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Health Policy Brief

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Medicare Advantage Plans. One in four Medicare beneficiaries belongs. How much will scheduled changes in payment affect future enrollment?

WHAT'S THE ISSUE?

One in four enrollees in Medicare, the federal health insurance plan for the elderly and disabled, receive their benefits through private health plans called "Medicare Advantage" plans. These plans have become increasingly popular in recent years because they offer features generally not available from traditional Medicare, such as additional benefits, lower premiums, and reduced cost sharing.

However, Medicare Advantage plans also cost the federal government about 10 percent more than the traditional Medicare fee-for-service program. This is a primary reason why the Medicare Advantage program was targeted for cost reductions in the Affordable Care Act of 2010.

Under the law, federal payments to Medicare Advantage plans are to decrease over time, bringing them closer to parity with traditional Medicare program costs. The Congressional Budget Office estimated that this change will cause enrollment in Medicare Advantage plans to drop to 9.1 million in 2019 from its previous estimate of 13.9 million enrollees that year.

This policy brief examines the background of Medicare Advantage plans, changes mandated by health care reform, and issues that may emerge from ongoing legislative and legal challenges.

WHAT'S THE BACKGROUND?

The Medicare program currently covers 47 million beneficiaries, including about 39 million people age 65 and older and 8 million younger disabled persons. The program is administered by the Centers for Medicare and Medicaid Services (CMS). It is subdivided into four parts, known as Parts A, B, C, and D.

MEDICARE COVERAGE: Part A primarily covers inpatient hospital stays and skilled nursing facility care. Part B covers professional and outpatient services, such as doctor visits, ambulance rides, and home medical equipment. Part C is the label given to private insurance plans that combine the benefits provided by Parts A and B. These are the plans known as Medicare Advantage plans. Enrollment in Part C is voluntary, and Medicare Advantage plans are available in almost all parts of the country.

Part D of Medicare covers outpatient prescription drugs. Medicare beneficiaries who are covered under Parts A and B typically sign up for freestanding private Part D drug plans. Alternatively, people who want a Medicare Advantage plan can choose a specific Medicare Advantage plan that also includes prescription drug benefits.

Most Medicare beneficiaries are automatically entitled to Part A benefits, and don't need to pay any premiums for coverage. Ben-

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47 million

Enrolled in Medicare
The Medicare program covers 47 million enrollees, including about 39 million people age 65 and older and 8 million younger disabled persons.

eficiaries may also choose to enroll in Parts B and D, for which they pay monthly premiums and copays. The premiums cover a portion of the costs for Part B and D services and the remainder is covered by the federal government. Many Part C plans require no additional premiums.

FIXED MONTHLY PAYMENTS: Medicare for the most part is considered a fee-for-service program, because it pays separately for services as they are provided to beneficiaries, with few incentives to manage or coordinate care. In contrast, Part C plans are paid a fixed per month amount for each beneficiary who's enrolled, regardless of the number of services that the plans deliver to the beneficiary. Payments are "risk-adjusted," meaning that the per month amounts they are paid vary according to each enrollee's overall health status.

Most people enrolled in Medicare Advantage participate in what are known as "coordinated care" plans. These plans typically require patients to use doctors and hospitals within a network, although patients may be able to see other providers if they agree to pay a greater share of the costs. Medicare Advantage plans may be health maintenance organizations (HMOs), which typically have tight network restrictions, or preferred provider organizations (PPOs), which have looser restrictions on beneficiaries' choices of hospitals and doctors.

Medicare Advantage options also include so-called private fee-for-service plans (that until recently were not required to form actual networks of hospitals or physicians) and so-called special needs plans (for beneficiaries who are eligible both for Medicare and Medicaid, or who have certain chronic or disabling conditions or require institutional care, such as care in a nursing home).

In return for joining a private plan that typically restricts their choice of providers, Medicare Advantage enrollees can benefit from lower out-of-pocket costs for covered services—in other words, for lower or no deductibles or copayments. They may also receive additional benefits, such as dental, hearing, vision care, and even discounted health club memberships not otherwise covered by Medicare.

As of February 2011, 11.7 million Medicare beneficiaries were enrolled in approximately 3,900 Medicare Advantage plans sponsored by about 180 organizations. More than half of the beneficiaries are enrolled in plans offered by a handful of large companies, including UnitedHealthcare, Humana, Kaiser Permanente, and Blue Cross-Blue Shield affiliates.

Medicare Advantage enrollment rates vary widely, from 41 percent of Medicare beneficiaries in Oregon and Hawaii to less than 1 percent in Alaska (Exhibit 1). HMOs account for the majority of Medicare Advantage enrollment (65 percent in 2010), followed by local and regional PPOs (19 percent), and private fee-for-service plans (14 percent). Exhibit 2 shows the overall growth of enrollment in Medicare Advantage plans during the previous decade.

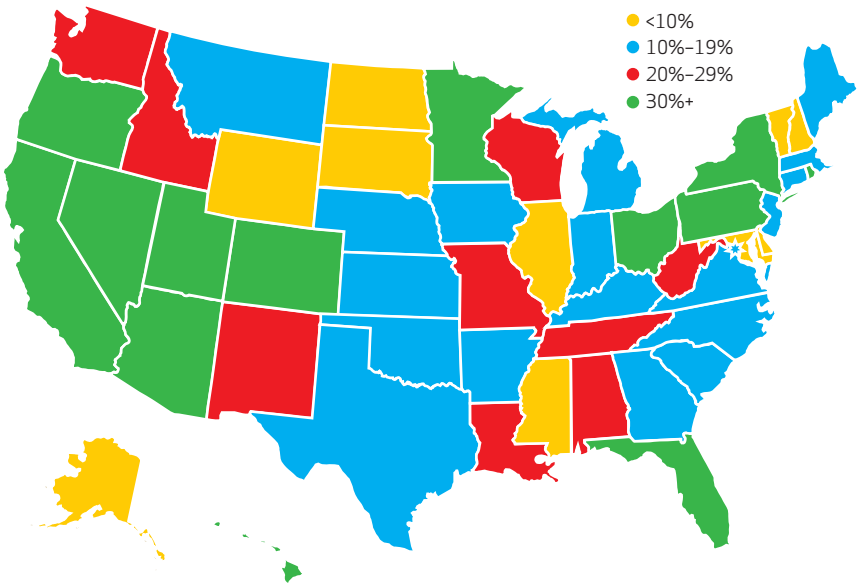
MEDICARE ADVANTAGE PAYMENTS: Medicare pays the Medicare Advantage plans to provide benefits in a complicated way. Here's how the system works.

First, plans submit "bids" to CMS, based on their estimated costs per enrollee to cover Part A and B benefits. CMS compares the bid to a "benchmark" amount—the maximum it will pay a plan in a given county or geographic region based on a formula established by statute.

CMS then reviews the bids to ensure they meet the agency's requirements. If a bid ex-

EXHIBIT 1

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



SOURCE Mathematica Policy Research, Kaiser Family Foundation analysis of Centers for Medicare and Medicaid Services State/County Market Penetration Files, 2010.

ceeds the benchmark, enrollees in that plan pay the difference. (That payment is added to what these enrollees pay as the premium for their Part B coverage.) If a bid is less than the benchmark, as most are in practice, CMS calculates the difference, and then gives 75 percent of that amount to the Medicare Advantage plan in the form of a payment known as a "rebate."

Medicare Advantage plans must use these payments, or rebates, to provide additional benefits that are not covered under Medicare Parts A and B or to reduce beneficiary out-of-pocket costs. These additional benefits might include vision, hearing, or dental care. Costs to beneficiaries may be reduced by lowering copayments, deductibles, or other cost sharing, or by reducing premiums for Part B or for prescription drug coverage. These benefit improvements are considered important ways to attract beneficiaries into private plans.

The benchmarks are adjusted over time according to the rate of growth in total Medicare spending. As a result, Medicare Advantage payments are affected by changes to payments under traditional Medicare. When payments to hospitals and doctors are reduced under fee-for-service Medicare, payments to Medicare Advantage plans also go down.

SUBSIDIZED PAYMENTS: On average, CMS's payments to Medicare Advantage plans are higher than fee-for-service spending for beneficiaries with the same health status. In 2011, Medicare Advantage payments are estimated to be 110 percent of the amount the program would pay for the same beneficiaries under traditional Medicare (Parts A and B).

The additional spending on Medicare Advantage enrollees is in effect subsidized by the nation's taxpayers, who pay more to help pay for the Part B program than they would if the same beneficiaries stayed in traditional Medicare. And the three in four Medicare enrollees who are not in Medicare Advantage plans pay more in higher Part B premiums to help cover the additional spending.

The Medicare Payment Advisory Commission, a nonpartisan panel that advises Congress on Medicare-related issues, recommended revising the method of setting the Medicare Advantage payments. The commission said that there should be "financial neutrality" between payments under the traditional Medicare and the Medicare Advantage program.

But there is an additional complication with setting rates for Medicare Advantage plans. The benchmarks are linked to the costs of the fee-for-service Medicare program in different counties across the country. There is a large variation in these costs. Some areas of the country have had historically low Medicare costs, so the benchmarks for Medicare Advantage plans are relatively low as well. Under previous law, the benchmarks were raised so that more Medicare Advantage plans would offer coverage in those areas and so that beneficiaries in those areas could have access to Medicare Advantage plans.

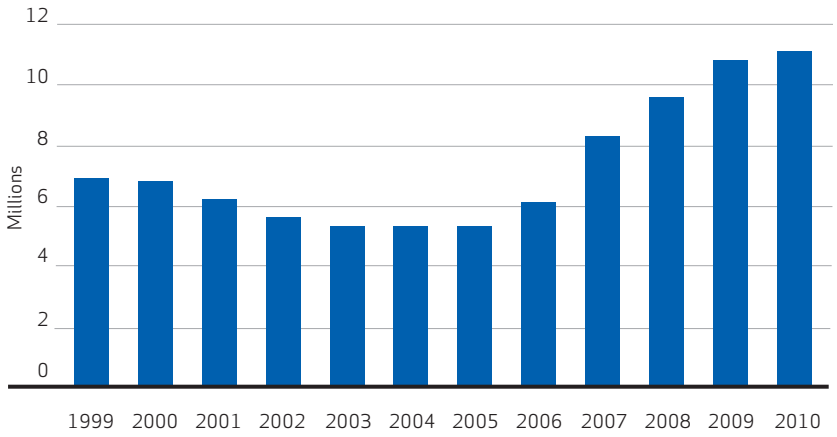
The bottom line: Medicare Advantage benchmarks and payments to the plans vary considerably around the country, and making adjustments to them is no simple matter.

11.7 million

Enrolled in Medicare Advantage
As of February 2011, 11.7 million beneficiaries were enrolled in about 3,900 plans sponsored by about 180 organizations.

EXHIBIT 2

Total Medicare Private Health Plan Enrollment, 1999–2010



SOURCE Mathematica Policy Research, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," February 1999–2010. **NOTES** Includes local health maintenance organizations, preferred provider organizations, regional preferred provider organizations, preferred service organizations, private fee-for-service plans, 1876 cost plans, demonstrations, health care prepayment plans, and Program of All-Inclusive Care for the Elderly (PACE) plans.

WHAT'S IN THE LAW?

The Affordable Care Act modifies payments to Medicare Advantage plans in several important ways, for a projected savings of $117 billion in federal expenditures for Medicare between fiscal years 2010 and 2019. The changes include the following:

- **Revised benchmarks.** For 2011, benchmarks are frozen at 2010 levels. Starting in 2012, reductions will be phased in to more closely align benchmarks with fee-for-service spending. The impact of these changes will vary geographically, depending on local fee-

for-service spending. For example, in high-Medicare-cost counties, such as Miami-Dade in Florida, benchmarks will be set at 95 percent of average fee-for-service costs. In low-cost areas, such as Boise, Idaho, they will be set at 115 percent. The transitions will occur over two, four, or six years and will be longer in areas that require the largest change.

- **Bonus payments.** Since 2008, CMS has assigned plans a rating of one to five stars based on their performance on certain quality measures, including clinical outcomes and contract performance. (One star signifies poor performance, two stars means below average, three stars is average, and four and five stars mean above-average and excellent performance, respectively.) Before health care reform, these ratings were intended to help beneficiaries choose from among available health plans, but did not affect federal payments to those plans.

Under the Affordable Care Act, bonus payments will be tied to quality performance. Specifically, beginning in 2012, benchmarks for plans that receive four or more stars will be increased by 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 in 2014 and beyond. The higher benchmarks will effectively increase payments to high-quality plans. Plans that earn fewer than four stars are not eligible for these increases.

But rather than adopting the approach specified in the law, CMS in November 2010 announced that it would use an alternative method for computing quality bonuses. Under its broad authority to create and fund demonstration projects, CMS has set up a Medicare Advantage Quality Bonus Payment Demonstration project.

In this demonstration, plans with as few as three stars (average performance) may qualify for bonus payments. Increases will vary based on the number of stars received from 3 percent for those with three stars to 5 percent for those with five stars. The project will run from 2012 to 2014. CMS estimates it will increase Medicare spending by $6.7 billion over three years, with the funds to come from the Medicare trust fund.

- **Revised rebates.** The law reduces the size of the rebate that plans can receive when their bids are less than the benchmarks. The percentage that a plan receives varies based on its star rating. By 2014, plan shares will be reduced from 75 percent to 50 percent for plans that receive three or fewer stars. Plans with 3.5 or 4 stars will receive a rebate of 65 percent, and plans with 4.5 or 5 stars will receive 70 percent.

By 2019, the Congressional Budget Office expects Medicare Advantage enrollment will decline by 35 percent or 4.8 million from its previous 2019 estimate of 13.9 million enrollees. CMS' Office of the Actuary predicts that Medicare Advantage enrollment will decline by 50 percent in 2017 from what it would have been if health care reform legislation had not been enacted.

10%

Additional cost
Medicare Advantage costs the federal government about 10 percent more than traditional Medicare fee-for-service program.

"Medicare Advantage plans are the focus of a policy debate over how best to constrain the growth rate of health spending and still allow for consumer choice."

WHAT'S THE DEBATE?

Medicare Advantage plans are the focus of a policy debate over how best to constrain the growth rate of health spending and still allow for consumer choice. In general, Republican members of Congress have emphasized the importance of providing beneficiaries with options to receive Medicare benefits through private plans and preferred policies that have encouraged plan participation in Medicare. Democratic members of Congress are more likely to support the notion that payment should be equitable between private plans and the traditional Medicare program.

TOO COSTLY: Critics of Medicare Advantage plans recommend that payments to the plans be closer to the amount that the traditional Medicare program would spend on beneficiaries with the same characteristics and health status. They argue that paying Medicare Advantage plans more than traditional Medicare to provide extra benefits is unfair to enrollees in the traditional Medicare program. If it's desirable to give Medicare beneficiaries these extra benefits, then all should receive them—not just those enrollees in Medicare Advantage plans.

LESS FRAGMENTED CARE: Medicare Advantage advocates suggest that the private plans offer less-fragmented care at lower costs to enrollees. The industry trade association, America's Health Insurance Plans, points to recent studies suggesting that people enrolled in Medicare Advantage plans may have fewer unnecessary hospitalizations and readmissions than do people enrolled in traditional Medicare.

Medicare Advantage supporters also emphasize the importance of the plans to low-income beneficiaries. These enrollees often can't afford private "Medigap" plans that

supplement Medicare by covering additional benefits and offering cost-sharing protection. They note that disruptions to the Medicare Advantage program disproportionately affect minority beneficiaries, since Hispanic and African American beneficiaries make up a larger share of Medicare Advantage enrollees.

WHAT'S NEXT?

Many supporters of Medicare Advantage fear that planned changes under the Affordable Care Act will hurt the program, because fewer plans will choose to participate and fewer Medicare beneficiaries will opt to enroll. In 2011, enrollment actually increased over 2010 levels. The Congressional Budget Office predicts that enrollment in 2012 will be the same as in 2011 and will begin to decline in 2013.

Plan sponsors are currently evaluating rates and policies for 2012. Plan bids for 2012 were due to CMS by June 6, 2011. The open enrollment period for beneficiaries to enroll in Medicare Advantage plans for 2012 will run from October 15 through December 7, 2011, and at that point it will become clearer how Medicare enrollees perceive the program changes.

As far as demand among Medicare enrollees for Medicare Advantage plans, that could also be affected by the slow pace of economic growth and low rates of return on retirement investments. In this environment, some Medicare enrollees may still prefer Medicare Advantage plans because they are somewhat more protected from copayments and deductibles than they would be if they were in the traditional Medicare program.

The role for private plans may change as Congress and the Obama administration contemplate further reforms in Medicare and other entitlements. Under some proposals, traditional Medicare would no longer be an option for those currently younger than age 55, and the entire system would evolve into one of private plans. Other proposals to place overall limits on the growth of Medicare spending would in turn affect the size of payments to Medicare Advantage plans.■

35%

Enrollment reduction
By 2019, Medicare Advantage enrollment will decline by 35 percent or 4.8 million from a previous estimate of 13.9 million enrollees, according to an estimate by the Congressional Budget Office.

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