

SECTION

9

Medicare Advantage

Chart 9-1. MA plans available to virtually all Medicare beneficiaries

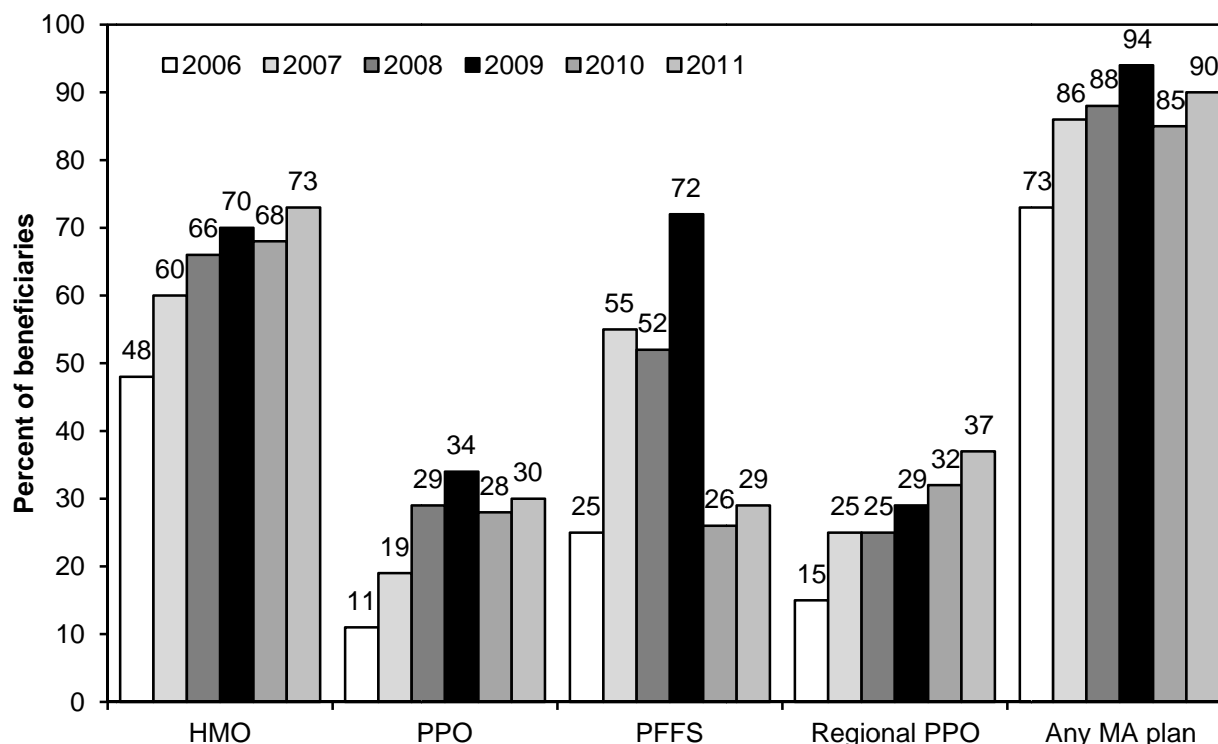
	CCPs			PFFS	Any MA plan	Average plan offerings per county
	HMO or local PPO	Regional PPO	Any CCP			
2005	67%	N/A	67%	45%	84%	5
2006	80	87	98	80	100	12
2007	82	87	99	100	100	20
2008	85	87	99	100	100	35
2009	88	91	99	100	100	34
2010	91	86	99	100	100	21
2011	92	86	99	63	100	12

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 coordinated care plans (CCPs.) Local CCPs include local preferred provider organizations (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. Private fee-for-service (PFFS) plans, which previously were not CCPs, are now (as of 2011) required to have networks in areas with two or more CCPs. In areas where there are not two or more CCPs, PFFS plans are not required to have networks and enrollees are free to use any Medicare provider.
- Local CCPs are available to 92 percent of Medicare beneficiaries in 2011—up from 67 percent in 2005. Regional PPOs are available to 86 percent of beneficiaries. The availability of Medicare Advantage (MA) PFFS plans has declined from 100 percent of beneficiaries in 2010 to 63 percent of beneficiaries in 2011. The decline is due to new provider network requirements in most of the country. For the past six years, virtually 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 2011 is about the same as in 2006. In 2011, beneficiaries can choose from an average of 12 plans operating in their counties. This number has continued to decrease since 2009, reflecting CMS's 2010 effort to reduce the number of duplicative plans and plans with small enrollment and the 2011 network requirements for PFFS plans.

Chart 9-2. Access to zero-premium plans with MA drug coverage, 2006–2011

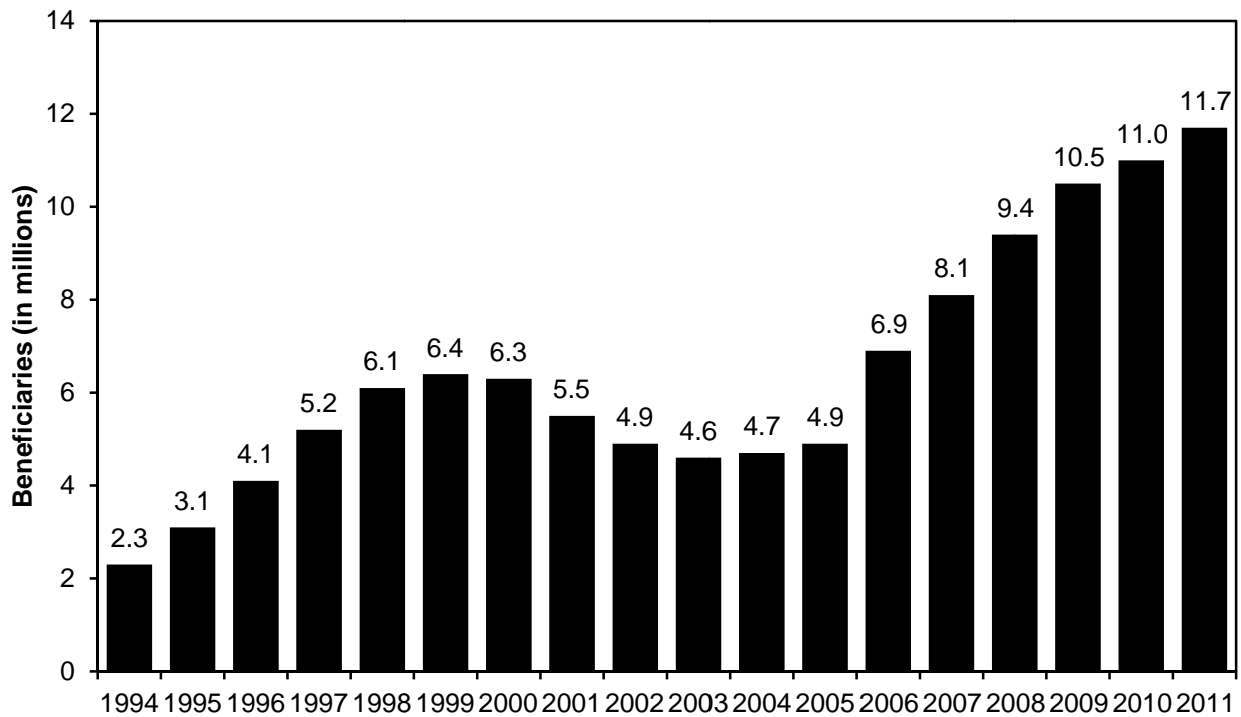


Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

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

- Across all plan types, the availability of “zero-premium” plans—plans with no premium payments other than the Medicare Part B premium—increased in 2011. More beneficiaries can obtain a Medicare Advantage–Prescription Drug (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 2011, 90 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 85 percent in 2010.
- Seventy-three percent of beneficiaries have zero-premium MA–PD HMOs available, while MA–PD preferred provider organizations (PPOs) without premiums are much less widely available. However, zero-premium regional PPOs are more available than they have been in the past. Private fee-for-service plans offering zero premiums and Part D drug coverage are available to 29 percent of beneficiaries in 2011.
- 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 9-3. Enrollment in MA plans, 1994–2011



Note: MA (Medicare Advantage).

Source: Medicare managed care contract 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 11.7 million enrollees (25 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. Medicare Advantage enrollment has increased steadily since 2003.

Chart 9-4. Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands)				Percentage change 2010–2011
	February 2008	February 2009	February 2010	February 2011	
Local CCPs	6,830	7,625	8,534	9,993	17%
Regional PPOs	257	377	760	1,132	49
PFFS	2,057	2,353	1,657	588	–65

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 coordinated care plans (CCPs) grew slower than enrollment in regional preferred provider organizations (PPOs) over the past year, while enrollment in private fee-for-service (PFFS) plans declined. Combined enrollment in the three types of plans grew by 7 percent from February 2010 to February 2011.
- While still the dominant form of enrollment, local CCP enrollment grew 17 percent over the past year, and enrollment in regional PPOs grew by 49 percent from a lower base. It is likely that much of the enrollment growth in local CCPs and regional PPOs came from the 65 percent decline in PFFS enrollment in the same time period.

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2011

State	Medicare eligibles (in thousands)	Distribution (in percent) of enrollees by plan type					Total
		HMO	Local PPO	Regional PPO	PFFS	Cost	
Alabama	844	13%	7%	1%	0%	0%	21%
Alaska	66	0	0	0	0	0	1
Arizona	872	35	2	1	1	0	40
Arkansas	532	5	2	2	5	0	15
California	4,744	34	0	2	0	0	37
Colorado	622	26	3	0	2	4	34
Connecticut	568	15	2	2	0	0	19
Delaware	149	2	1	0	0	0	4
Florida	3,339	24	1	7	0	0	32
Georgia	1,237	5	8	4	5	0	22
Hawaii	207	14	9	13	0	7	43
Idaho	229	10	14	0	5	1	29
Illinois	1,842	5	2	1	0	0	9
Indiana	1,007	1	7	7	2	0	17
Iowa	517	5	5	1	1	2	13
Kansas	433	3	5	1	2	1	11
Kentucky	761	3	4	8	1	1	17
Louisiana	686	21	1	1	2	0	24
Maine	265	7	6	0	1	0	13
Maryland	786	3	1	0	0	3	8
Massachusetts	1,061	15	2	1	0	0	18
Michigan	1,654	10	12	1	1	0	23
Minnesota	786	15	4	2	0	23	44
Mississippi	497	4	2	2	2	0	10
Missouri	1,003	14	4	1	3	0	22
Montana	170	0	7	1	7	0	15
Nebraska	279	5	2	1	3	1	12
Nevada	354	27	2	2	1	0	31
New Hampshire	219	0	1	0	5	0	6
New Jersey	1,329	12	1	0	0	0	13
New Mexico	313	18	7	0	1	0	26
New York	2,991	23	6	1	1	0	31
North Carolina	1,489	10	3	1	4	0	18
North Dakota	109	0	1	0	3	4	9
Ohio	1,899	14	8	10	1	1	34
Oklahoma	602	10	3	0	2	0	15
Oregon	618	22	19	0	0	0	42
Pennsylvania	2,277	24	12	0	1	0	38
Puerto Rico	660	60	8	0	0	0	69
Rhode Island	183	27	1	6	0	0	35
South Carolina	774	2	5	5	4	0	16
South Dakota	137	0	3	1	3	2	9
Tennessee	1,056	20	4	1	1	0	25
Texas	3,001	14	2	2	1	1	20
Utah	283	16	13	0	5	1	35
Vermont	112	0	1	2	2	0	5
Virginia	1,144	2	4	1	5	1	14
Washington	969	19	5	0	1	0	26
Washington, DC	78	2	1	0	0	7	10
West Virginia	380	1	6	10	2	3	23
Wisconsin	911	14	8	3	2	3	30
Wyoming	80	0	1	0	3	1	6
U.S. total	47,123	17	5	2	1	1	26

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, 2010–2011.

- 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 Puerto Rico, Minnesota, Hawaii, and Oregon, with 69 percent, 44 percent, 43 percent, and 42 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 private fee-for-service (PFFS) plans, while other states have little or none of their enrollment in PFFS plans.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2011

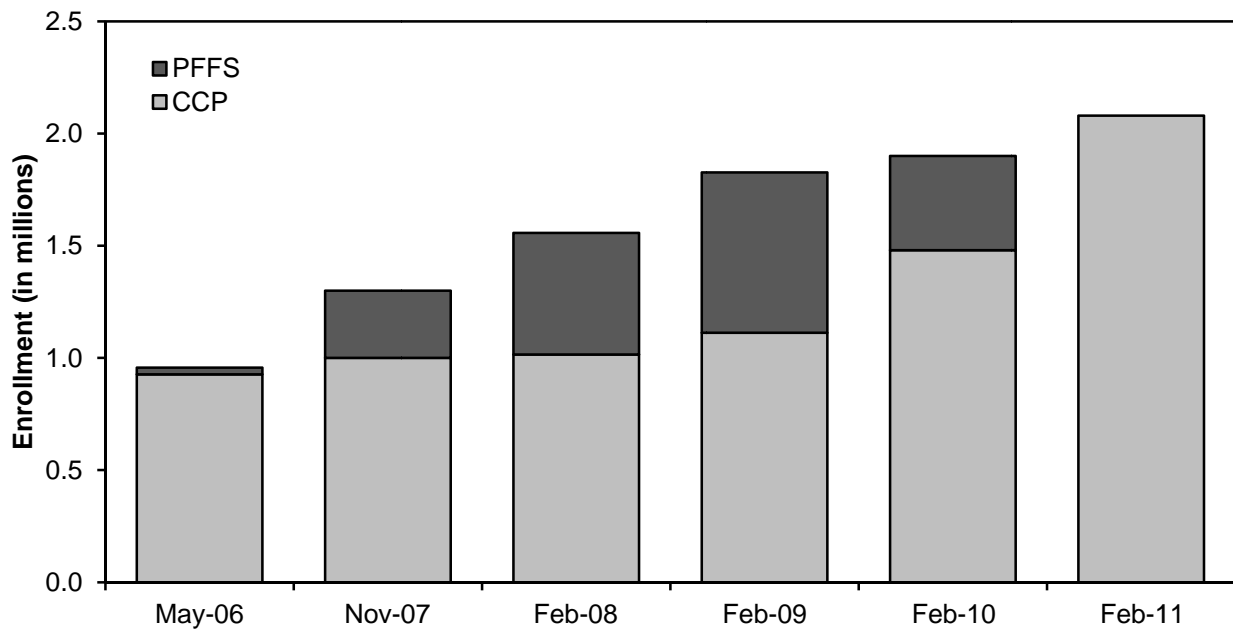
	All Plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	113%	113%	116%	110%	116%
Bids/FFS	100	97	109	104	110
Payments/FFS	110	109	114	110	114

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

Source: MedPAC analysis of plan bid data from CMS, November 2010.

- 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 113 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 2011 MA payments will be 110 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 Medicare Advantage plan. HMOs and regional preferred provider organization (PPO) payments are estimated to be 109 percent and 110 percent of FFS, respectively, while payments to private fee-for-service and local PPOs will average 114 percent.

Chart 9-7. Enrollment in employer group MA plans, 2006–2011

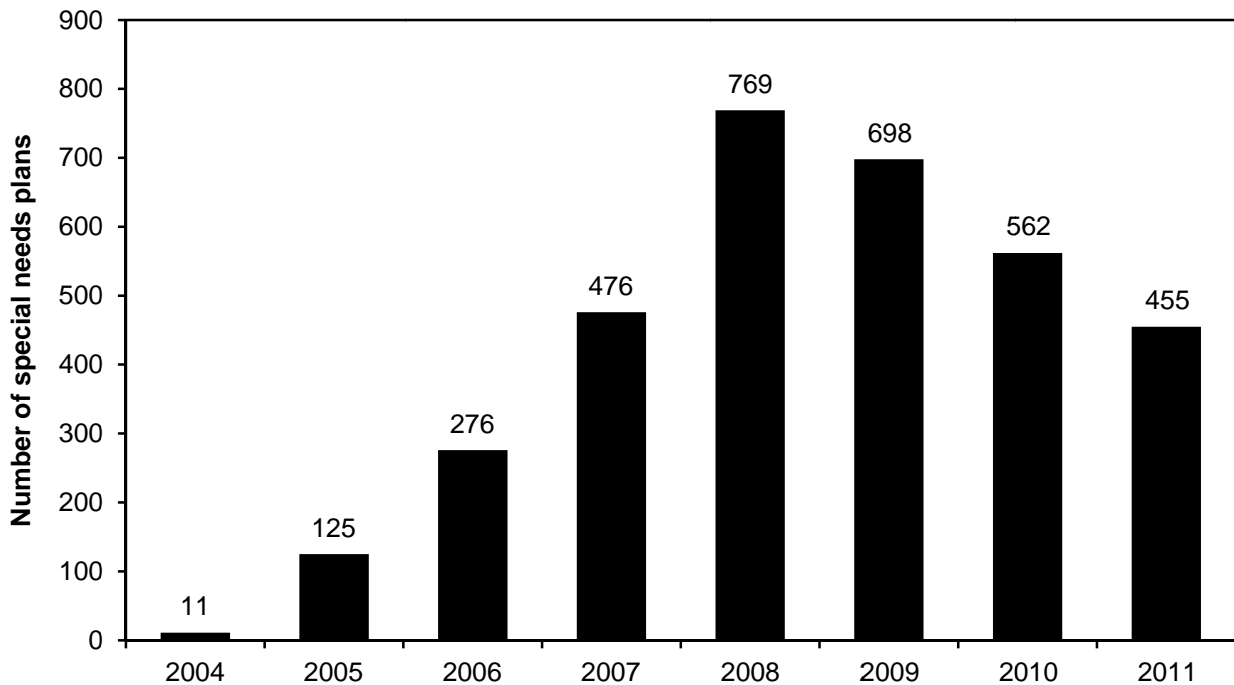


Note: MA (Medicare Advantage), PFFS (private fee-for-service), CCP (coordinated care plan).

Source: CMS enrollment data.

- While most Medicare Advantage (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 five years, enrollment in employer group plans has more than doubled, while overall MA enrollment grew by about 65 percent. As of February 2011, about 2.1 million enrollees were in employer group plans, or about 18 percent of all MA enrollees.
- Under a requirement in the Medicare Improvements for Patients and Providers Act of 2008, employer group plans were required to have networks and after 2010 could no longer be private fee-for-service (PFFS) plans.
- Our analysis of MA bid data shows that employer group plans on average have bids that are higher relative to FFS spending than individual plans, meaning that group plans appear less efficient than individual market MA plans. Employer group plans bid an average of 108 percent of FFS, compared with 99 percent of FFS for individual plans (not shown in chart above).

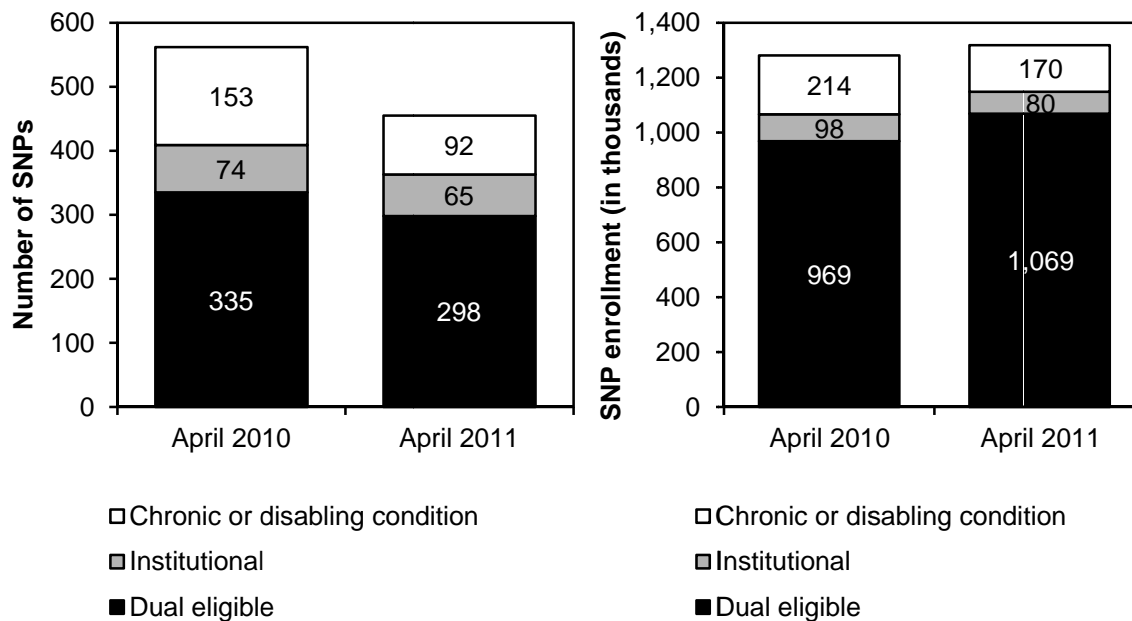
Chart 9-8. Number of special needs plans continues to decline from 2008 peak



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, April 2010, and April 2011.

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 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 2011, there are 455 SNPs. As is the case with all MA plans, this number marks a steady decrease from 2008 as CMS has made efforts 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 congressional action, SNP authority will expire at the end of 2014.

Chart 9-9. Number of SNPs decreased while SNP enrollment rose from 2010 to 2011



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2010 and 2011.

- Although the number of special needs plans (SNPs) decreased by 19 percent from April 2010 to April 2011, the number of SNP enrollees increased by 3 percent.
- In 2011, most SNPs (66 percent) are for dual-eligible beneficiaries, while 20 percent are for beneficiaries with chronic conditions, and 14 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 2011.
- The availability of SNPs has changed slightly and varies by type of special needs population served. In 2011, 76 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (down from 79 percent in 2010), 47 percent live where SNPs serve institutionalized beneficiaries (down from 49 percent), and 46 percent live where SNPs serve beneficiaries with chronic conditions (down from 63 percent).

Web links. Medicare Advantage

- Chapter 12 of MedPAC's March 2011 Report to the Congress provides information on Medicare Advantage plans.

http://www.medpac.gov/chapters/Mar11_Ch12.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_10_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/>