses the competitive environment for MA plans, the range of plan types included in the MA program, plan bidding, and the range of MA plan offerings. The chapter concludes with a special focus on MA special needs plans (SNPs).

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## Medicare Advantage plans available for 2006

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Medicare beneficiaries will have more MA plans to choose from in 2006 than in previous years, and almost all beneficiaries have access to plans. Many of those plans will have low premiums and enhanced benefits not available in the Medicare FFS package.

### Features of available plan types

For this chapter, we distinguish four available plan types: local health maintenance organizations (HMOs), local PPOs, regional PPOs, and private fee-for-service (PFFS) plans.<sup>2</sup> These plans are available to most Medicare beneficiaries. In general:

- HMOs have comprehensive provider networks and members must use network providers in all nonemergency situations.
- PPOs have comprehensive networks, but members may use out-of-network providers if they pay higher cost sharing.
- PFFS plans are not required to have any networks and members may go to any willing Medicare provider.

In practice, some of the distinctions between the plan types may be blurred, as illustrated by a few examples. An HMO that has an out-of-network option may look much like a PPO. A local PPO could cover an entire region, making it resemble a regional PPO. And a PFFS plan may have a network that would make it hard to distinguish from a PPO.

SNPs are other plan types with restrictions on beneficiary enrollment. They will be discussed in detail in a later section of this chapter and will be excluded from most quantitative analyses in this section because of their special nature. Enrollment in SNPs may be limited to beneficiaries with Medicaid eligibility, beneficiaries in long-term care institutions, or beneficiaries with certain chronic or disabling conditions.

As there is a great deal of variation in plan attributes within each type of plan and because the lines between plan types are not always sharp, the statements about plan types should be seen as generalizations and may not apply

## Payments to plans based on benchmarks and bids

The benchmark is a bidding target. CMS sets local plan benchmarks for every county administratively, as directed by law. The 2006 benchmarks are the 2005 Medicare Advantage (MA) county payment rates, updated by the projected national growth rate in per capita Medicare spending. If a local MA plan serves a multicounty area, the benchmark against which it bids is an average of the different benchmarks for the counties it serves, weighted by its projected enrollment from each county. In our June 2005 report to the Congress, the Commission recommended several changes to the benchmarks that would result in lowering the benchmarks to a level equal to Medicare's fee-for-service costs (MedPAC 2005).

CMS determines the benchmarks for the MA regional preferred provider organizations (PPOs) by using a more complicated formula that incorporates the plan bids. The region's county benchmarks are aggregated to produce a component of the regional benchmark. This component is averaged with the regional PPO bids to produce the final regional benchmark. The lower the regional PPOs bid, the lower the resulting regional benchmark.

Every plan submits a separate set of bids to cover beneficiaries in each of its service areas. Each bid consists of up to three separate components:

- *The bid for Medicare Part A and Part B benefits (except hospice).* This portion of the bid must assume that the plan would collect the standard Medicare cost sharing from its enrollees. This bid is standardized to

a nationally average beneficiary (a CMS risk factor of 1.0) enrolled in the plan's service area.

- *The bid for supplemental benefits (if any) that the plan covers.* Supplemental benefits may include lower cost sharing on Medicare services, as well as benefits that fee-for-service Medicare does not cover.
- *The bid for the Medicare Part D drug benefit (when offered).*

CMS bases the Medicare Parts A and B payment for private plans on the relationship between their bids and the benchmarks. If a plan's bid falls above the benchmark, then the plan receives the benchmark as its payment and the enrollees will have to pay an additional premium for Medicare Parts A and B that equals the difference between the bid and the benchmark. If the plan's bid falls below the benchmark, the law defines the difference as the plan's savings. The Medicare program retains 25 percent of the savings (if it is a regional plan, CMS places half of this 25 percent into the regional PPO stabilization fund), and the plan receives the other 75 percent of the savings as a rebate, in addition to its bid. The plan must return the rebate to its enrollees in the form of supplemental benefits or lower premiums. The plan can apply any premium savings to the Part B premium (in which case the government retains the amount for that use), to the Part D premium, or to the premium for the total package that may include supplemental benefits. ■

to any individual plan. Some distinctions between the definitions of plan types are in law or regulation:

- Local HMOs with an out-of-network option may be very similar to local PPOs. The major difference is that HMOs are required to submit quality data for all services while PPOs must report some data only for services provided in-network. If a plan's sponsoring organization does not have an HMO license in the relevant state,<sup>3</sup> CMS presumes the plan is a PPO and looser reporting requirements will apply.<sup>4</sup>

- The only difference in the definitions between regional PPOs and local PPOs is the service areas they choose to serve.
- A PFFS plan may not be a regional plan and is not required to have a provider network if it pays providers at least Medicare FFS rates.

What motivates plan sponsors (typically insurers) to offer, beneficiaries to enroll in, and providers to participate in different types of plans? Exploration of these dynamics



may help explain plan availability and, eventually, plan enrollment.

### **Plan sponsor perceptions**

When a plan sponsor decides whether to enter a market and what types of plans to offer, it examines the payment it would receive and the network construction required and assesses where it could offer plans that would appeal to beneficiaries. Plan sponsors perceive that different plan types have trade-offs, including Medicare payments, administrative costs of building and maintaining an appropriate provider network, and market competition.

Plans face different requirements for network adequacy and quality data collection. HMOs require a comprehensive network. Local PPOs also require a comprehensive network, but members may go outside the network in exchange for higher cost sharing. Because establishing a comprehensive network across vast regions has presented such a difficult challenge to plans, CMS has chosen to make the regional PPO network requirements looser than the local PPO requirements. Regional PPOs are not required to have network providers in all locations. Instead, the plans must guarantee to find providers when members need care, pay the providers Medicare FFS rates, and charge members the in-network levels of cost sharing. This guarantee is different than the PFFS plans who only must guarantee that they will pay Medicare FFS rates to any provider that agrees to treat plan members. If a PFFS plan pays Medicare rates, it has no network requirements.

Generally, it is easier for plans to build networks in competitive urban markets. Providers in this type of market may sometimes be more willing to take lower rates in exchange for the promise of higher volume. In such markets, plans may be able to provide better benefits in plan types with tighter networks such as HMOs. In rural areas and other areas with low provider density, plans might only be able to offer looser network or non-network options.

The law has added financial incentives to encourage regional PPOs to participate in MA, including risk sharing for 2006 and 2007, and a regional stabilization fund that CMS may use to enhance the benchmarks only for regional PPOs bidding in regions that are having difficulty attracting plans. In addition, local PPO plans can not start in 2006 and 2007 (existing local PPOs can offer new products within the existing service area). This

moratorium is intended to prompt private plans to consider participating as regional PPOs.<sup>5</sup>

### **Beneficiary perceptions**

Many economists and health policy observers have concluded that beneficiaries see a trade-off between narrowing their choice of provider or submitting to more management in return for receiving a benefit package they perceive as having higher value. Plan sponsors may respond to these beneficiary trade-offs by marketing multiple products along the continuum to different subsets of beneficiaries. For example, studies have found that lower income (but not Medicare/Medicaid dual-eligible) beneficiaries are more likely to join MA HMOs than are higher income beneficiaries (Thorpe et al. 2002). Generally the lower out-of-pocket plans tend to appeal more to low-income beneficiaries and other beneficiaries who value lower cost sharing over expanded choice of providers. PPOs tend to appeal to those who want to have more flexibility in choice of providers. The regional PPOs and PFFS plans are more likely to appeal to those who want maximum choice of providers or those in rural or other low-competition areas that can not support more tightly managed options. Beneficiaries in those areas were previously likely to choose medigap. Bear in mind, these statements are generalizations; there is great variability in the benefits within each plan type and in the beneficiaries who choose them. For example, some of the PFFS plans for 2006 have generous benefits, such as low maximum out-of-pocket liability limits and zero-premium Part D benefits that could attract lower income beneficiaries.

### **Provider perceptions**

Providers must also consider trade-offs when deciding whether to participate with a plan. The provider decides how much to give up in order to secure access to the plan's members. In competitive market areas, HMOs usually pay less than Medicare FFS and may offer capitated rates but may promise volume. Participation in local PPOs may sometimes offer similar trade-offs. Plan sponsors may offer several types of plans and providers may decide to participate in one plan in order to be able to participate in another of the sponsors' plans. In competitive areas, providers may feel pressure to give plans attractive terms or rates so that the providers can see plan members.

However, in less competitive areas, such as many rural areas, plans may have trouble attracting enough providers to guarantee an adequate network. The regional PPOs must have networks that cover entire states, so providers

**TABLE  
9-1****Percent of Medicare beneficiaries with access to MA plans, 2004–2006**

	Local plans			Regional PPO	Any MA plan
	HMO or PPO	PFFS	Any local plan		
2006	80%	80%	99%	88%	100%
2005	67	45	84	N/A	84
2004	61	31	77	N/A	77

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not available).

Source: MedPAC analysis of CMS Landscape Tool, October 2005.

in less competitive areas of the state may have more leverage in negotiations with plans. In fact, regional PPOs may have been having trouble convincing providers to join their networks. Providers in sparsely populated areas could get FFS rates from regional PPOs even if they do not join because the plans are required to pay those rates where their network is incomplete. Further, regional PPO representatives have indicated to us that providers would not participate in order to discourage plan entry into their local areas.

PFFS plans are not required to establish a network, as long as they pay providers at least FFS Medicare rates. Because there is no network requirement, providers do not need to decide whether to participate in a plan until a plan member requests service from the provider. As under FFS Medicare, in nonemergency situations the provider can decide whether or not to accept Medicare rates for that patient for that encounter. And as in FFS Medicare, providers can choose not to treat beneficiaries under these circumstances.

### Implications for the Medicare program

The Commission wants to examine the value of the different plan types to the Medicare program. In 2006, beneficiaries in most plans likely cost the program more than they would if they were in FFS Medicare because the benchmarks are higher than FFS spending (MedPAC 2005). The regional PPOs and the PFFS plans are probably more costly relative to Medicare FFS because they are likely to attract enrollees disproportionately from areas where the benchmarks are especially high relative to Medicare FFS spending.

Different plan types may also have more or less potential to improve the quality of care for Medicare beneficiaries.

HMOs are often regarded as having the most potential to improve care through coordination and following quality standards as their providers are typically accountable to the plan. PPOs have somewhat less potential because the providers are usually less accountable to the plan and in some cases the PPOs do not collect enough information on quality to judge their performance. Currently, PFFS plans have even less ability to influence providers because they rarely maintain networks. Some plan sponsors, however, have suggested that PFFS plans could provide coordination and management through disease management programs. Pay-for-performance systems may also work to improve care quality in plans with looser networks. We have no data on whether any PFFS plans use these management techniques.

### Almost all Medicare beneficiaries have access to MA plans

In 2006, almost 100 percent of beneficiaries have MA plans available to them, an increase from 84 percent in 2005 and from 77 percent in 2004 (Table 9-1). Greater availability reflects growth in participation of coordinated care plans (CCPs)—HMOs or PPOs—and PFFS plans in the MA program.<sup>6</sup> In 2006, 80 percent of Medicare beneficiaries will have a local HMO or PPO plan operating in their counties of residence, up from 67 percent in 2005 and from 61 percent in 2004. Previously, the highest availability of local CCPs (74 percent) occurred in 1998.

PFFS plan availability has also increased substantially in 2006 to 80 percent of beneficiaries. In 2005, PFFS service areas included 45 percent of Medicare beneficiaries, up from 31 percent in 2004. In 2006, PFFS plans provide local plan access to almost all Medicare beneficiaries who

do not have access to a local HMO or PPO. Overall, 99 percent of beneficiaries have a local plan available in 2006.

### Regional plan availability

Regional PPO plans—which must cover entire state-based regions—are new in 2006. All plans that are not regional are considered “local,” meaning that they define their own county-based local service areas. Regional PPOs must have PPO-like networks, which may sometimes be looser than the ones required of local PPOs.

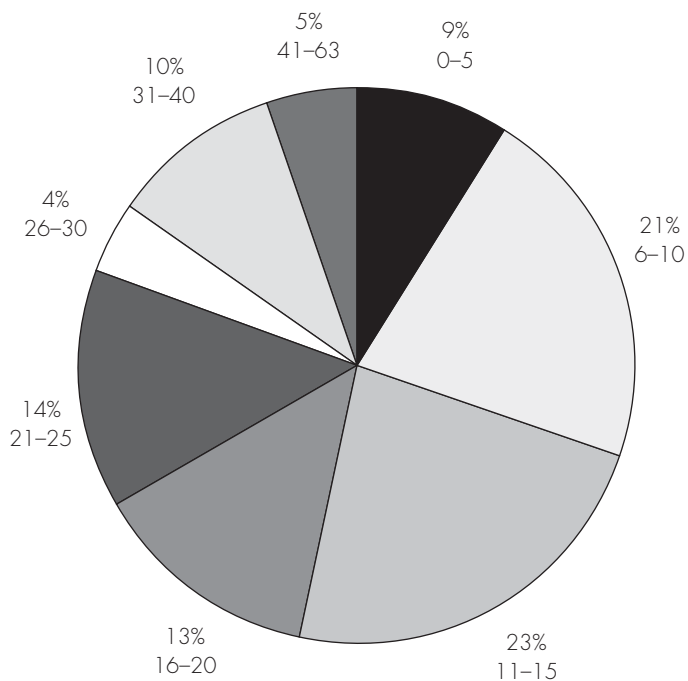
CMS established 26 bidding regions for regional PPOs. No plans bid in 5 of the regions, but CMS approved bids for 71 plans in the other 21 regions. Beneficiaries in Florida have six regional PPOs from which to choose—the most in the country. The number of plans in a region may give a false impression because most regions have only one organization that sponsors several regional plans. Of the 21 regions with regional PPOs, a single organization offers all the plans within each of 16 regions, and two organizations offer all the plans within each of the other five regions. Overall, 42 plans are offered by one sponsor—Humana. (MA organizations offer multiple local plans as well, but we highlight the regional PPO pattern because the decisions made by one or two sponsors could change the regional plan landscape significantly.)

Regional PPOs are available to 88 percent of beneficiaries, but their availability does not appreciably increase beneficiaries’ access to MA plans; 99 percent of beneficiaries have access to MA plans through the combination of local PPO, HMO, and PFFS plans. The inclusion of the regional PPOs increases beneficiaries’ range of choices. Also, regional PPOs help expand the availability of coordinated care plans; local or regional CCPs will be available to 98 percent of the Medicare population, compared with 67 percent in 2005.

Two other types of plans are eligible to participate in the Medicare Advantage program: plans with Medicare savings accounts and SNPs. Although plans with Medicare savings accounts are a permanent option under the MA program, no plans have come forward to participate for 2006. On the other hand, SNPs—first authorized in 2004—are growing rapidly, as discussed in the next section. They have increased from 11 plans in 2004, to 125 plans in 2005, and to 276 plans in 2006. They are now available in counties where 59 percent of Medicare beneficiaries live.

**FIGURE 9-1**

**Most beneficiaries have access to 11 or more plans, 2006**



Source: MedPAC analysis of CMS Landscape Tool, October 2005.

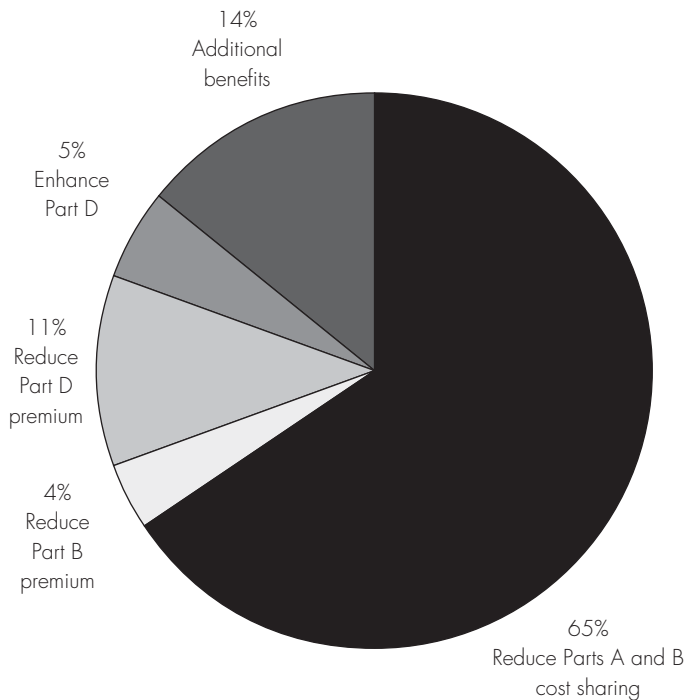
### Many beneficiaries will have numerous MA choices

Virtually all (99.4 percent) beneficiaries have two or more MA plans available.<sup>7</sup> Greater choice is available, not just because MA plans are entering new areas; more plans are entering already well-established MA areas potentially stimulating competition. Overall, 12 plans on average are offered per county in 2006, compared with 5 plans per county in late 2005. Beneficiaries in Broward county, Florida have the most choices available: 63 MA plans, up from 39 in 2005.

As a result of all the changes, beneficiaries have many plans from which to choose (Figure 9-1). Almost half of all beneficiaries can choose from among 16 or more MA plans and 5 percent can choose from over 40 plans. These plan choices are in addition to the stand-alone prescription drug plan offerings.

**FIGURE 9-2**

**Medicare Advantage plans used the largest share of rebate dollars to reduce cost sharing for Medicare services**



Note: Figure based on unweighted data. Additional benefits may include dental, vision, and hearing services.

Source: CMS 2006 unpublished bid data.

**Preliminary information from Medicare Advantage plan bids**

The Commission has been concerned that the current benchmarks are higher than average per capita spending in FFS Medicare. We have pursued a policy of financial neutrality, under which the Medicare program would be financially neutral with regard to whether a beneficiary enrolled in an MA plan or remained in FFS Medicare. If payments to private plans are too high, it aggravates Medicare's financial problems. If plan payments are below FFS Medicare, plans may be discouraged from participating in MA even if they are more efficient than FFS Medicare.

In our June 2005 report to the Congress, the Commission recommended several changes to the benchmarks that would have resulted in lowering the benchmarks to a level equal to Medicare's FFS costs. In addition, we

recommended that Medicare's share of savings from bids below the benchmark be redistributed back to the plans based on quality performance measures.

Based on our preliminary analysis, plans were able to bid under their current benchmarks and had funds to rebate to their enrollees.<sup>8</sup> The Medicare program retains 25 percent of the amount by which the benchmark exceeds the bid, and the plan is given the other 75 percent to rebate to its members in one of five ways: 1) reduce Medicare Parts A and B cost sharing, 2) reduce the Part B premium, 3) reduce the Part D premium, 4) enhance the Part D benefit, and 5) provide other additional benefits. Probably as a result of high benchmarks and effective management techniques, about 95 percent of bids were under the benchmark, thus almost all plans had funds to rebate to members. Most plans chose to spend rebates to improve benefits in more than one service category. Almost two-thirds of rebate dollars (65 percent) were devoted to lowering cost sharing for Parts A and B services (Figure 9-2). With 14 percent of the rebates, plans provided additional benefits—such as dental care and vision care—and lowered Part B or Part D premiums with another 15 percent of total rebates.

We have also begun examining 2006 bid data by plan type. For this analysis, we divided plans into four groups: local HMOs, local PPOs, PFFS plans, and regional PPO plans. We found that average bids differed by plan type. The local HMOs were most often able to bid below the benchmark and had the largest average rebates. Local HMO bids came in below the benchmark 98 percent of the time and when they did, the average rebate was about \$80 per month (Table 9-2). Local PPOs were not as likely to be below the benchmark, and even when they were, they received substantially lower rebates (\$50) than HMOs. PFFS plans were able to bid below the benchmark in most cases (93 percent), but their average rebates (\$40) were about half of the HMOs' rebates. Regional PPOs were least likely to bid below the benchmarks; only 69 percent of their bids came in below them.

Because HMOs had larger average rebates to distribute, they more often could fund benefit packages that lower Parts A and B cost sharing, provide supplemental benefits, and have lower premiums. These results will generally translate to the greater availability of HMO plans with reduced cost sharing, low premiums, and enhanced drug benefits.

**TABLE  
9-2**

**HMOs most likely to bid below benchmark and have highest rebates**

	Local plans			
	HMO	PPO	PFFS	Regional PPO
Percentage of plans bidding below benchmark	98%	86%	93%	69%
Average monthly rebate	\$80	\$50	\$40	\$30

Note: PPO (preferred provider organization), PFFS (private fee-for-service). Data are unweighted for enrollment. Benchmarks are bidding targets with which Medicare Advantage plan bids are compared. When a plan bids below its benchmark, the plan receives 75 percent of the difference to rebate to its members in the form of additional benefits, lower cost sharing, or lower premiums.

Source: CMS 2006 unpublished bid data.

**Many plan choices have low premiums and include enhanced benefits**

Under Medicare Advantage, plans can charge a premium for additional benefits. This premium is in addition to the Part B premium. However, many plans do not charge any premium for the additional benefits. These plans are called zero-premium plans. While a few zero-premium plans have used rebates to eliminate or reduce Part B premiums, we consider a plan to be zero-premium even if its members pay the full Part B premium and a Part D premium but no supplemental premium.

**Low-premium plans are widely available**

Zero-premium MA plans are available to 84 percent of Medicare beneficiaries in 2006, up from 58 percent of beneficiaries in 2005. HMOs are the most widely available zero-premium plans, with 54 percent of beneficiaries having access to one. Also, about one-third of beneficiaries have access to zero-premium PFFS plans and a similar share of beneficiaries have access to zero-premium regional PPOs in 2006 (Figure 9-3).<sup>9</sup>

Even where there are no zero-premium plans, low-premium plans are often available. MA plans that cost less than \$10 per month in 2006 are available to 92 percent of Medicare beneficiaries.

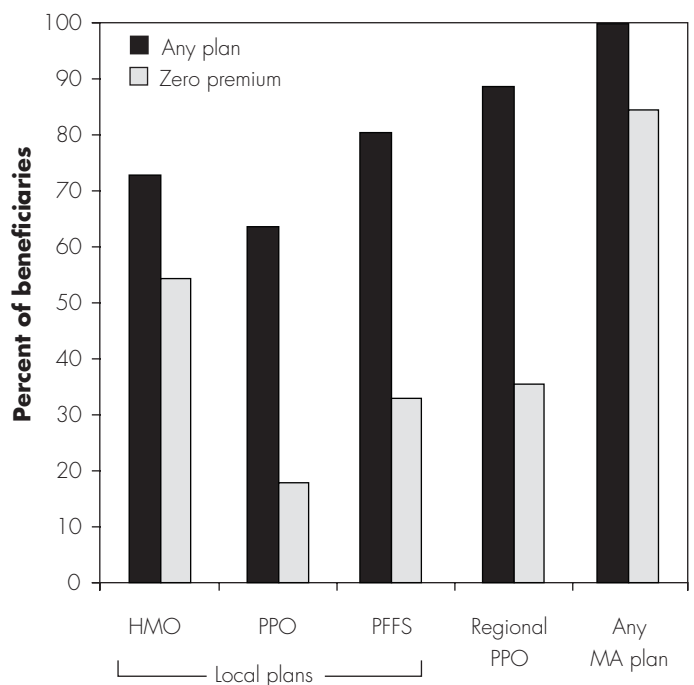
**Plans that include both Part D and enhanced benefits are widely available**

All MA CCP sponsors must offer at least one plan that includes Part D benefits (MA-PDs). Thus, 99 percent of beneficiaries will have access to MA-PDs. PFFS plans, which are not required to offer Part D coverage, have done so in service areas containing 70 percent of Medicare beneficiaries in 2006 (Table 9-3, p. 210).

As explained in detail in Chapter 7, the standard Part D benefit package in 2006 has a gap in coverage after a beneficiary has accrued drug expenses of \$2,250. Beneficiaries in the standard plan are responsible for all drug expenses until they reach the catastrophic portion of the benefit.<sup>10</sup> Plans with enhanced Part D benefits

**FIGURE  
9-3**

**Zero-premium plans are widely available**



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

Source: MedPAC analysis of CMS Landscape Tool, October 2005.

**TABLE  
9-3**

**MA-PDs are widely available and enhanced cost-sharing protections are available in some areas**

	Local plans			Regional PPO	Any MA plan
	HMO	PPO	PFFS		
MA-PD	72%	63%	70%	88%	99%
with some coverage in gap	46	34	0	14	62
with coverage of brand name drugs in gap	13	5	0	0	14
Zero premium MA-PD	48	11	25	15	68
with some coverage in gap	26	3	0	0	27
with coverage of brand name drugs in gap	13	0	0	0	13
Out-of-pocket limit:					
\$5,000 or less	53	41	75	88	98
\$2,000 or less	28	16	37	4	65
Cost sharing for 6-day hospital stay, \$500 or less	63	45	43	13	87

Note: MA-PD (Medicare Advantage–Prescription Drug [plan]), PPO (preferred provider organization), PFFS (private fee-for-service), MA (Medicare Advantage). Plans with gap coverage include some benefits in the range of beneficiary drug spending above the standard benefit’s initial coverage limit and below its out-of-pocket threshold. Part D’s defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap.

Source: CMS 2006 unpublished bid data.

may offer some coverage in the gap. Almost two-thirds of beneficiaries have MA-PDs available that offer some coverage in the Part D coverage gap, mostly from local HMOs and local PPOs. Regional PPOs offer gap coverage with generic drugs to 14 percent of beneficiaries, but no PFFS plans offer any gap coverage.<sup>11</sup> While most of the coverage in the gap is for generics only, 14 percent of beneficiaries have access to MA-PDs that fill in coverage with both brand name and generic drugs.

Zero-premium MA-PD plans are also widely available. Almost 70 percent of beneficiaries have access to MA-PD plans that charge no premium for Parts A and B benefits and have a zero premium for the Part D benefits they offer. Local HMOs are the most widely available zero-premium MA-PDs, providing access to 48 percent of Medicare beneficiaries. Further, 27 percent of beneficiaries have access to a zero-premium plan with Part D that offers some coverage in the Part D coverage gap, with almost all of that coverage being offered by local HMOs. Finally, some of the zero-premium MA-PDs include brand and generic coverage throughout the gap; 13 percent of Medicare beneficiaries will have access to such a plan (all local HMOs).

Eighty percent of beneficiaries have access to MA-PDs with total premiums of \$20 or less per month in 2006 (Figure 9-4). About 11 percent of beneficiaries would have to pay at least \$40 per month to enroll in an MA-PD, and some beneficiaries would have to pay as much as \$116 per month.

**Beneficiaries’ cost-sharing liability**

MA enrollees face cost-sharing requirements in addition to any plan premiums. While in FFS Medicare, beneficiaries’ average cost-sharing liability (about \$1,500 in 2006) is higher than that typical for MA enrollees (CMS 2005a). The Commission found in 2004 that enrollees with certain illnesses in some plans could also face high cost sharing (MedPAC 2004a). This section discusses some of the aspects of plans’ benefit designs that affect members’ cost-sharing liability.

An out-of-pocket (OOP) limit is one way to protect beneficiaries against high cost-sharing liability. In its 2006 Medicare Advantage call letter, CMS encouraged plans to offer an OOP limit in exchange for providing greater latitude on individual services (CMS 2005b). Also, the MMA mandated that regional PPOs have an OOP limit

on beneficiary cost-sharing liability for covered Medicare services provided in-network.

Overall, 98 percent of beneficiaries have access to a plan that includes an annual OOP limit of \$5,000 or less, and 65 percent of beneficiaries have a plan available that includes an OOP limit of \$2,000 or less (Table 9-3). PFFS plans with an OOP limit no higher than \$2,000 are available to 37 percent of beneficiaries. Also, HMOs with OOP limits of \$2,000 or lower are available to 28 percent of Medicare beneficiaries, and local PPOs with these limits are available to 16 percent. We note that many plans may charge low enough cost sharing that they do not need to provide an OOP limit.

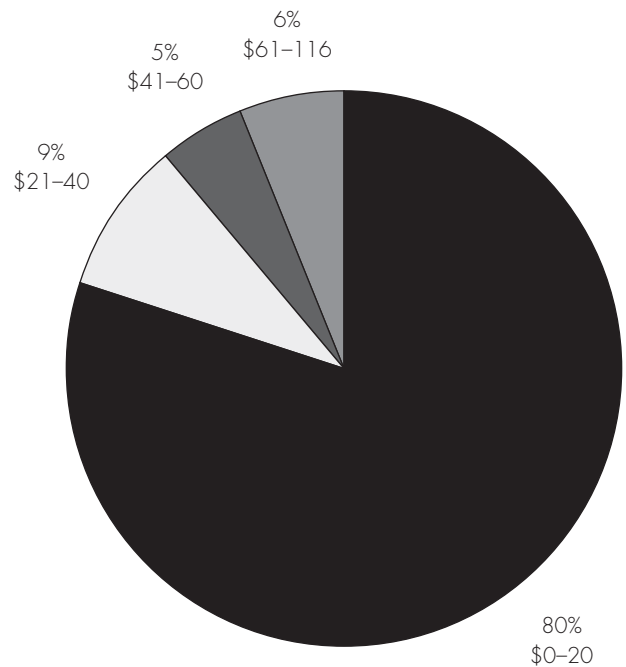
While by law all regional PPOs offer OOP limits, only 4 percent of Medicare beneficiaries live in regions where a regional plan with an OOP limit of \$2,000 or less is offered. The MMA and subsequent regulations did not set specific dollar values for the mandated OOP limit. Regional PPOs decided to offer OOP limits ranging from \$1,000 per year to \$5,000 per year, with the most common plan design having a limit of \$5,000.<sup>12</sup>

Cost sharing in plans varies across many different measures. An inpatient hospital stay is a relatively common and costly service in terms of cost sharing. In FFS Medicare, there is a \$952 deductible for a hospital stay for 2006. The Commission has estimated the average stay is between five and six days, and the average cost per day is around \$1,000. For this analysis, we look at the OOP costs for a beneficiary with a six-day stay. For those few plans that impose cost sharing as a percentage of cost, we assume a daily cost of \$1,000. Most plans impose a flat daily copayment and often have a limit on total cost sharing for a hospital stay or an overall OOP limit. Across all plans, cost-sharing liability for a six-day hospital stay varies from zero to over \$2,000. We focused on the availability of plans with cost sharing of \$500 or less for a six-day stay, because we view that level of cost sharing as a significant savings from FFS Medicare for an average stay.

Eighty-seven percent of Medicare beneficiaries have access to a plan with expected cost sharing of \$500 or less for a six-day hospital stay. Availability of these plans is greater for HMOs and other local plans. Only 13 percent of beneficiaries have access to a regional PPO with this level of cost sharing.

**FIGURE 9-4**

**Most beneficiaries have access to an MA-PD with a premium of \$20 or less**



Note: MA-PD (Medicare Advantage–Prescription Drug [plan]).

Source: MedPAC analysis of CMS Landscape Tool, October 2005.

**Benefit differences between urban and rural areas**

Additional benefits are more widely available in urban than in rural areas. Zero-premium plans are available to about 89 percent of beneficiaries living in urban areas and about 65 percent of rural beneficiaries. Availability is also wider in urban areas for zero-premium plans that include Part D benefits and for those that provide some coverage in the Part D coverage gap. Plans with annual limits on OOP liability for Medicare services of \$5,000 or less are available to 98 percent of both urban and rural beneficiaries, but plans with OOP limits of \$2,000 or less are available to 68 percent of urban beneficiaries and 55 percent of rural beneficiaries. Also, 92 percent of urban beneficiaries have access to a plan that has a \$500 or lower OOP cost for a six-day hospital stay, while only 70 percent of rural beneficiaries have access to such a plan (Table 9-4, p. 212).

The key factor in the benefit differences between urban and rural areas is that benefits tend to vary by plan type,

**TABLE  
9-4****Differences in plan availability  
between urban and rural areas**

	Urban	Rural
Available plan:	100%	99%
Local HMO	86	27
Local PPO	75	26
PFFS	75	96
Regional PPO	88	89
Zero premium:	89	65
with Part D	73	47
with Part D and gap coverage	34	2
Out-of-pocket limit:		
\$5,000 or less	98	98
\$2,000 or less	68	55
Cost sharing for 6-day hospital stay, \$500 or less	92	70

Note: PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of CMS Landscape Tool, October 2005.

as shown earlier. Although the overall availability of plans is similar in urban (100 percent) and rural (99 percent) areas, the types of plans available tend to differ. Urban beneficiaries are much more likely to have local HMOs and local PPOs available than if they lived in rural areas. Local HMOs and PPOs are available to 86 percent and 75 percent, respectively, of urban beneficiaries and are available to only 27 percent and 26 percent of rural beneficiaries. On the other hand, PFFS plans are available to 96 percent of rural beneficiaries and only 75 percent of urban beneficiaries. Regional PPOs are available to about the same percentages of urban and rural beneficiaries. Thus, the plans in rural areas are more likely to be the regional PPOs and PFFS plans that do not generally have tight networks of providers and tend to bid higher than local managed care plans.

We see that the plans in urban areas, through the greater ability to build networks and manage care, tend to be able to bid lower relative to their benchmarks than plans in rural areas (even though benchmarks in rural areas tend to be higher relative to local FFS costs than benchmarks in urban areas). As a result, the rebates tend to be larger in urban areas, allowing the managed care plans there to offer additional benefits.

In future work, we will examine some of the broader questions about the value of private plans to the Medicare program. Such questions may focus on quality, efficiency, and payment issues.

### Special needs plans

Almost since the beginning of the program, Medicare has included special plans for beneficiaries who tend to report lower health status, use more health care services, and cost the Medicare program more than other beneficiaries. These existing plans include the Program of All-Inclusive Care for the Elderly (PACE), Social Health Maintenance Organizations, Evercare, and various demonstration plans.

Plans for beneficiaries who are dually eligible for Medicare and Medicaid have faced the additional challenge of integrating services from these two payers. In theory, these plans are designed to both improve care coordination for beneficiaries and reduce program spending. However, the inherent incentive to shift costs among multiple payers raises the longstanding question of whether these plans do result in Medicare program savings.

The Commission has sought creative ways of delivering high-quality health care to dual-eligible Medicare beneficiaries. The policy and practical issues we described in the June 2004 report chapter on dual-eligible beneficiaries might be addressed through special plans (MedPAC 2004b). Special needs plans, a new type of MA plan, build on the earlier demonstrations and other existing plans. They also offer the potential to address the care needs and costliness of dual eligibles and other special needs beneficiaries. While our chapter is largely descriptive of the early days of the program, our interest is in three fundamental questions. First, do SNPs tailor benefit packages to better serve the needs of enrollees than fee-for-service Medicare or regular MA plans? Second, does risk adjustment result in an appropriate payment amount? Third, do dual-eligible SNPs merge Medicare and Medicaid benefit programs in a way that better serves beneficiaries, and is there cost shifting among payers?

### Creation of special needs plans

The Congress created SNPs as a new MA plan type to provide a common framework within the regular MA program for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to



and choice among MA plans. This means that many of the existing special plans, which were operating as demonstrations, could transition to become SNPs.<sup>13</sup> In fact, existing demonstrations for special needs beneficiaries had to become SNPs to include the Part D prescription drug benefit. SNPs are not a permanent feature of MA. Absent congressional action, SNP authority will expire at the end of 2008.

### **SNP requirements**

SNPs function essentially like any other MA plan, but must also provide the Part D drug benefit as well as additional services that go beyond regular Medicare services and are tailored to the special needs population. In exchange, they are allowed to limit their enrollment to their targeted population.

### **Payment and risk adjustment**

SNPs are paid like regular MA plans, including the same risk-adjustment method.<sup>14</sup> MA plan payments have historically been risk adjusted based on the demographic characteristics of their enrollees. Recently, CMS began phasing in a risk-adjustment system that uses diagnosis data, known as the hierarchical condition categories (HCCs). The CMS–HCC formula generally results in higher payments for special needs beneficiaries than for the general Medicare population.<sup>15</sup> In 2006, MA plan payments are 75 percent risk adjusted using CMS–HCCs. In 2007, payments will be fully risk adjusted in this manner.

### **Enrollment**

Special needs beneficiaries have more opportunities to join or switch MA plans than regular beneficiaries. Dual eligibles have a special election period, which begins when they become dually eligible and continues as long as they remain dually eligible. During the open enrollment period for institutionalized individuals, which is continuous beginning in 2006, beneficiaries going into, residing in, or leaving an institution can join any open MA plan. Individuals with severe or disabling chronic conditions have a special election period to enroll in a SNP designed for beneficiaries with those conditions, which begins with diagnosis of the condition and ends upon enrollment in a SNP. CMS provides a special election period for those who are no longer eligible for a SNP, such as those who lost their Medicaid eligibility, to enable them to enroll in a regular MA plan. With the implementation of “lock-in” this year, which limits beneficiaries’ ability to change

plans, special needs beneficiaries will be the largest group of beneficiaries eligible to enroll in MA plans after the regular election period.

### **SNP types**

The MMA authorizes Medicare to contract with SNPs for three types of beneficiaries: dual eligibles, institutionalized beneficiaries, and patients with severe chronic diseases or conditions. SNPs may limit their enrollment to their targeted special needs population exclusively, or they may enroll any other beneficiaries as long as their membership includes a disproportionate percentage of their targeted population. This means that the percentage of the special needs target population in the plan must be greater than the percentage that occurs nationally in the Medicare population. Most SNPs in 2006 have chosen to limit their enrollment to their targeted population exclusively. Each of the three types of SNPs can enroll beneficiaries who fall into additional targeted populations. For example, an institutional SNP can enroll a beneficiary who resides in an institution and is also dually eligible.

Next, for each type of SNP—dual eligible, institutional, and chronic condition—we discuss the plan and target population characteristics. Because most SNPs offered this year are for dual eligibles, the discussion focuses primarily on this type.

### **Dual-eligible SNPs**

Medicare beneficiaries can qualify for Medicaid if they meet certain income and resource requirements or have high health care bills. Each state sets its own eligibility standards and determines the scope of benefits provided to Medicaid beneficiaries within federal guidelines.

These dual-eligible beneficiaries are divided into several different categories based on their income and assets (Table 9-5, p. 214). There are more than 7 million dual eligibles; of these, about 6 million are “full duals”—they qualify to receive full Medicaid benefits. Beneficiaries with somewhat higher income and asset levels are eligible for more limited Medicaid coverage under multiple categories collectively known as the Medicare Savings Program (MSP).

Dual-eligible SNPs may choose to accept all dual eligibles or limit enrollment to the full benefit dual category. In other words, an MA organization can offer two dual-eligible SNPs in the same county—one for full-benefit duals and another for all duals. Plans can not

**TABLE  
9-5**

**Categories of dual eligibles**

Type of dual eligible	Income limit for eligibility	Medicaid covers		
		Medicare Part B premium	Cost sharing	Full Medicaid benefits
<b>Full benefit</b>				
Meets low income standard	≤73% FPL <sup>a</sup>	yes	yes	yes
Medically needy (spend-down)	None	yes	yes	yes
<b>Medicare Savings Program</b>				
Qualified Medicare beneficiary	≤100% FPL	yes	yes	some <sup>b</sup>
Specified low-income Medicare beneficiary	Between 100% and 120% of FPL	yes	no	no
Qualifying individual	Between 120% and 135% of FPL	yes	no	no

Note: FPL (federal poverty level). All types of dual eligibles except for medically needy also have asset limits; full duals are limited to \$2,000 per individual or \$3,000 per couple, and Medicare Savings Program dual eligibles are limited to \$4,000 per individual or \$6,000 per couple. The 2006 FPL is \$9,800 for an individual and \$13,200 for a family of two. The FPL is higher in Alaska and Hawaii.  
 a States set their own Medicaid eligibility levels, usually at or below the supplemental security income eligibility level of 73 percent of the FPL.  
 b Some states have extended full Medicaid benefits to qualified Medicare beneficiaries.

Source: CMS. [http://www.cms.hhs.gov/DualEligible/02\\_DualEligibleCategories.asp#TopOfPage](http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp#TopOfPage).

limit enrollment to MSP duals alone as these tend to be healthier individuals than their full-dual counterparts. Although this policy is designed to prevent selection, there may still be opportunities for selection.

**Coordination of Medicare and Medicaid** The law does not mandate any Medicaid involvement in SNPs. Although dual-eligible SNPs are not required to, they may choose to contract with states to provide Medicaid benefits.<sup>16</sup> Institutional and chronic condition SNPs that have, or plan to have, dual-eligible enrollees may also incorporate Medicaid. It is unclear how SNPs that do not integrate Medicare and Medicaid services can better coordinate the two programs. It is also unclear how these dual-eligible SNPs differ from regular MA plans.

**Why integration is a good idea** Having beneficiaries enrolled in one managed care plan for Medicare benefits and another for Medicaid benefits raises a variety of problems for care coordination. For example, a Medicaid managed care plan often has no incentive to manage beneficiaries' care to limit unnecessary acute care use. Similarly, the Medicare managed care plan does not have an incentive to manage beneficiaries' care to avoid spending on long-term care.

Case studies suggest that care coordination is challenging even when dual-eligible beneficiaries are enrolled in Medicare and Medicaid managed care plans (but not an integrated plan) offered by the same managed care

organization. Beneficiaries have two separate membership cards and different points of contact for the Medicare and Medicaid benefits. Plans may not be equipped to coordinate across the requirements of the two programs. Also, most Medicaid managed care plans are not responsible for long-term care services (Walsh et al. 2003).

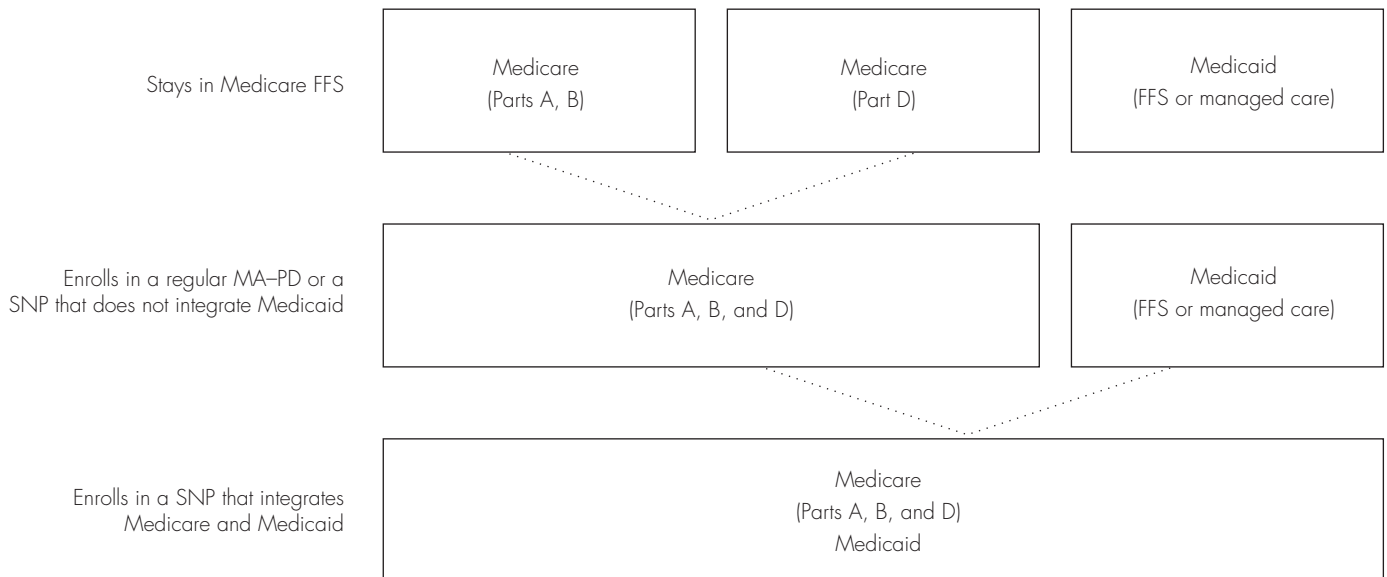
Many of these coverage and payment issues are resolved if the dual eligible is enrolled in the same plan for both Medicare- and Medicaid-covered services, and if that plan is committed to integrating benefits (Figure 9-5).

**States lack incentives to partner with SNPs** Medicare, whether beneficiaries are in fee-for-service or managed care plans, is the primary insurer for dual eligibles and covers medically necessary acute care services—including physician, hospital, hospice, skilled nursing facility, and home health services—and durable medical equipment. As the secondary payer, Medicaid generally covers:

- Services not covered by Medicare, such as transportation, dental, and vision.<sup>17</sup>
- Wrap-around services, such as cost sharing for services covered by Medicare as well as acute care services that are delivered after the Medicare benefits are exhausted or if certain Medicare criteria are not met. These services include inpatient hospital, skilled nursing facility, and home health care.

**FIGURE  
9-5**

**Options for dual eligibles in 2006**



Note: FFS (fee-for-service), MA-PD (Medicare Advantage-Prescription Drug [plan]), SNP (special needs plan).

- Long-term care, including custodial nursing facility care, home- and community-based services, and personal care services.

States must pay Medicare's Part B premium for all dual-eligible beneficiaries and cost sharing for full duals and qualified Medicare beneficiaries (Table 9-5). States are not required to pay any MA plan premium on behalf of dual eligibles who enroll in MA plans.<sup>18</sup> States' cost-sharing responsibility is less clear for duals who enroll in MA plans, as plans generally have different cost-sharing structures than FFS Medicare and can offer additional benefits. States generally are responsible for plans' cost sharing for services that are covered by FFS Medicare, but not for additional benefits. In addition, states may avoid paying cost sharing on services altogether. The Balanced Budget Act of 1997 allowed states to set providers' reimbursement for dual eligibles equal to the Medicaid payment rate and generally prevented providers from balance billing.<sup>19</sup> About one-third of states have set their rates at 80 percent or less of Medicare FFS rates, which virtually eliminates their cost-sharing responsibility (Atherly 2005). States can also choose not to pay cost sharing for services if they are delivered by non-Medicaid-approved providers.

States may have little incentive to take on the administrative complexity of partnering with SNPs because now that prescription drugs are covered under Part D, their largest payment responsibility for duals is long-term care. While states may contract with SNPs to cover long-term care and other Medicaid services, few have done so.<sup>20</sup> Furthermore, given recurring state budget pressures, many state Medicaid programs have reduced or eliminated coverage for optional services and more may do so in the future, leaving even fewer services to contract out to SNPs.

**Special managed care programs for dual eligibles** Several programs integrate the financing and delivery of care for the full range of health care needs of dual eligibles and thereby avert some of these coordination-of-benefit issues. By aligning incentives, this integrated payment approach is also intended to help plans coordinate care for dual eligibles. The following two types of programs combine Medicare and Medicaid capitated payments to integrate care for the dual-eligible population, and thus may be models for integrated SNP plans.

*Program of All-Inclusive Care for the Elderly* PACE is a capitated benefit authorized by the Balanced Budget Act of 1997 that serves frail elderly beneficiaries, age 55 and older, who meet states' standards for nursing home placement and reside in areas served by the PACE organizations.<sup>21</sup> Most enrollees are dually eligible. PACE plans feature a comprehensive medical and social service delivery system, an interdisciplinary team that provides services in an adult day health center setting, and in-home and referral services in accordance with participants' needs.

These plans receive separate capitated payments from Medicare and Medicaid. Until recently, the Medicare rate was equal to 2.3 times the Medicare county rate amount for MA plans, but this adjustment has been replaced with a frailty adjuster based on limitations in activities of daily living among enrollees in the plan. The PACE plan negotiates the Medicaid rate with the state Medicaid agency. Separate contracts mean that plans still have to deal with two payers with different policies.

*State demonstration waivers* Minnesota, Wisconsin, and Massachusetts have operated state programs that pool Medicaid and Medicare payments under Medicare demonstration authority. These plans are transitioning to SNPs.

In Minnesota Senior Health Options and Disability Health Options, Medicare and Medicaid each pay a capitated rate for their respective benefits, including home- and community-based care and nursing facility services (except for those provided beyond 180 days, which are paid on a FFS basis). Enrollment is offered to dual-eligible seniors and people with disabilities—both those who qualify for nursing home care (“nursing home certified”) and those who do not—as a voluntary alternative to Minnesota’s mandatory managed care program.

The Wisconsin Partnership Program includes community-based organizations that have entered into a Medicaid managed care contract with the Wisconsin Department of Health and Family Services and a Medicare contract with CMS. They receive monthly capitated payments for each participant from which they pay for all participant services. The Wisconsin Partnership Program serves both seniors over 55 and physically disabled dual eligibles. Qualifying beneficiaries must be nursing home certified.

Massachusetts’s MassHealth Senior Care Options includes organizations that contract with the state’s Division of Medical Assistance and CMS to offer the full range of

Medicare and Medicaid benefits available to dual eligible beneficiaries. Senior Care Options organizations serve community-well, community-frail, and institutionalized people ages 65 and over.

**Passive enrollment** Medicaid managed care plans that chose to offer SNPs could apply to CMS in 2005 to “passively enroll” their members into their new SNP. Approved plans passively enrolled their dual-eligible members into their SNP effective January 1, 2006. Plans had to send affected members a letter in fall 2005 notifying them of their choices to remain in the plan, switch to another MA plan, or return to Medicare FFS. Forty-two SNPs that had operated Medicaid managed care plans passively enrolled their dually eligible beneficiaries in 13 states (McClard 2006).<sup>22</sup>

### **Institutional SNPs**

Institutional SNPs may enroll beneficiaries who reside or are expected to reside for 90 days or longer in a long-term care facility, including skilled nursing facilities, nursing homes, skilled nursing facilities/nursing facilities, intermediate care facilities for the mentally retarded, or inpatient psychiatric facilities. They may also enroll beneficiaries living in the community who require an equivalent level of care to beneficiaries in these facilities. With CMS approval, they may limit their enrollment and marketing to select facilities within their geographic service area.

### **Importance of managing institutionalized**

**beneficiaries** From a state’s perspective, it is clear that fragmented Medicare acute care can lead to nursing facility placement—paid briefly under Medicare, but ultimately leading to long-term stays that may be paid by Medicaid. Integrated Medicare and Medicaid plans that include long-term care are designed to prevent or delay disability and health deterioration that would necessitate institutional long-term care and manage the care of enrollees already in institutions to prevent recurring hospitalizations.

### **Chronic condition SNPs**

Chronic condition SNPs are designed for beneficiaries with severe chronic diseases or conditions, which CMS has not yet defined. CMS has stated that because chronic condition SNPs are a new offering, the agency did not want to limit their potential application by specifically defining a chronic condition. Instead, the agency evaluates proposed plans on a case-by-case basis, considering

appropriateness of target population, clinical programs and expertise, and how the SNP will cover the full spectrum of the target population without discriminating against the sicker members. New chronic condition SNPs are targeted to beneficiaries with cardiovascular disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease, asthma, hypertension, coronary artery disease, osteoarthritis, mental illness, end-stage renal disease, and HIV/AIDS.

### Importance of managing chronic condition beneficiaries

Fully 83 percent of Medicare beneficiaries have at least one chronic condition. However, this includes conditions that are less expensive to treat, such as arthritis. Twenty-three percent of Medicare beneficiaries have five or more chronic conditions and account for 68 percent of program spending (Anderson 2005). Improving care coordination for these beneficiaries and reducing unnecessary utilization could result in significant Medicare savings. For more information, see Chapter 2 on care coordination.

### SNPs have grown quickly

2006 marked a significant increase in the number of SNPs available to beneficiaries. In 2004, there were just 11 SNPs. By 2005, that number had grown to 125. This year, the total number of SNPs has more than doubled to 276 (CMS 2006b).

By January 1, 2006, CMS had signed 164 MA contracts with organizations that offer one or more SNP plans.<sup>23</sup> These contracts represent 91 distinct corporate entities (CMS 2006b). Most are for profit (CMS 2006a). Many of these entities offer more than one SNP. All three types of SNPs—dual eligible, institutional, and chronic condition—are available in 2006; most SNPs are for dual eligibles (Figure 9-6).

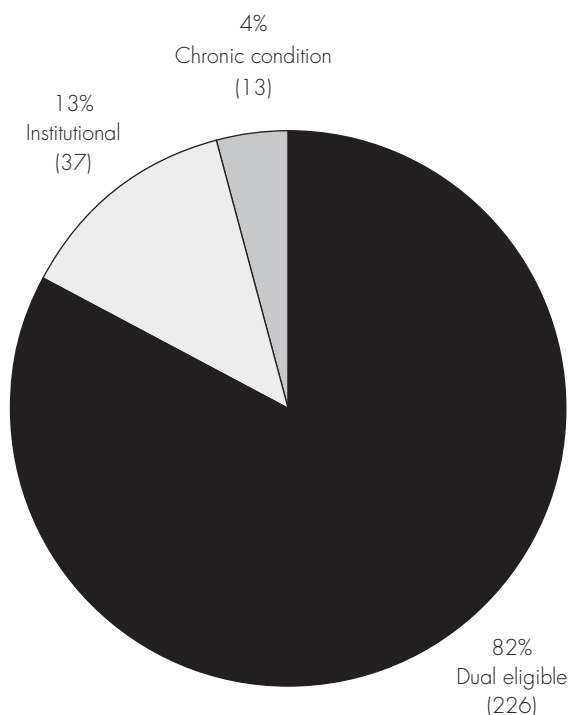
SNPs are available in at least part of 42 states, the District of Columbia, and Puerto Rico (Figure 9-7, p. 218). Eight states, the District of Columbia, and Puerto Rico have at least one SNP available throughout the entire area. Several states have multiple types of SNPs available.

### Reasons for offering and joining a special needs plan

MA organizations, health care providers, beneficiaries, and federal and state governments have different levels of interest and reasons for taking part in a SNP.

**FIGURE 9-6**

### Special needs plans available in 2006



Note: Percentages do not sum to 100 due to rounding. Number of plans is given in parentheses.

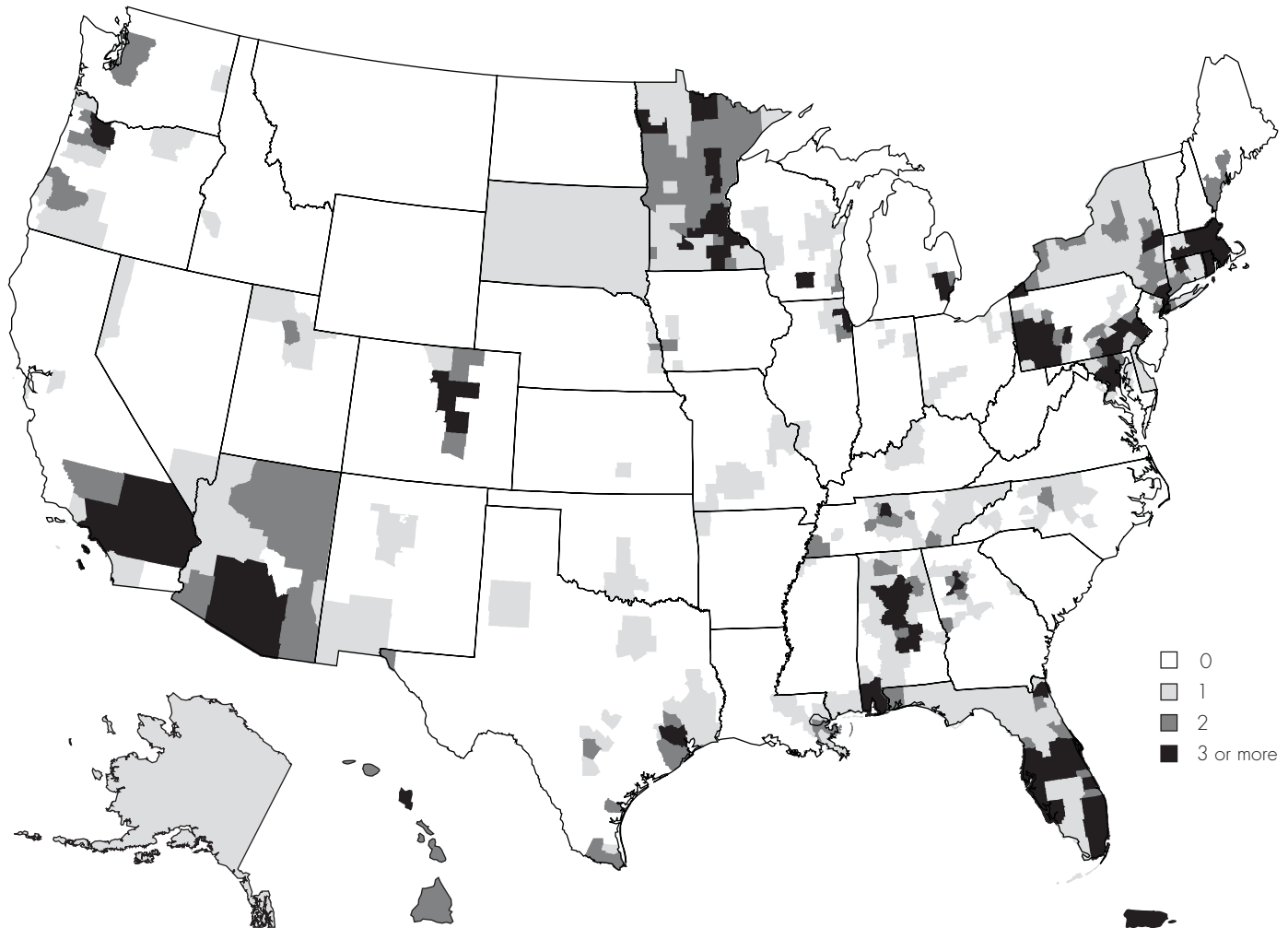
Source: CMS special needs plan fact sheet and data summary. February 14, 2006.

### Plans

Organizations entering the SNP market include those with experience partnering with Medicaid and serving special needs populations, such as the Massachusetts demonstration, but also include MA organizations with little or no similar experience that have chosen to add SNPs to their menu of plans. Some organizations are offering multiple SNP plans. In fact, some offer more than one dual-eligible SNP in the same geographic area. This allows organizations to offer a plan only to full duals with a benefit and cost-sharing structure designed to appeal to these beneficiaries and potentially attract state partnerships. (States have greater cost-sharing responsibility for full duals than for Medicare Savings Program duals.) At the same time, they can offer a plan with a different structure to all duals, including MSP participants. Some observers have noted that risk adjustment has the potential to make enrollment of special needs beneficiaries more profitable than it has been.

**FIGURE  
9-7**

**Number of organizations offering special needs plans, by county, 2006**



Source: MedPAC analysis of CMS 2006 Plan Benefit Package data.

### Providers

Physicians and hospitals who have served dual eligibles through a Medicaid managed care plan may find SNP payment rates more generous. The traditional MA plans that have added SNPs may be able to build on networks already in place for their regular MA plans. However, because special needs beneficiaries tend to have greater health needs than their counterparts, SNPs will probably have to tailor their networks by including a somewhat different mix of providers. This may be difficult in areas where Medicare physicians do not want to participate in managed care. We have heard reports that some Medicare

physicians resist enrolling in SNP networks and encourage their dual-eligible beneficiaries who have been passively enrolled to switch back to FFS Medicare.

### Beneficiaries

Dual eligibles' incentive to join MA plans is not as strong as for other beneficiaries. They can have their choice of provider under FFS Medicare with cost-sharing protection and additional services provided by Medicaid. In fact, the vast majority of dual eligibles have been in FFS. SNPs' advantage over FFS Medicare is that they can offer greater integration, including acute care, prescription

drugs, and possibly long-term care. SNPs must offer sufficient additional benefits or reduced cost sharing to attract beneficiaries to join. Beneficiaries' decisions will probably be largely influenced by the comparative benefits of their states' Medicaid plans and available SNPs' benefit packages.

### **Federal and state government**

Special needs beneficiaries have high health care costs. In 2002, dual eligibles accounted for 17 percent of Medicare enrollment and 29 percent of Medicare spending as well as 14 percent of Medicaid enrollment and 42 percent of Medicaid spending (Elam 2006). Dual eligibles can be in FFS Medicare and managed care in Medicaid or vice versa. They can even be enrolled in two different managed care plans simultaneously—one sponsored by Medicare and one by Medicaid. Most duals have been enrolled in FFS in both programs. SNPs offer the potential for better care management and resulting efficiencies. However, SNP cost savings on Medicare services may be achieved by shifting some costs to Medicaid, especially if the SNP does not have a contract with the state for coverage of Medicaid services. This may have implications for the continuation of SNPs, which are scheduled to expire at the end of 2008. If some of the plans fail to demonstrably improve care for beneficiaries and deliver savings, the Congress may wish to modify the definition of SNPs—if it chooses to extend SNP authority—to better match the characteristics of effective plans.

### **Site visits**

To learn more about SNPs, we visited some SNP organizations, state agencies, and CMS regional offices in Baltimore, Maryland; Boston, Massachusetts; Phoenix, Arizona; and Miami, Florida. Together these markets met the following selection criteria:

- a large number of competing SNPs;
- the presence of existing special plans that converted into SNPs;
- passive enrollment of Medicaid managed care enrollees into dual-eligible SNPs;
- the presence of organizations that offer multiple dual-eligible SNPs; and
- the presence of all three types of SNPs: dual eligible, institutional, and chronic care (Mathematica 2006).

### **SNP goals and strategy**

Plans' goals and strategies for the future reflected differences in their experience with the target population, experience in local markets, relationships to Medicaid, and histories in Medicare and Medicaid. Some SNPs told us that they plan to wait before attempting to significantly increase their enrollment, alter their benefit packages, or expand their service areas. Others are considering expanding their service areas, adding new plans, pursuing partnerships with states, and increasing their marketing efforts.

SNPs are generally offered by organizations that fall into one of two groups: 1) organizations that have experience providing services to special needs beneficiaries through a Medicare demonstration, Medicaid plan, or similar specialized plan and view SNPs as a natural extension of their mission, and 2) organizations that have experience operating Medicare managed care plans and view SNPs as an opportunity to expand their selection of products.

### **Relationships with states**

SNP relationships with states vary: Some have very close and long-established relations with states while others have none at all. Some dual-eligible SNPs receive payment from states to include some or all Medicaid benefits in their benefit package. Other SNPs are actively pursuing partnerships with states, but some SNPs have no plans to incorporate Medicaid. States may have little incentive to take on the administrative complexity of partnering with SNPs, especially now that prescription drugs are covered under Part D and about one-third of states have set their Medicaid rates at or below 80 percent of the Medicare fee schedule to limit their cost-sharing liability (Atherly 2005). The exception is for states that have or are planning Medicaid managed care programs that cover long-term care services. SNPs may offer a promising partnership option for these services.

### **Coordination challenges**

SNPs that contracted with Medicaid noted the numerous conflicts between Medicare and Medicaid rules dealing with bidding, contracting, enrollment, marketing, complaints and grievances, reporting, monitoring, and rate setting. Plans are eager for CMS and states to work to reduce these administrative barriers to achieve better integration of the two programs.

Plans expressed frustration with CMS's lack of support of their efforts to integrate Medicare and Medicaid. For example, several plans told us that they had to deal with separate Medicare and Medicaid officials at CMS and that these two groups rarely seemed to coordinate.

### **Coordinating Medicare and Medicaid payment**

Some dual-eligible SNPs indicated that keeping track of separate funding streams was burdensome, but other SNPs indicated this was no problem. All SNPs indicated that the accounting requirements had no effect on their clinical care coordination efforts or on their relationships with providers.

### **Contracting with CMS**

It appears that SNP applications were reviewed and approved entirely by the CMS central office. CMS's central office is primarily responsible for reviewing and approving applications for regular MA plans. Because SNPs, especially dual-eligible SNPs, are significantly affected by state and local conditions and regional offices are responsible for overseeing SNPs' operation, it may be appropriate for regional offices to have a more active role in reviewing and approving their applications.

Some plans noted that CMS approved their applications with few changes. In contrast, other SNPs described their interaction with CMS as somewhat unpredictable and filled with last-minute changes.

### **Outreach and enrollment**

Even before the creation of SNPs, outreach and enrollment have been an issue for special plans. If SNPs are unable to enroll a sufficient number of special needs beneficiaries, they can not act as a driver of greater integration.

SNPs have mostly opted for targeted marketing, with little emphasis so far on broader marketing. Few SNPs believe that television, newspapers, or other media will be effective in reaching potential members.

SNP approaches to outreach and enrollment differ significantly, depending on their target populations (dual eligibles, institutionalized, or chronic condition) and whether they kept many former members through passive enrollment. The following are broad generalizations as individual SNP's marketing strategies varied. Dual-eligible SNPs have the broadest marketing strategies aimed at physicians, hospitals, community organizations, and beneficiary advocacy groups. Institutional SNPs market primarily to nursing facilities and families of residents.

Chronic condition SNPs focus primarily on physicians, other chronic care providers, and related advocacy groups.

SNPs with passive enrollment focus on retaining their current enrollees. Organizations that offer SNPs along with other MA plans may focus on encouraging members to shift from their other plans. If they offer commercial products, they may also focus on marketing to members aging into Medicare. In most markets, the overwhelming majority of dual eligibles were auto-enrolled into stand-alone prescription drug plans. Many SNPs do not focus on marketing to these beneficiaries.

The CMS web-based plan finder tool is difficult for SNPs to take advantage of as their specialized focus and broader benefits do not fit well into the current plan finder format. SNPs are often indistinguishable from other MA plans on the plan finder. At least one SNP opted to be listed as "information not available—contact plan" rather than list inaccurate information.

### **Quality monitoring and improvement**

To allow SNPs to continue to operate, the Congress must extend the SNP authorization beyond 2008. A CMS evaluation of SNPs is due to the Congress at the end of 2007. However, there may be limited data available upon which to evaluate SNPs. 2006 data may be muddled by start-up issues, such as incorrect enrollment data. In addition, plans designed to improve care quality and reduce unnecessary costs may not exhibit measurable differences within a year. The evaluators' task may be further complicated by challenges in gathering information from plans. For example, some plans do not maintain websites or use post office boxes instead of street addresses.

Several SNPs expressed concern that CMS's MA quality monitoring and reporting system is not as applicable to their special target populations and benefit packages because these systems were designed more for acute care than for ongoing care of chronic or disabling conditions. Some SNPs have additional significant quality monitoring and reporting systems in place to meet Medicare demonstration or state Medicaid requirements. Other SNPs do not appear to have any special quality efforts underway at this point, beyond what CMS requires. SNPs recognize the importance of quality monitoring and performance reporting systems to enable SNPs to demonstrate that they are adding value beyond what a standard MA-PD or PDP might offer.



## **Concluding observations**

SNPs offer the opportunity to improve the coordination of care for special needs beneficiaries. Dual-eligible SNPs (or any SNP that integrates Medicare and Medicaid) also offer the opportunity to improve the coordination of Medicare and Medicaid. Although it is too early to determine whether SNPs result in improved quality and significant program savings, they may not fulfill this opportunity. For instance, many dual-eligible plans do not contract with states to include Medicaid benefits. As SNPs are a new offering, the Commission plans to continue to assist the Congress and CMS in defining what distinguishes them from other MA plans. To do so, we

will further evaluate the plans that enter the market and examine their special characteristics. For example, the goal for dual-eligible SNPs is less clear now that coverage for prescription drugs has been moved from Medicaid to Medicare, leaving much less state financial responsibility for duals who are not in institutions. Because of the rapid growth of new SNPs, we also plan to look at how the CMS–HCC risk adjuster applies to special needs beneficiaries. The results of these analyses will allow us to advise the Congress and CMS on program elements that would better support SNPs’ goal to fulfill the opportunity for better integration and care coordination. ■

## Endnotes

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- 1 A plan may limit its service area to a partial county if it can explain to CMS why its network is unable to serve the entire county.
- 2 Beneficiaries may sometimes also enroll in demonstration project plans and in plans reimbursed based on the cost the plan incurs while providing Medicare services to enrollees. Enrollees in the cost plans retain their Medicare FFS eligibility for services provided outside the plan.
- 3 Plan sponsors of PPO products must be licensed as risk-bearing entities.
- 4 Another difference between an HMO with a point-of-service option and a PPO is that the HMO may limit its level of financial responsibility for out-of-plan care by saying, for example, that out-of-network services are covered up to a limit of \$1,000 per year. A PPO must cover all out-of-network care; it may impose higher cost-sharing levels for out-of-network care, but it may not have a spending cap.
- 5 For more detail on these provisions, see MedPAC 2005.
- 6 A coordinated care plan is a Medicare approved plan (other than a PFFS plan) that delivers Medicare services to its members through a provider network.
- 7 Plan sponsors often offer more than one plan. For example, one plan may be a “standard” option and another may be a “high” option. Sponsors may also offer more than one type of plan. Thus, one sponsor could offer multiple HMO options and multiple PPO options in one service area.
- 8 For this analysis, we depart from past practice and show all plan bids weighted equally regardless of enrollment.
- 9 Some zero-premium plans include a supplemental benefit of a rebate of some or the entire Part B premium. Enrollees in these plans would pay a lower net Part B premium than beneficiaries remaining in FFS Medicare.
- 10 See Chapter 7 a more detailed explanation of out-of-pocket spending for Part D benefits.
- 11 Enrollees in PFFS plans without drug coverage can enroll in a stand-alone PDP.
- 12 Some regional SNPs for dual eligibles have out-of-pocket limits below \$1,000, but it is unclear whether enrollees would be responsible for the copayments anyway.
- 13 PACE is a separate integrated Medicare and Medicaid program. It is included neither in SNP nor MA authority.
- 14 MMA granted CMS the authority to waive regular MA enrollment rules, but not payment methodologies.
- 15 In addition, CMS is exploring the feasibility of implementing a frailty factor. This factor is used for PACE and demonstration plans that serve frail, community-dwelling beneficiaries and is intended to improve the accuracy of predicting costs by considering beneficiaries’ difficulties with activities of daily living for the entire MA program, but CMS has said that the earliest it could take effect is 2008.
- 16 A few SNPs are transitioning from demonstrations where their relationship with the state has already been worked out.
- 17 Until the implementation of Part D in 2006, Medicaid covered most outpatient prescription drugs.
- 18 After three consecutive months of nonpayment of premium, plans may disenroll a beneficiary. Plans can elect to charge a premium but not collect it from members who are unable to pay. However, they are not allowed to advertise that they do this.
- 19 In general, providers can not bill the dual eligible for any portion of the coinsurance unless the state charges a nominal Medicaid copayment for the service.
- 20 Long-term care is often considered to be a very expensive and difficult benefit to integrate. Even some Evercare plans targeted at institutional beneficiaries have not taken this on.
- 21 The model was tested through CMS (then the Health Care Financing Administration) demonstration projects that began in the mid-1980s. The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide PACE services to Medicaid beneficiaries as a state option.
- 22 CMS approved 44 SNPs’ applications for passive enrollment, but only 42 plans passively enrolled their members. The states affected were Arizona, California, Colorado, Florida, Kentucky, Minnesota, New Jersey, Oregon, Pennsylvania, Tennessee, Texas, Utah, and Washington (McClard 2006).
- 23 MA plans are offered by MA organizations, which sign contracts with CMS.

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