

SECTION

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**Medicare Advantage**

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

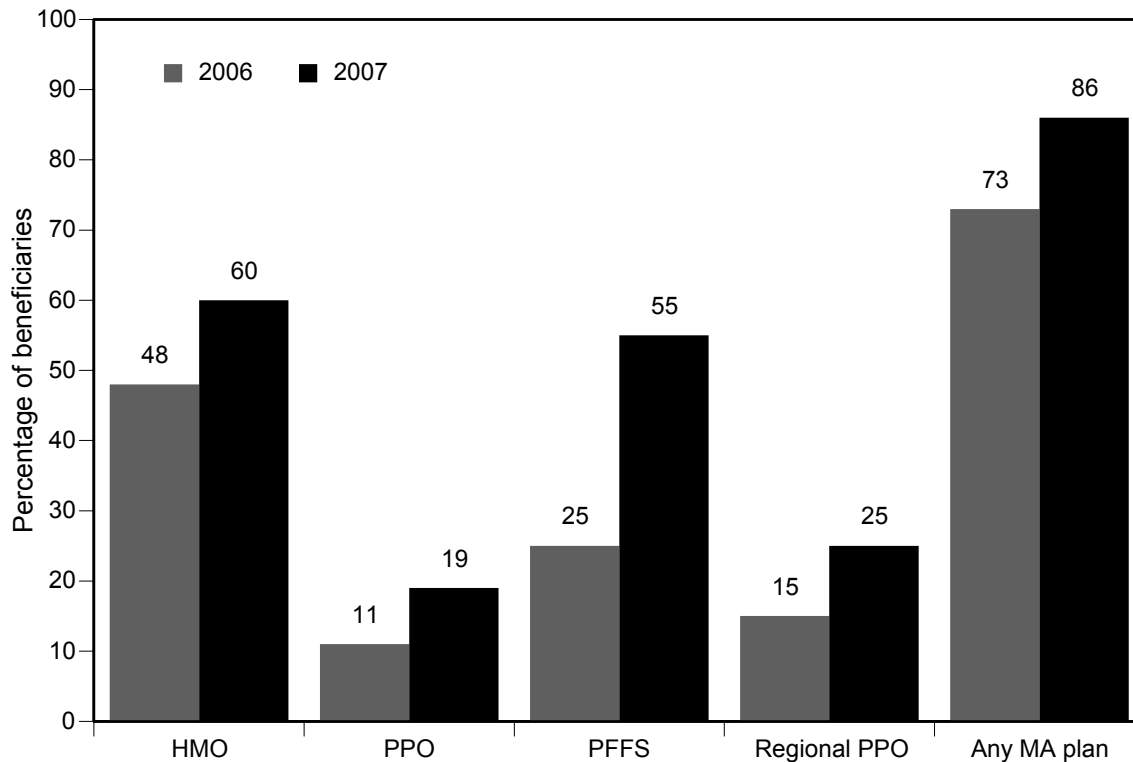
	CCPs			PFFS	Any MA plan	Average plan offerings per county
	HMO or local PPO	Regional PPO	Any CCP			
2005	67%	N/A	67%	45%	84%	5
2006	80	87	98	80	100	12
2007	82	87	99	100	100	20

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

Source: MedPAC analysis of plan finder data from CMS.

- Local coordinated care plans (CCPs) are local preferred provider organizations (PPOs) and health maintenance organizations (HMOs), which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional CCPs (regional plans are required by statute to be PPOs) cover entire state-based regions and have networks that may be looser than the ones required of local PPOs. Regional PPOs were only available beginning in 2006. Another type of Medicare Advantage (MA) plan is a private fee-for-service (PFFS) plan. PFFS plans are not required to have networks and members may go to any willing Medicare provider.
- Local CCPs are available to 82 percent of Medicare beneficiaries in 2007—up from 67 percent in 2005. Regional PPOs are available to 87 percent of beneficiaries. Virtually all beneficiaries live in a county where MA PFFS plans are available in 2007—up from 45 percent in 2005. In both 2006 and 2007, 100 percent of Medicare beneficiaries have MA plans available, up from 84 percent in 2005.
- The number of plans from which beneficiaries may choose has increased. In 2007, beneficiaries can choose from an average of 20 plans operating in their counties, up from a choice of 12 plans in 2006 and 5 plans in 2005.
- These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process. That is, special needs plans, cost-based plans, employer-only plans, and certain other demonstration plans are excluded.

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

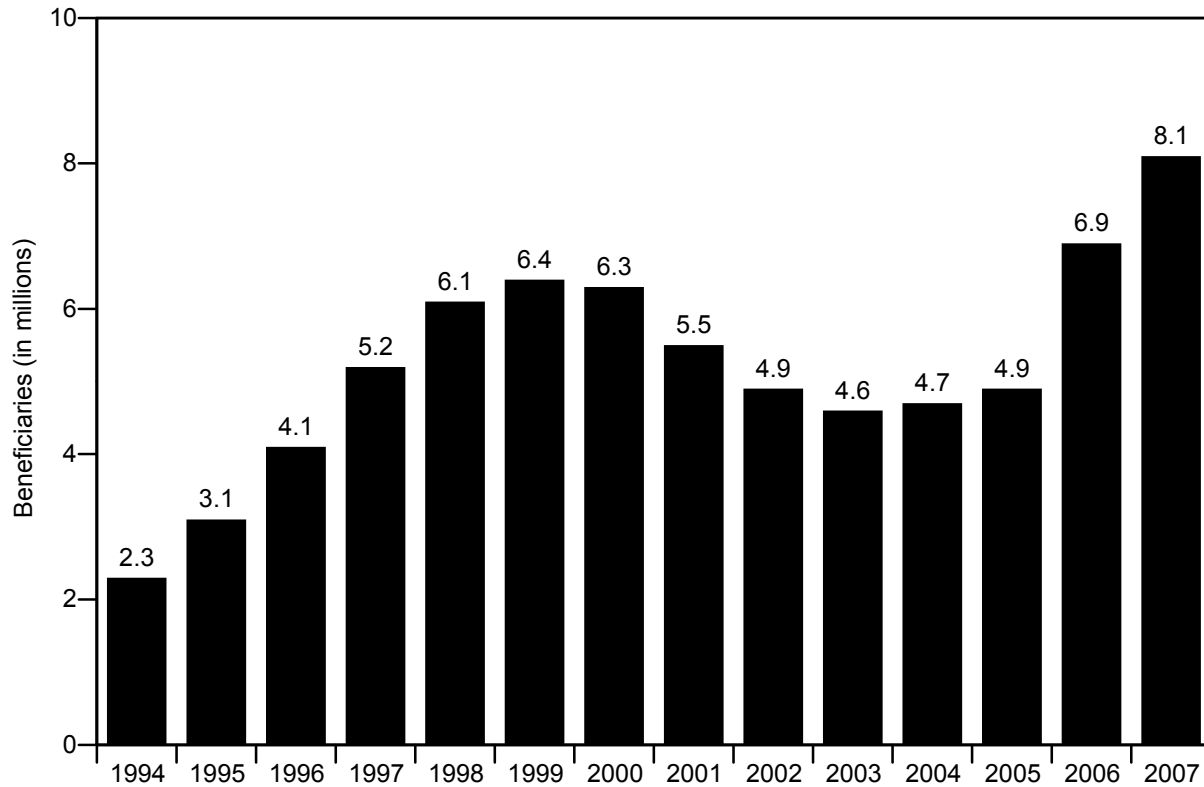


Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

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

- Across all plan types, in 2007 there is increased availability of “zero-premium” plans—plans with no premium payments other than the Medicare Part B premium. More beneficiaries can obtain an MA plan with Part D drug coverage (an MA–PD plan) for which the enrollee pays no premium for either the drug coverage or the coverage of Medicare Part A and Part B services. In 2007, 86 percent of Medicare beneficiaries have access to at least one MA–PD plan with no premium (beyond the Medicare Part B premium) for the combined coverage (and no premium for any non-Medicare-covered benefits included in the benefit package), compared with 73 percent in 2006.
- Sixty percent of beneficiaries have zero-premium MA–PD HMOs available, while MA–PD PPOs without premiums are much less widely available. Particularly noteworthy is the increased availability of PFFS plans offering zero premiums. In 2006, 25 percent of beneficiaries had access to a PFFS plan with no plan premium for Part C and Part D coverage—a figure that grew to 55 percent in 2007.
- In most cases, enrollees of MA plans continue paying their Medicare Part B premium, but some MA–PD plans use rebate dollars to reduce or eliminate their enrollees’ Part B premium obligation.

**Chart 10-3. Enrollment in MA plans, 1994–2007**



Note: MA (Medicare Advantage).

Source: Medicare Managed Care Contract (MMCC) Plans, Monthly Summary Reports, CMS.

- Medicare enrollment in private health plans paid on an at-risk capitated basis is at an all-time high at 8.1 million enrollees (19 percent of all Medicare beneficiaries). Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999, and declined steadily to a low of 4.6 million enrollees in 2003.

## Chart 10-4. Enrollment in PFFS plans grew faster than in other major plan types

Plan type	Total enrollees (in thousands)		Percentage change
	July 2006	February 2007	
Local CCPs	5,480	6,065	11%
PFFS	774	1,328	72
Regional PPOs	82	121	48

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

Source: CMS health plan monthly summary reports.

- Enrollment in private fee-for-service (PFFS) has been growing rapidly. While local coordinated care plans grew about 11 percent between July 2006 and February 2007, enrollment in PFFS plans accounted for nearly half the growth in Medicare Advantage, rising from about 774,000 to 1.3 million—a 72 percent increase.

## Chart 10-5. Enrollment in types of plans, 2007

State	Medicare eligibles (in thousands)	Distribution (in percent) of MA enrollees by plan type				Cost	Total
		HMO	Local PPO	Regional PPO	PFFS		
Alaska	55	0%	0%	0%	0%	0%	1%
Alabama	782	11	1	0	2	0	15
Arkansas	489	2	0	0	7	0	9
Arizona	819	30	1	0	4	0	35
California	4,386	32	0	1	1	0	33
Colorado	541	22	1	0	3	5	31
Connecticut	541	9	0	0	1	0	10
District of Columbia	78	1	0	0	1	6	8
Delaware	132	0	0	0	1	0	2
Florida	3,130	21	0	2	2	0	25
Georgia	1,077	2	1	0	7	0	10
Hawaii	189	12	2	1	1	20	36
Iowa	503	1	0	1	6	3	11
Idaho	199	8	2	0	9	2	21
Illinois	1,749	4	1	0	2	1	8
Indiana	935	0	1	0	6	2	9
Kansas	410	2	1	0	3	1	8
Kentucky	705	3	1	0	7	1	11
Louisiana	643	13	0	0	3	0	17
Massachusetts	1,007	14	1	0	2	0	17
Maryland	718	2	1	0	0	2	6
Maine	243	0	0	0	1	0	2
Michigan	1,538	3	0	0	11	0	14
Minnesota	722	10	0	1	8	10	30
Missouri	943	11	1	0	3	0	16
Mississippi	472	1	0	0	6	0	7
Montana	153	0	1	0	11	0	12
North Carolina	1,319	6	0	0	7	0	14
North Dakota	106	0	0	0	5	1	6
Nebraska	268	3	0	1	5	1	9
New Hampshire	194	0	0	0	2	0	2
New Jersey	1,270	8	1	0	0	0	9
New Mexico	278	16	3	0	3	0	22
Nevada	309	28	0	1	1	0	31
New York	2,879	20	1	0	1	0	23
Ohio	1,812	11	1	0	3	1	17
Oklahoma	560	9	0	0	3	0	12
Oregon	558	23	8	0	3	5	39
Pennsylvania	2,189	26	3	0	2	0	32
Puerto Rico	620	52	4	0	0	0	56
Rhode Island	178	33	1	0	1	0	34
South Carolina	674	0	0	1	8	0	9
South Dakota	955	13	0	0	4	0	17
Texas	2,641	10	1	0	3	1	15
Utah	245	2	6	0	13	1	22
Virginia	1,022	1	0	0	7	1	9
Vermont	100	0	0	0	1	0	1
Washington	852	14	1	0	4	0	20
Wisconsin	855	5	1	0	11	1	19
West Virginia	367	1	2	0	3	4	11
Wyoming	74	0	0	0	3	1	5
U.S. Total	43,597	14	1	0	4	1	19

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

Source: CMS enrollment data, May 2007.

- Medicare private plans attract more beneficiaries in some areas than in others. At the state level, private plans attract only 1 percent of beneficiaries in Alaska and Vermont. The highest penetration of Medicare private plans is in Oregon and Puerto Rico, with 39 percent and 56 percent of beneficiaries, respectively, enrolled in plans.
- The popularity of different types of plans varies as well. For example, some states have all their plan enrollment in private fee-for-service (PFFS) plans, while other states have none of their enrollment in PFFS plans.

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

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

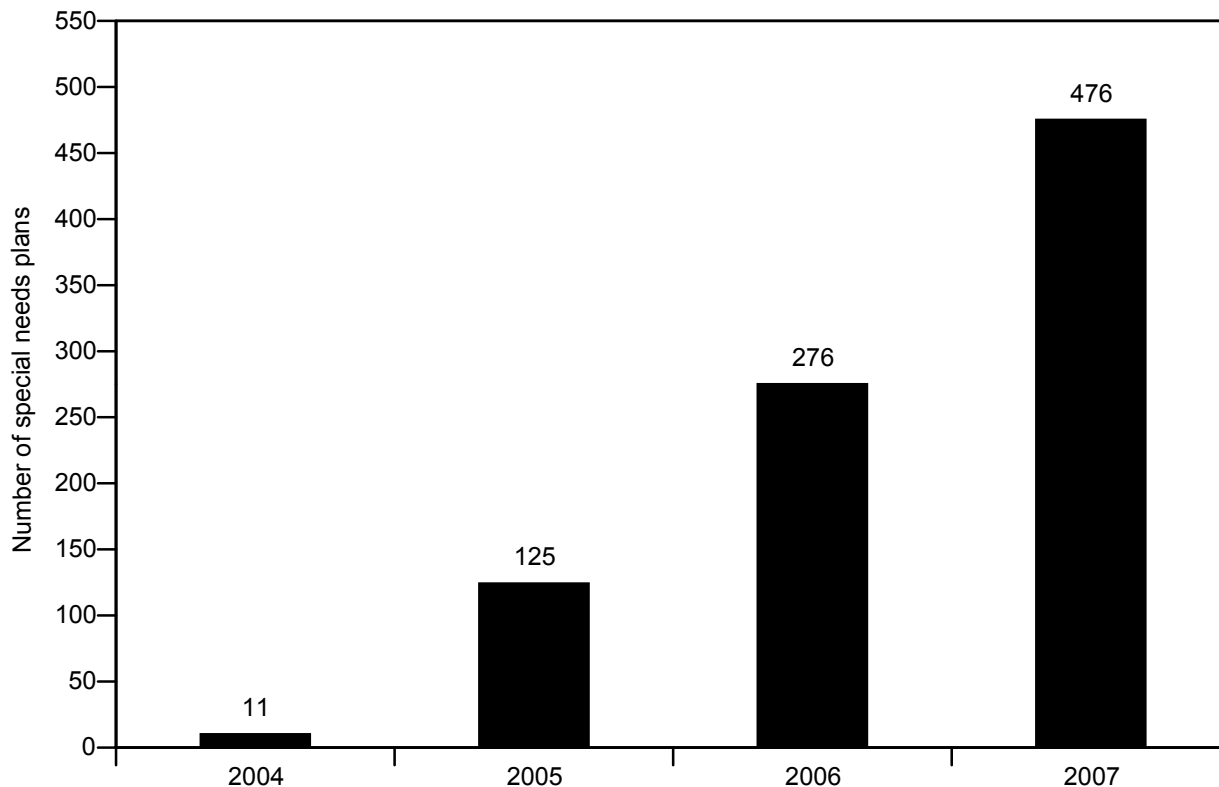
Note: MA (Medicare Advantage), PFFS (private fee-for-service), MSA (medical savings account), HMO (health maintenance organization), PPO (preferred provider organization), SNP (special needs plan).

\*Effective as of 2008 contract year; requirement does not apply to PFFS and MSA plans.

Source: MedPAC analysis of MA statutory and regulatory requirements.

- Different requirements apply to different plan types in Medicare Advantage (MA). Private fee-for-service (PFFS) plans and medical savings account (MSA) plans are exempt from many requirements that apply to coordinated care plans (CCPs). PFFS and MSA plans are not required to build networks, report on all CCP-required quality measures, offer the Part D drug benefit, or have the level of their bids approved by CMS. Also, beginning in 2008, non-network PFFS plans and MSA plans will not be subject to the requirement that they offer nongroup MA plans if they offer employer group MA plans.
- MSA plans have a payment advantage over other types of MA plans (though currently only three MSA plans are in operation). When an MSA plan bids below the benchmark, its enrollees retain the full difference in their accounts, while non-MSA plans receive only 75 percent of the difference between the bid and benchmark to provide extra benefits to their enrollees. In non-MSA plans, the Medicare program retains the other 25 percent of the difference.
- Only regional preferred provider organizations and MSA plans are required to have benefit structures that include an out-of-pocket limit on enrollee expenditures. The plans are allowed to determine their own level of the out-of-pocket limits. Special needs plans are allowed to limit their enrollment to one of three special populations: Medicare/Medicaid dual eligibles, institutionalized beneficiaries, and beneficiaries with chronic or disabling conditions.

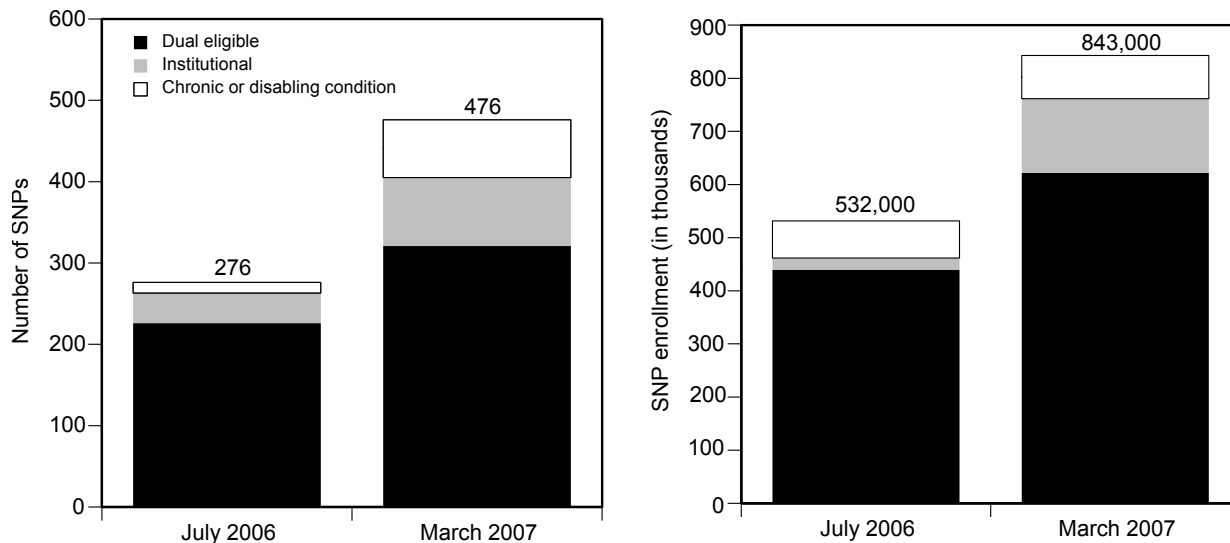
**Chart 10-7. Special needs plans have grown quickly**



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

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.
- In 2007, 476 SNPs are approved to operate.
- SNPs were authorized for only five years. Absent congressional action, SNP authority will expire at the end of 2008.

**Chart 10-8. The number of SNPs and SNP enrollment increased from 2006 to 2007**



Note: SNP (special needs plan).

Source: CMS special needs plans fact sheet and data summary, February 14, 2006; CMS special needs plans comprehensive report, March 21, 2007; and CMS annual report by plan, July 26, 2006.

- In 2007, most special needs plans (SNPs) (67 percent) are for dual-eligible beneficiaries, while 15 percent are for beneficiaries with chronic conditions, and 18 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need).
- This is a change from 2006 when 82 percent of SNPs were for dual eligibles.
- Enrollment in SNPs has grown quickly from 532,000 in July 2006 to 843,000 in March 2007.
- The rate of enrollment growth was especially rapid for dual-eligible SNPs (42 percent) and institutional SNPs (530 percent). The institutional SNP enrollment growth is largely accounted for by the re-designation of the SCAN demonstration Social-HMO as an institutional SNP. This change added nearly 90,000 enrollees, 76 percent of institutional SNP enrollment growth. (For more information, see Chapter 3 of MedPAC's June 2007 Report to the Congress at [http://medpac.gov/chapters/Jun07\\_Ch03.pdf](http://medpac.gov/chapters/Jun07_Ch03.pdf).)

## Web links. Medicare Advantage

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

[http://medpac.gov/chapters/Jun07\\_Ch03.pdf](http://medpac.gov/chapters/Jun07_Ch03.pdf)

- Chapter 4 of MedPAC's March 2007 Report to the Congress provides information on Medicare Advantage plans.

[http://medpac.gov/chapters/Mar07\\_Ch04.pdf](http://medpac.gov/chapters/Mar07_Ch04.pdf)

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

[http://www.medpac.gov/publications/other\\_reports/Sept06\\_MedPAC\\_Payment\\_Basics\\_MA.pdf](http://www.medpac.gov/publications/other_reports/Sept06_MedPAC_Payment_Basics_MA.pdf)

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

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

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

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

