

SECTION

10

Medicare Advantage

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

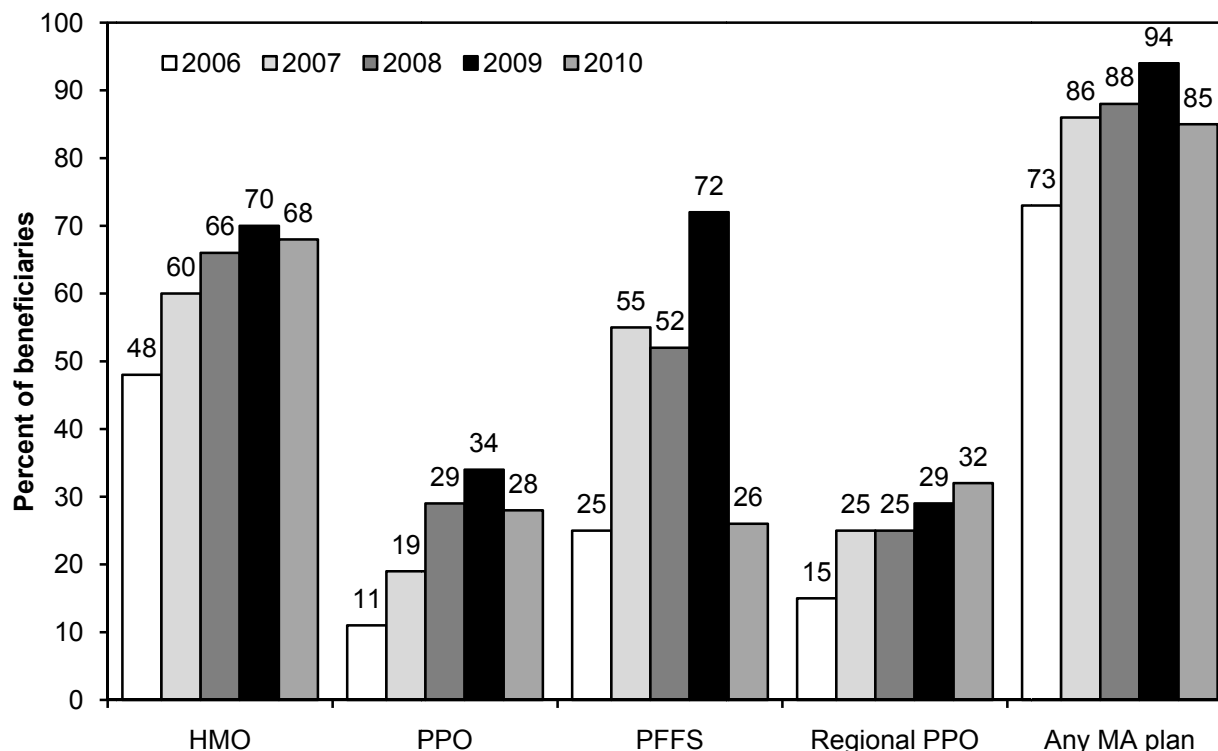
	CCPs			PFFS	Any MA plan	Average plan offerings per county
	HMO or local PPO	Regional PPO	Any CCP			
2005	67%	N/A	67%	45%	84%	5
2006	80	87	98	80	100	12
2007	82	87	99	100	100	20
2008	85	87	99	100	100	35
2009	88	91	99	100	100	34
2010	91	86	99	100	100	21

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

Source: MedPAC analysis of plan finder data from CMS.

- There are four types of plans, three of which are CCPs. Local CCPs include local PPOs and 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 available beginning in 2006. PFFS plans, which are not CCPs, are not required to have networks and members may go to any willing Medicare provider.
- Local CCPs are available to 91 percent of Medicare beneficiaries in 2010—up from 67 percent in 2005. Regional PPOs are available to 86 percent of beneficiaries. Virtually all beneficiaries live in a county where MA PFFS plans are available in 2010—up from 45 percent in 2005. For the past five years, 100 percent of Medicare beneficiaries have had MA plans available, up from 84 percent in 2005.
- The number of plans from which beneficiaries may choose in 2010 is about the same as in 2007. In 2010, beneficiaries can choose from an average of 21 plans operating in their counties. This number is a decrease from 2008 and 2009, reflecting CMS's 2010 effort to reduce the number of duplicative plans and plans with small enrollment.

Chart 10-2. Access to zero-premium plans with MA drug coverage, 2006–2010

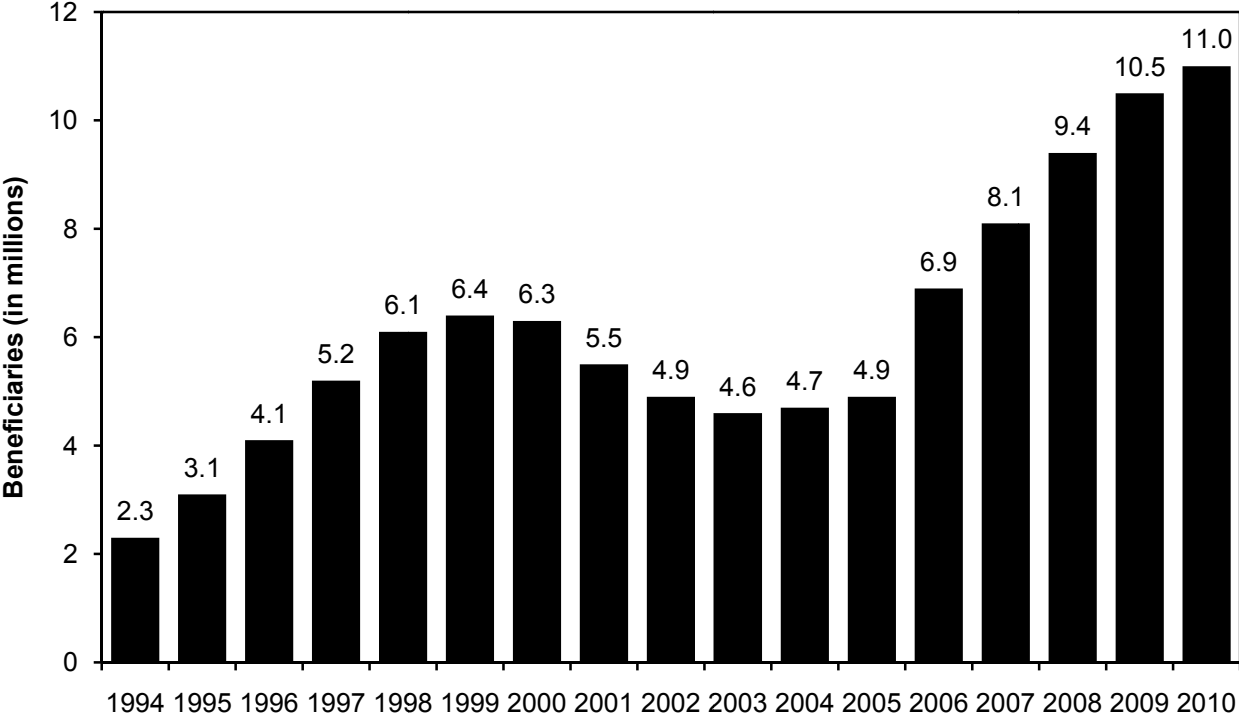


Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

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

- Across most plan types, the availability of “zero-premium” plans—plans with no premium payments other than the Medicare Part B premium—declined in 2010. Fewer beneficiaries can obtain an MA–Prescription Drug plan (MA–PD plan), an MA plan that includes Part D drug coverage, for which the enrollee pays no premium for either the drug coverage or the coverage of Medicare Part A and Part B services. In 2010, 85 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 94 percent in 2009.
- Sixty-eight percent of beneficiaries have zero-premium MA–PD HMOs available, while MA–PD PPOs without premiums are much less widely available. However, zero-premium regional PPOs are more available than they have been in the past. PFFS plans offering zero premiums were available to 72 percent of beneficiaries in 2009, but to only 26 percent of beneficiaries in 2010.
- In most cases, MA plan enrollees 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, 1994–2010



Note: MA (Medicare Advantage).

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

- Medicare enrollment in private health plans paid on an at-risk capitated basis is at an all-time high at 11.0 million enrollees (24 percent of all Medicare beneficiaries). Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999, and then declined to a low of 4.6 million enrollees in 2003. MA enrollment has increased steadily since 2003.

Chart 10-4. Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands)				Percentage change 2009–2010
	February 2007	February 2008	February 2009	February 2010	
Local CCPs	6,065	6,830	7,625	8,354	10%
Regional PPOs	121	257	377	760	102
PFFS	1,328	2,057	2,353	1,657	–30

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

Source: CMS health plan monthly summary reports.

- Enrollment in local CCPs grew slower than enrollment in regional PPOs over the past year, while enrollment in PFFS plans declined. Combined enrollment in the three types of plans grew by 4 percent from February 2009 to February 2010.
- While still the dominant form of enrollment, local CCP enrollment grew 10 percent over the past year, while enrollment in regional PPOs grew by 102 percent from a much lower base. It is likely that much of the enrollment growth in regional PPOs came from the 30 percent decline in PFFS enrollment over the same time period.

Chart 10-5. MA and cost plan enrollment by state and type of plan, 2010

State	Medicare eligibles (in thousands)	Distribution (in percent) of enrollees by plan type					Total
		HMO	Local PPO	Regional PPO	PFFS	Cost	
Alabama	829	12%	7%	0%	2%	0%	21%
Alaska	63	0	0	0	0	0	1
Arizona	891	32	2	1	2	0	37
Arkansas	522	4	1	2	7	0	14
California	4,267	36	0	1	1	0	39
Colorado	604	24	2	0	4	4	34
Connecticut	559	15	1	1	1	0	18
Delaware	145	1	1	0	2	0	4
District of Columbia	77	2	1	0	0	6	10
Florida	3,270	23	1	5	1	0	30
Georgia	1,201	3	2	3	12	0	20
Hawaii	201	13	7	2	1	18	41
Idaho	222	11	6	0	12	1	29
Illinois	1,812	5	2	1	2	0	10
Indiana	987	1	4	4	5	0	16
Iowa	513	3	2	1	6	1	13
Kansas	427	3	4	1	3	1	11
Kentucky	745	4	3	3	5	1	16
Louisiana	674	19	0	1	4	0	24
Maine	260	5	1	0	6	0	12
Maryland	766	3	1	0	1	3	8
Massachusetts	1,408	10	1	0	2	0	14
Michigan	1,620	7	2	1	5	0	15
Minnesota	771	14	1	2	7	17	41
Mississippi	489	3	1	1	4	0	9
Missouri	988	12	4	1	4	0	21
Montana	165	0	3	0	15	0	18
Nebraska	276	4	1	1	6	1	12
Nevada	343	27	1	1	2	0	31
New Hampshire	212	0	0	0	6	0	7
New Jersey	1,308	10	0	0	2	0	12
New Mexico	305	18	4	0	3	0	25
New York	2,941	23	4	1	2	0	30
North Carolina	1,450	8	1	0	8	0	18
North Dakota	108	0	0	0	6	2	8
Ohio	1,873	14	7	8	3	1	33
Oklahoma	594	10	2	0	3	0	15
Oregon	603	22	16	0	4	0	42
Pennsylvania	2,253	25	9	0	3	0	38
Puerto Rico	632	59	8	0	0	0	67
Rhode Island	181	29	1	4	0	0	35
South Carolina	749	1	1	3	9	0	15
South Dakota	135	0	1	1	5	0	8
Tennessee	1,032	17	2	1	5	0	24
Texas	2,907	13	1	2	2	1	19
Utah	274	12	13	0	7	1	33
Vermont	108	0	0	1	3	0	4
Virginia	1,109	1	2	0	9	1	14
Washington	940	17	3	0	5	0	25
West Virginia	378	1	4	9	4	3	22
Wisconsin	895	11	5	2	8	2	29
Wyoming	78	0	0	0	5	1	7
U.S. Total	46,172	16	3	2	4	1	25

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports to CMS rather than bids. Totals may not sum due to rounding.

Source: CMS enrollment and population data, 2010.

- Medicare private plans attract more beneficiaries in some areas than in others. At the state level, private plans attract only 1 percent of beneficiaries in Alaska. The highest penetrations of Medicare private plans are in Oregon and Puerto Rico, with 42 percent and 67 percent of beneficiaries, respectively, enrolled in plans.
- The popularity of different types of plans varies as well. For example, some states have almost their entire plan enrollment in PFFS plans, while other states have little or none of their enrollment in PFFS plans.

Chart 10-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2010

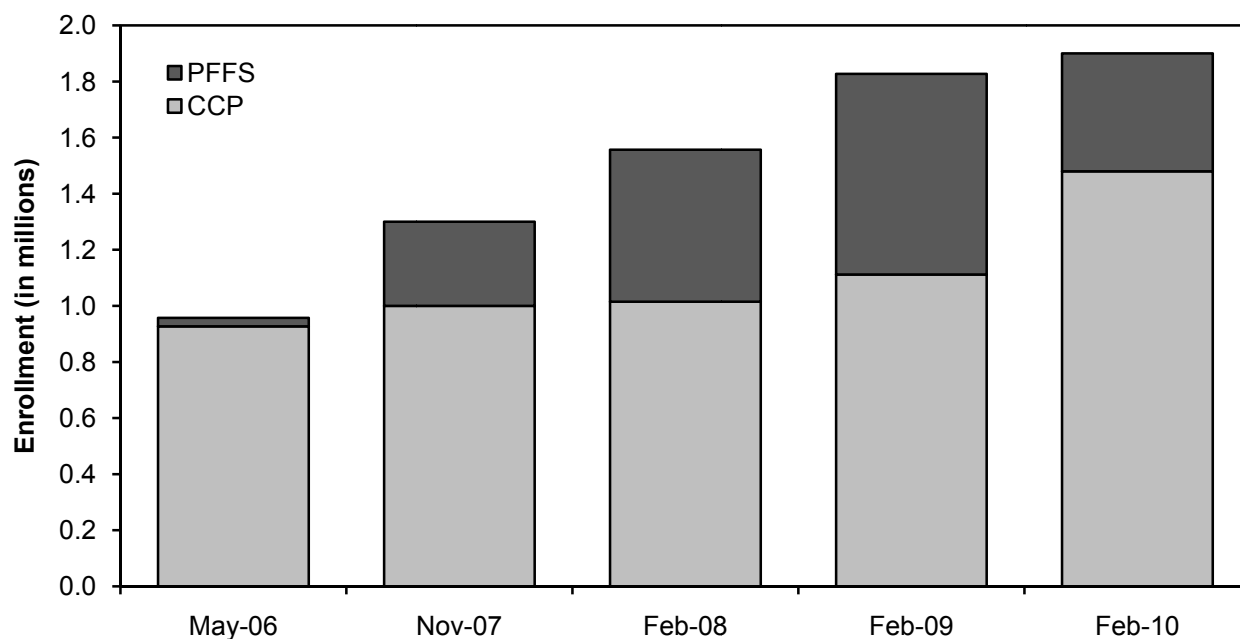
	All Plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	112%	112%	115%	109%	114%
Bids/FFS	100	97	108	104	111
Payments/FFS	109	108	113	108	113

Note: MA (Medicare Advantage), FFS (fee-for-service), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Table assumes that physician rates are not reduced by the sustainable growth rate formula between publication date and the end of 2010.

Source: MedPAC analysis of plan bid data from CMS, November 2009.

- Since 2006, plan bids have partially determined the Medicare payments they receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is handled separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.
- The benchmark is an administratively determined bidding target. Legislation in 1997 established benchmarks in each county, which included a floor—a minimum amount below which no county benchmarks could go. By design, the floor rate exceeded fee-for-service (FFS) spending in many counties. Benchmarks are updated yearly by the national growth in FFS spending.
- If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid, plus a "rebate," defined by law as 75 percent of the difference between the plan's bid and its benchmark. The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.
- We estimate that MA benchmarks average 112 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type, because different types of plans tend to draw enrollment from different types of areas.
- Plans' enrollment-weighted bids average 100 percent of FFS spending. We estimate that HMOs bid an average of 97 percent of FFS spending, while bids from other plan types average at least 104 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS, while other plan types tend to charge more.
- We project that 2010 MA payments will be 109 percent of FFS spending. It is likely this number will decline significantly over the next few years as benchmarks are gradually reduced relative to FFS levels to meet requirements under the Patient Protection and Affordable Care Act of 2010.
- The ratio of payments relative to FFS spending varies by the type of MA plan. HMOs and regional PPO payments are estimated to be 108 percent of FFS, while payments to PFFS and local PPOs will average 113 percent.

Chart 10-7. Enrollment in employer group MA plans, 2006–2010

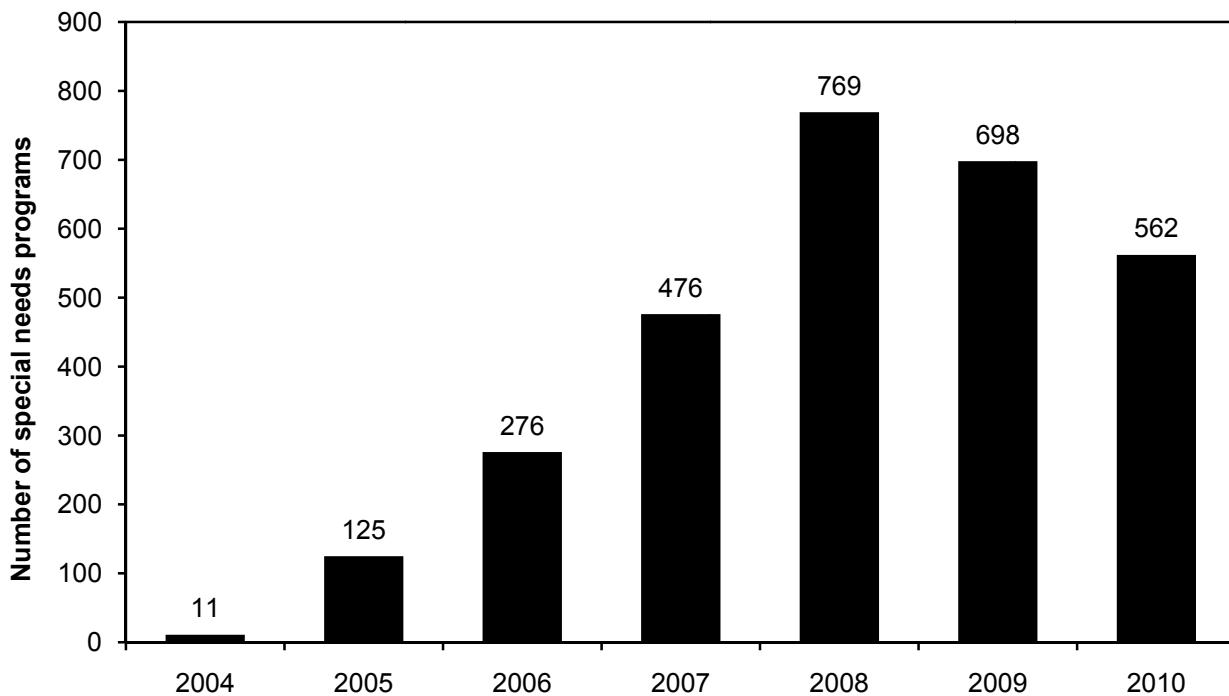


Note: MA (Medicare Advantage), PFFS (private fee-for-service), CCP (coordinated care plan).

Source: CMS enrollment data.

- While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.
- In the last four years, enrollment in employer group plans has doubled, while overall MA enrollment grew by about 55 percent. As of February 2010, about 1.9 million enrollees were in employer group plans, or about 18 percent of all MA enrollees.
- Our analysis of MA bid data shows that employer group plans on average have bids that are higher relative to fee-for-service (FFS) spending than individual plans, meaning that group plans appear less efficient than individual market MA plans. Employer group plans bid an average of 107 percent of FFS, compared with 99 percent of FFS for individual plans.

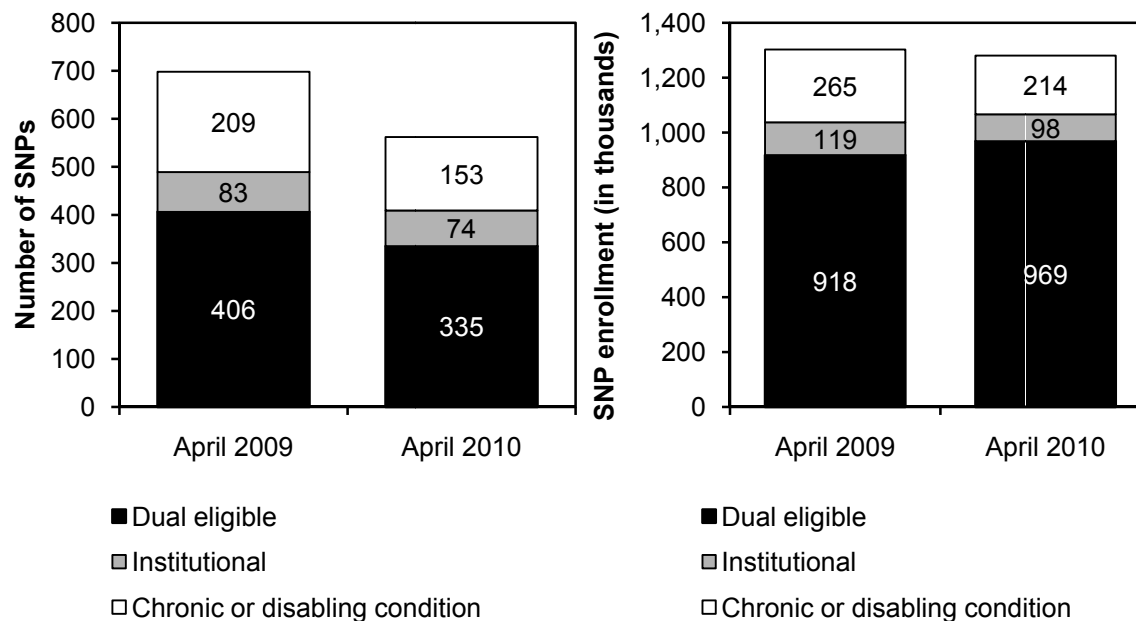
Chart 10-8. Number of special needs plans peaked in 2008



Source: CMS special needs plans fact sheet and data summary, February 14, 2006, and CMS special needs plans comprehensive reports, March 21, 2007, April 2008, April 2009, and April 2010.

- 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 2010, there are 562 SNPs. As is the case with all MA plans, this is a decrease from 2008 and 2009 as CMS made an effort in 2010 to reduce the number of duplicative plans and plans with small enrollment.
- SNPs were originally authorized for five years. SNP authority was extended, subject to new requirements, by the Medicare, Medicaid, and SCHIP Extension Act of 2007, the Medicare Improvements for Patients and Providers Act of 2008, and the Patient Protection and Affordable Care Act of 2010. Absent additional congressional action, SNP authority will expire at the end of 2014.

Chart 10-9. The number of SNPs decreased while SNP enrollment was flat from 2009 to 2010



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2009 and 2010.

- Although the number of SNP plans decreased by 19 percent from April 2009 to April 2010, the number of SNP enrollees decreased by only 2 percent.
- In 2010, most SNPs (60 percent) are for dual-eligible beneficiaries, while 27 percent are for beneficiaries with chronic conditions, and 13 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need).
- Enrollment in SNPs has grown from 0.8 million in March 2007 (not shown) to 1.3 million in April 2010.
- The availability of SNPs has changed slightly and varies by type of special needs population served. In 2010, 79 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 76 percent in 2009), 49 percent live where SNPs serve institutionalized beneficiaries (down from 53 percent), and 63 percent live where SNPs serve beneficiaries with chronic conditions (down from 72 percent).

Web links. Medicare Advantage

- Chapter 7 of MedPAC's June 2009 Report to the Congress provides information on Medicare Advantage plans.

http://www.medpac.gov/chapters/Jun09_Ch07.pdf

- Chapter 4 of MedPAC's March 2010 Report to the Congress provides information on Medicare Advantage plans.

http://www.medpac.gov/chapters/Mar10_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/documents/MedPAC_Payment_Basics_09_MA.pdf

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

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

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

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