CHAPTER 3

The Medicare Advantage program

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Chapter summary

The Medicare Advantage (MA) program provides Medicare beneficiaries with an alternative to the fee-for-service (FFS) Medicare program. It enables them to choose a private plan to provide their health care. Those private plans can use alternative delivery systems and care management techniques, and—if paid appropriately—they have the incentive to innovate. The Commission supports private plans in the Medicare program but has concerns about the current MA payment system.

In our analyses of data on enrollment, availability, payments, benefits, and quality, we find:

- About 22 percent of Medicare beneficiaries were enrolled in MA plans in 2008. All beneficiaries have access to an MA plan in 2009, with an average of 34 plans available in each county. In 2009, 88 percent of Medicare beneficiaries have an HMO or local preferred provider organization plan in their county, and all beneficiaries have a private fee-for-service (PFFS) plan available.

In this chapter

- Current status of the MA program
- High benchmarks increase payments and distort incentives
- Conclusion

- In 2009, payments to MA plans continue to exceed what Medicare would spend for similar beneficiaries in FFS. MA payments per enrollee are projected to be 114 percent of comparable FFS spending for 2009, compared with 113 percent in 2008. This added cost contributes to the worsening long-range financial sustainability of the Medicare program.
- In aggregate, the MA program continues to be more costly than the traditional program. Plan bids for the traditional Medicare benefit package are 102 percent of FFS in 2009, compared with 101 percent of FFS in 2008. As an exception, HMOs continue to bid below FFS, bidding 98 percent of FFS in 2009.
- MA plans provide enhanced benefits to enrollees, but, except for HMOs (which finance a portion of those benefits through bids below FFS), the enhanced benefits are financed entirely by the Medicare program and by beneficiaries—and at a high cost. For example, each dollar's worth of enhanced benefits in PFFS plans costs the Medicare program more than $3.00.
- Quality is not uniform among MA plans or plan types. High-quality plans tend to be established HMOs; plans that are new in the MA program have lower performance on many measures.

We are concerned that the average MA bid for Medicare Part A and Part B services is above average FFS spending and increasing. Thus, in aggregate, enhanced benefits are funded by the taxpayers and all beneficiaries (whether they belong to MA plans or not), rather than being funded through savings achieved as a result of plan cost efficiencies. In addition, a portion of the value of the enhanced benefits consists of funds used for plan administration and profits and not direct health care services for beneficiaries. Paying a plan more than the cost for delivering the same services under the FFS system is not an efficient use of Medicare funds, particularly in the absence of evidence that such extra payments result in better quality compared to FFS.

To be clear, even though we are using the FFS Medicare spending level as a measure of parity for the MA program, it should not be taken as a conclusion that the Commission believes FFS Medicare is an efficient delivery system in most markets. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements to the program.

Current MA payment rates allow plans to be less cost efficient than they would be if they faced the financial pressure of payments closer to Medicare FFS levels. As the Commission has stated in the past, organizations are more likely to be efficient when they face financial pressure. The Medicare program needs to exert consistent financial pressure on both the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance programs, to maximize value for each dollar it spends. The Commission has made recommendations in previous years to further these aims in the MA program, and those recommendations are reiterated in this chapter. ■

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. The Commission supports private plans in the Medicare program, as they enable beneficiaries to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have greater ability to innovate and to use care management techniques and, if paid appropriately, would have the incentive to do so.

However, the Commission also supports financial neutrality between FFS and the MA program. Financial neutrality means that the Medicare program should pay the same amount for a defined set of services regardless of which Medicare option a beneficiary chooses. Currently, Medicare spends more under the MA program for similar beneficiaries than it does under FFS. This higher spending results in increased government outlays and beneficiary Part B premiums (including for those who are in traditional Medicare FFS) at a time when Medicare and its beneficiaries are under increasing financial stress. To encourage efficiency and innovation, MA plans need to be put under financial pressure, just as the Commission advocates for providers in the traditional FFS program.

Current status of the MA program

By some measures, the MA program appears to be successful, but excessive payment rates preclude the program from achieving desired efficiencies. MA plans are widely available to beneficiaries, plans provide enhanced benefits for their members, and MA enrollment continues to grow. However, taxpayers and beneficiaries in traditional FFS subsidize these benefits, often at a high cost.

Our analysis of the MA program uses the most recent data available and reports it by plan type. The plan types are:

- ***HMOs and local preferred provider organizations (PPOs)***. These plans have provider networks and can use tools such as selective contracting and utilization management to coordinate and manage care. These plans can choose to serve individual counties and can vary their premiums and benefits across counties.
- ***Regional PPOs.*** Regional PPOs are required to serve and offer a uniform benefit package and premium across designated regions made up of one or more states. They are the only plan type required to have limits, or caps, on out-of-pocket expenditures. Regional PPOs have less extensive network requirements than local PPOs.
- ***Private FFS (PFFS) plans (and plans tied to medical savings accounts (MSAs)).*** These plans typically do not have provider networks. They use Medicare FFS payment rates, have fewer quality reporting requirements, and have less ability to coordinate care than other types of plans.
- ***Coordinated care plans (CCPs).*** CCP is a larger grouping, which includes all HMOs, local PPOs, and regional PPOs.

Two additional plan classifications cut across plan types. First are special needs plans (SNPs), which offer benefits packages tailored to specific populations (i.e., beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have a chronic condition). SNPs must be CCPs. Second are employer group plans, which are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. Employer group plans may be any plan type. Both SNPs and employer group plans are included in our plan data, with the exception of availability figures, as these plans are not available to all beneficiaries.

Plan enrollment grew in 2008

From November 2007 to November 2008, enrollment in MA plans grew by 16 percent, or 1.4 million enrollees (Table 3-1, p. 256). About 9.9 million Medicare beneficiaries, or 22 percent, are now enrolled in MA plans.

Enrollment patterns differ in urban and rural areas. The share of MA enrollment among urban Medicare beneficiaries (about 25 percent) continues to be greater than MA enrollment among Medicare beneficiaries residing in rural counties (about 13 percent), even though plan enrollment grew at a faster rate in rural areas (about 30 percent) than in urban areas (about 15 percent) between 2007 and 2008.[1] As of last year, 54 percent of rural plan enrollees were in PFFS plans (not shown in Table 3-1), compared with about 17 percent of urban enrollees.

Enrollment growth in 2008 continues the trend since 2003 (Figure 3-1, p. 256). Enrollment has more than doubled in the last five years. Some plan types have grown more rapidly than others. Since 2005, PFFS has grown 11-fold and CCPs have grown by 50 percent. This rapid PFFS growth has occurred at the same time this type of plan experienced a high rate of disenrollment. The Government

TABLE 3–1

Medicare Advantage enrollment grew rapidly in 2008

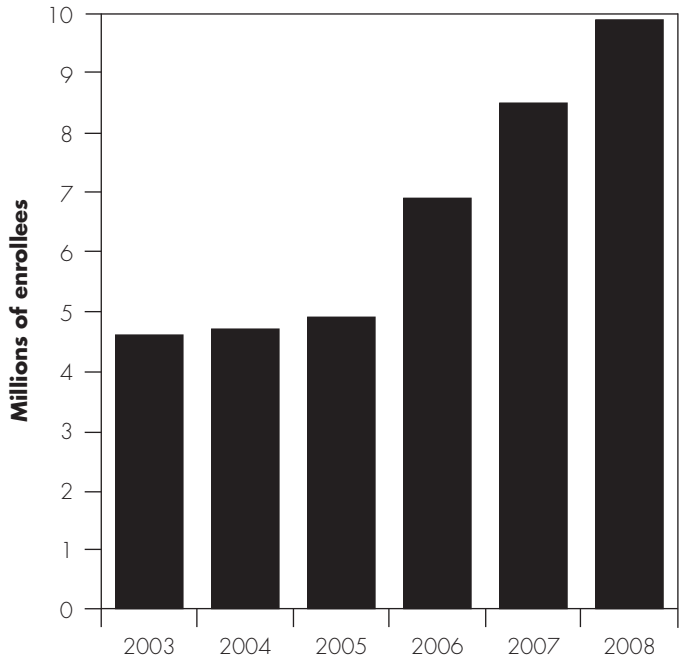
	MA enrollment (in millions)		Percent change	2008 MA enrollment as a share of total Medicare
	November 2007	November 2008		
Total	8.5	9.9	16%	22%
Urban	7.4	8.5	15	25
Rural	1.1	1.4	30	13
Plan type				
CCP	6.8	7.6	12	17
HMO	6.1	6.5	7	15
Local PPO	0.4	0.7	53	2
Regional PPO	0.2	0.3	37	1
PFFS	1.7	2.3	35	5
Restricted availability plans included in totals above				
SNPs*	1.1	1.3	21	3
Employer group*	1.3	1.7	30	4

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNPs (special needs plans). CCP includes HMO, local PPO, and regional PPO. Totals may not sum due to rounding.
* SNPs and employer group plans have restricted availability and their enrollment is included in the statistics by plan type and location. They are presented separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

FIGURE 3–1

Medicare Advantage enrollment continues to grow rapidly



Source: CMS monthly Medicare Advantage enrollment reports.

Accountability Office (GAO) found that in 2007 the disenrollment rate for PFFS plans was 21 percent. This rate was much higher than for other types of plans, which averaged 9 percent (GAO 2008a). Examining this disparity in disenrollment rates may be a fruitful area for future analysis.

HMOs continue to enroll the most beneficiaries of all plan types, with 15 percent of all Medicare beneficiaries now in HMOs. All plan types (HMO, PPO, and PFFS) had enrollment growth in 2008. In 2008, PFFS had about 2.3 million enrollees, an increase of 35 percent since 2007. CCP enrollment grew 12 percent, or by about 800,000 enrollees since 2007. SNP enrollment and employer group enrollment have also continued to grow rapidly.

Plan availability remains high for 2009

Access to MA plans remains high in 2009, giving Medicare beneficiaries access to a large number of plans. While all beneficiaries have had access to some type of MA plan since 2006, local CCP plans are more widely available in 2009 than in previous years (Table 3-2). In 2009, 88 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence,

TABLE 3–2

Access to Medicare Advantage plans remains high

Type of plan	Percent of beneficiaries with access to plan type				
	2005	2006	2007	2008	2009
All plan types	84%	100%	100%	100%	100%
CCP					
Local HMO or PPO	67	80	82	85	88
Regional PPO	N/A	87	87	87	91
PFFS	45	80	100	100	100
MSA	0	0	77	100	68
Zero-premium plans with Part D	N/A	73	86	88	94
Average number of MA plans open to all beneficiaries in a county	5	12	20	35	34

Note: CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service), MSA (medical savings account), MA (Medicare Advantage). These figures exclude special needs plans and employer-only plans. A zero-premium plan with Part D includes Part D coverage and has no premium beyond the Part B premium. Regional PPOs were created in 2006. Part D began in 2006.

Source: MedPAC analysis of MA/SNP Landscape File.

up from 85 percent in 2008 and 67 percent in 2005. Similarly, access to regional PPOs has also increased, up from 87 percent in 2008 to 91 percent in 2009. PFFS plans continue to be available to all beneficiaries.[2]

In 2009, high-deductible plans linked to MSAs are available to 68 percent of Medicare beneficiaries. This value represents a drop in availability, due to one plan that had been available nationwide in 2008 leaving the program. As of November 2008, about 3,000 Medicare beneficiaries were enrolled in MSA-linked plans. MSAs were available for the first time in 2007. (See MedPAC's March 2007 report for a more detailed description of MSA plans.)

In 2009, 94 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D drug coverage and has no premium (beyond the Medicare Part B premium) compared with 88 percent in 2008.

On average, 34 plans are offered in each county in 2009, down slightly from the historic high of 35 plans in 2008. The slight decrease is due to fewer PFFS choices, despite an increase in CCP options. The number of plans varies significantly across counties. For example, in Miami, beneficiaries can choose from 89 plans, while a few counties have only one.

The availability of SNPs (not shown in Table 3-2) remains largely stable and varies by type of special need. In 2009, 76 percent of beneficiaries reside in areas where SNPs serve beneficiaries dually eligible for Medicare and Medicaid, 53 percent live where SNPs serve institutionalized beneficiaries, and 72 percent live where SNPs serve beneficiaries with chronic conditions. Only the last type decreased in availability—down from 89 percent in 2008 because of the withdrawal of one plan from the MA program.

Payment to plans continues to exceed Medicare FFS spending for similar beneficiaries in 2009

Plan payment rates are determined by the MA plan "bid" (the dollar amount the plan estimates will cover the Part A and Part B benefit for a beneficiary of average health status) and the "benchmark" in that payment area (the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits). If a plan's bid is above the benchmark, then the plan's payment rate is equal to the benchmark, and enrollees have to pay an additional premium equal to the difference. If a plan bid is below the benchmark, the plan's MA payment rate is its bid plus 75 percent of the difference between the plan's bid and its benchmark. Because benchmarks are often set well above what it costs Medicare to provide benefits to similar beneficiaries in the traditional FFS program, MA payment rates usually exceed FFS spending. In a later section, we examine why benchmarks are above FFS spending and what the ramifications are for the Medicare program. (Actual plan

TABLE 3–3

Medicare Advantage payments exceed FFS spending for all plan types in 2009

Plan type	Enrollment November 2008 (in millions)	Percent of FFS spending in 2009		
		Benchmarks	Bids	Payments
All MA plans	9.9	118%	102%	114%
HMO	6.5	118	98	113
Local PPO	0.7	121	108	118
Regional PPO	0.3	114	106	112
PFFS	2.3	120	113	118
Restricted availability plans included in totals above				
SNP*	1.3	122	99	116
Employer groups*	1.7	117	109	115

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans. FFS spending by county is estimated using the 2009 MA rate book. Spending related to the double payment for indirect medical education payments made to teaching hospitals was removed. Totals may not sum due to rounding.
*SNPs and employer group plans have restricted availability and their enrollment is included in the statistics by plan type. They are presented separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

payments, as opposed to payment rates, are risk adjusted. A more detailed description of the MA program payment system can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_MA.pdf.)

We estimate that, on average, 2009 MA benchmarks will be 118 percent of spending in Medicare's traditional FFS program, bids will be 102 percent of FFS spending, and payments will be 114 percent of FFS spending (Table 3-3). (Benchmarks, bids, and payments are weighted by plan enrollment by county to estimate overall averages and averages by plan type.) Last year we estimated that, for 2008, benchmarks, bids, and program payments would be, respectively, 118 percent, 101 percent, and 113 percent. In 2009, the Medicare program is paying about $12 billion more for the beneficiaries enrolled in MA plans than it would have spent if they were in FFS Medicare. (We include plans in Puerto Rico in our totals although the MA market there has some unusual characteristics. The statute set benchmarks in Puerto Rico effectively at 180 percent of FFS expenditures. Excluding Puerto Rico from the overall statistics in the updated analysis results in benchmarks of 117 percent (rather than 118 percent) of FFS and puts MA payments at 113 percent (rather than 114 percent) of FFS.)

Benchmarks by plan type vary depending on the counties the plans serve and where they draw their enrollment. By law, certain counties were given higher benchmarks to increase plan availability. Those counties, called "floor" counties, have benchmarks that average 120 percent of FFS spending, whereas nonfloor counties' benchmarks average 112 percent of FFS spending. Local PPOs and PFFS plans tend to operate in counties with higher benchmarks than other plan types. Local PPOs draw more heavily from urban floor counties and PFFS plans draw more heavily from rural floor counties. SNPs have the highest benchmarks relative to FFS because they draw heavily from Puerto Rico, which has very high benchmarks relative to FFS (180 percent).

Plan bids also vary by plan type from the overall average of 102 percent of FFS spending. We estimate that HMO bids were on average 98 percent of FFS spending. This suggests that HMOs can provide Part A and Part B services for less than the cost of FFS. Plan bid averages for other plan types exceeded the overall average. PFFS plan bids average 113 percent of FFS, an increase from 108 percent in 2008.

In 2009, the ratio of payments relative to FFS spending will vary by the type of MA plan, but the ratios for all plan types are substantially higher than 100 percent. We estimate that 2009 payments to plans overall will average 114 percent of FFS spending. HMO payments are estimated to average 113 percent of FFS, while payments to PFFS plans are estimated to average 118 percent. These payment ratios are each a percentage point higher than we estimated for 2008.[3]

We separately analyzed bids and payments to SNPs and employer group plans, because their bidding behavior differs from that of other plan types. Payments to SNPs are estimated to average 16 percent above FFS spending because the plans have high benchmarks. Notably, 86 percent of SNP enrollees are in HMOs, but the average SNP payment is higher than that of HMOs as a group because, in 2008, about 16 percent of all SNP enrollees lived in Puerto Rico, which has high benchmarks. (Average SNP benchmarks, without Puerto Rico, are projected to be 117 percent rather than 122 percent; SNP program payment levels would have been projected to be 112 percent rather than 116 percent of FFS if Puerto Rico had been excluded.)

Employer group plans consistently bid higher than plans open to all Medicare beneficiaries. In aggregate, their bids are 9 percent above FFS spending—higher than all but PFFS plans—and their payments are estimated to average 15 percent above FFS spending. The dynamic of the bidding process for employer group plans is more complicated, because these plans can negotiate the specific benefits and premiums with employers after the Medicare bidding process is complete. Conceptually, the closer the bid is to the benchmark the better it is for the plans and the employer, because a higher bid brings in more revenue from Medicare, potentially offsetting expenses that would have required a higher pay-in from employers. Excluding the employer group plans from our calculations would lower the average MA bid to 100 percent of FFS from 102 percent and would lower the average HMO bid from 98 percent to 96 percent.

Enhanced benefits are common but costly for Medicare

Enhanced benefits—benefits beyond those provided under traditional FFS Medicare—are built into the MA program payment system. As described above, when a plan bids below the payment area benchmark, 75 percent of the difference between the plan's bid and the benchmark—both adjusted for the health status of the plan's projected enrollees—is paid to the plan, but the plan must use that amount to fund enhancement of the MA benefit for its enrollees.[4] The remaining 25 percent of the difference is deducted from the benchmark to compute the total plan payment. (For example, if a payment area's benchmark is 110 percent of FFS and a plan serving the area bids 100 percent of FFS, 7.5 percentage points of the difference would be used to fund benefit enhancements and 2.5 percentage points would be subtracted from the benchmark to yield a payment to the plan of 107.5 percent of FFS.) The enhancements to the benefit package that the law allows MA plans to provide are:

- reduction of cost sharing for Medicare Part A and Part B services;
- provision of added, non-Medicare benefits, such as routine dental and vision care;
- reduction of the Part D premium of a Medicare Advantage–Prescription Drug (MA–PD) plan;
- enhancement of the drug benefit in an MA–PD plan; or
- reduction of the member's Part B premium.

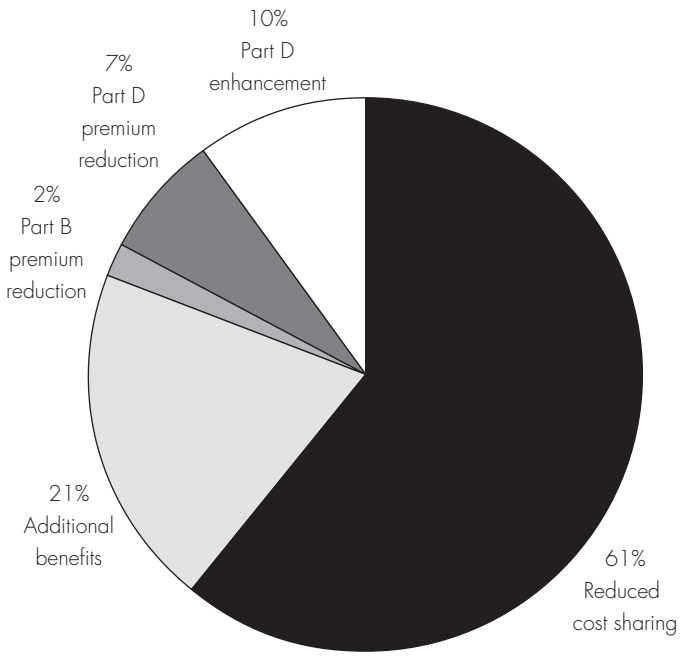
By far, the most common benefit enhancement by dollar value is the reduction of cost sharing for Medicare Part A and Part B services—that is, lower out-of-pocket spending at the point of service or lower premiums charged for Medicare cost sharing (Figure 3-2, p. 260). Provision of additional benefits is the next most common benefit enhancement.

There are three components of the plan's bid: medical expenses (estimated costs of providing Medicare Part A and Part B services to the expected enrollee population), administrative costs, and margins (profits or losses).[5] The last two components—administrative costs and the plan margin—are referred to as the "load" or loading factor. A "fully loaded" cost includes all three bid components. Across all MA plans for 2009, the enrollment-weighted average loading factor is projected to be 13.4 percent. Thus, on average medical expenses would be 86.6 percent of the bid and the load would be 13.4 percent of the bid.

This projection could be an underestimate. The GAO found in 2006 that actual (not projected) profits were 6.6 percent and nonmedical expenses were 10.1 percent, for a load totaling 16.7 percent. At the time of the bid submissions for 2006, the load was projected to be 13.1 percent. A similar result was found for 2005 projected and actual profits and nonmedical expenses (GAO 2008b).

When the plan's bid requires the plan to provide enhanced benefits, such benefits have a load factor applied. With respect to the reduction of Medicare Part A and Part B cost sharing and for the added, non-Medicare benefits, the load factor is the same for these enhancements as it is for Part A and Part B medical expenses in the bid. For the reduction in the Part B premium, no load factor applies. In the case of Part D benefits—premium reduction or benefit

FIGURE 3–2 **Reduced cost sharing is the most common benefit enhancement**



Note: Values are given as a percentage of the average total dollar value of benefit enhancements. Total may not sum to 100 percent due to rounding.

Source: CMS plan bids for 2009.

enhancement—a load factor is a component of the Part D bid, not the Part A and Part B bid.

The level of benefit enhancements available to MA enrollees varies by plan type (Table 3-4). As we mentioned earlier, MA plans in aggregate are paid more than Medicare would have spent if those enrollees were in FFS. The first column in Table 3-4 is the average payment to plans in excess of Medicare FFS, expressed in dollars per member per month (PMPM). For MA plans overall, the excess is $103 PMPM. Fourteen dollars of that amount subsidizes the plan's cost of providing the traditional Part A and Part B benefit, and the remainder ($89 PMPM) is the enhanced benefit plus load (an amount that varies from $0 to $441 across non-SNP plans). The amount spent on enhanced benefits varies by plan type, with HMOs spending $115 PMPM (benefit plus load), almost three times the $40 PMPM for PFFS plans. Adjusting for the average loading factor (subtracting the average amount of administrative costs and margin associated with the enhanced benefits) reduces the $89 PMPM to $79 PMPM. This amount is the estimated value of the enhanced benefits the average enrollee will receive.[6] The last column in Table 3-4 shows payment above FFS divided by the value of the enhanced benefit; this value represents the Medicare subsidy per dollar of enhanced benefit—$1.30 for all plans. In the case of HMOs, shown in the second row, because their bids for the Medicare benefit package are below Medicare FFS spending, the program subsidy is 97 cents for each $1.00 of enhanced benefits. In the case of PFFS plans, on average, the program subsidy is $3.26 for each dollar of enhanced benefits. In other words, HMOs are the only MA plan type that finances any part of enhanced benefits through plan efficiencies: 3 cents of every dollar. Enhanced benefits in other plan types are completely subsidized by Medicare.

Quality

Paying a plan more than the cost for delivering the same services under the FFS system is not an efficient use of Medicare funds, particularly in the absence of evidence that such extra payments result in better quality compared to FFS. However, making such a determination is difficult, because the indicators of quality differ greatly among plans and across plan types in MA, and we currently do not have a basis for comparing plan performance with the quality of care in FFS Medicare. The Commission is investigating how to compare quality in MA and FFS, and we plan to issue a report on that topic as mandated by the Congress in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

MA plan quality varies

At an aggregated level, Table 3-5 shows that performance by plan types differs according to CMS's relative rankings of health plans. CMS ranks MA plans by using a star rating system that summarizes performance on the Healthcare Effectiveness Data and Information Set (HEDIS®), the Consumer Assessment of Health Care Providers and Systems, the Health Outcomes Survey (HOS), and other plan performance indicators that CMS monitors.[7] The maximum rating is five stars for CMS's "summary rating of health plan quality." About 36 percent of all plans had a rating of 3.5 stars or better in 2008; 51 percent of established HMOs (those that have been Medicare contractors since 2003 or earlier) had a rating of 3.5 stars or better in 2008 compared with 21 percent of new HMOs (those that began contracting with Medicare in 2004 or later).[8]

TABLE 3–4

Enhanced benefits and Medicare subsidy differ by plan type, 2009

Plan type	Payment above FFS (per member per month)	Enhanced benefit (per member per month)		Medicare subsidy per dollar of enhanced benefits
		Benefit plus load	Benefit only	
All MA plans	$103	$89	$79	$1.30
HMO	99	115	102	0.97
Local PPO	111	65	58	1.91
Regional PPO	87	44	39	2.23
PFFS	114	40	35	3.26

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service). Load is the sum of projected administrative costs and profits from plan bids. Medicare subsidy is the payment above FFS divided by benefit. The benefit only column slightly overstates the net value because we do not take into consideration the Part D load when the benefit enhancement is a drug benefit enhancement.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

PPOs and PFFS plans are subject to different quality reporting requirements than HMOs. Non-HMO plans are currently not permitted to use medical record review for reporting their performance on certain HEDIS measures. This situation will change in 2010, when all plan types will use medical record review for certain measures. In Table 3-6 (p. 262), for example, the hemoglobin A1c testing is a measure for which HMOs use medical record review. Because HEDIS scores are a component of the CMS star rating system, the potentially lower HEDIS scores of non-HMO plans for the 13 measures (out of 48 total measures in 2008) that are "hybrid" measures (those for which medical record review only occurs among HMOs) also affect the plans' CMS star ratings.

HEDIS

The pattern of quality differences between established and new HMOs is further illustrated by comparing plan performance on HEDIS measures—a set of process and outcomes measures that plans report. As was the case last year for year-to-year changes, established plans showed more improvement between 2007 and 2008 than newer plans (Table 3-5). Comparing the simple average score across all plans reporting a measure for each year, 75 percent of established HMOs showed improvement for 38 HEDIS measures for which we have data in each year, compared to a little over 50 percent for newer HMOs that can be compared to the set of established plans (i.e., HMOs that are new to the MA program reporting on the same measures). By contrast, commercial HMOs showed more improvement in average HEDIS scores, as was true last year (NCQA 2008b).

TABLE 3–5

Aggregate MA quality differs by plan type

Plan type	Percent of plans with a CMS rating of 3.5 stars or above	Percent of 38 HEDIS® measures showing improvement (2007–2008)
All MA plans	36%	40%
HMO		
Established	51	75
New	21	50
Plans subject to different reporting requirements		
PPO	27*	N/A
PFFS	N/A*†	N/A

Note: MA (Medicare Advantage), HEDIS® (Healthcare Effectiveness Data and Information Set), PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not available). Established HMOs are plans beginning Medicare operations in 2003 or earlier; new HMOs are plans beginning as Medicare contractors in 2004 or later. CMS's maximum star rating is 5.0, with 4.0 defined as very good and 3.0 as good. Rating shown is for "summary rating of health plan quality." Out of 616 plans in 2008, 336 participated in HEDIS® reporting (including 14 out of 47 PFFS plans that reported on a voluntary basis). Not all plans report every HEDIS® measure. *For some HEDIS® measures, HMOs supplement their administrative information with medical record review to potentially improve their scores, while PPOs and PFFS plans currently are not permitted to use medical record information. Because the CMS star ratings include performance on HEDIS® measures, PPO and PFFS star ratings are affected by their inability to use medical record information for the 13 HEDIS® measures (out of 41 total effectiveness of care measures in 2008) that are "hybrid" measures. † Only 11 PFFS plans have star ratings in the CMS data, with one plan at 3.5 and the rest below.

Source: MedPAC analysis of HEDIS® public use files and CMS plan ratings.

TABLE 3–6

MA performance on individual quality measures differs by plan type

HEDIS® 2008 rates on selected individual measures for reporting plans

Plan type	HbA1c testing*	Annual monitoring for patients on persistent medications	Breast cancer screening, ages 52-69	Glaucoma screening
All MA plans	86%	85%	67%	60%
HMO				
Established	90	86	71	64
New	85	81	62	51
Plans subject to different reporting requirements				
PPO	82*	87	65	62
PFFS	77*	81	57	48

Note: MA (Medicare Advantage), HEDIS® (Healthcare Effectiveness Data and Information Set), HbA1c (hemoglobin A1c), PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not available). Established HMOs are plans beginning Medicare operations in 2003 or earlier; new HMOs are plans beginning as Medicare contractors in 2004 or later. Out of 616 plans in 2008, 336 participated in HEDIS® reporting (including 14 out of 47 PFFS plans that reported on a voluntary basis). Not all plans report every HEDIS® measure. All 336 plans reported the HbA1c testing measure; 97 percent reported the monitoring of medications measure; 91 percent reported the breast cancer screening rate; and 94 percent reported the glaucoma measure.
*The HbA1c testing measure is a "hybrid" measure for which HMOs supplement their administrative information with medical record review to potentially improve their scores, while PPOs and PFFS plans currently are not permitted to use medical record information.

Source: MedPAC analysis of HEDIS® public use files and CMS plan ratings.

Performance varies across plan types within MA (Table 3-6). The MA data for 2008 include HEDIS scores reported by HMOs, PPOs, and—for the first time—PFFS plans (with PFFS reporting on a voluntary basis). The scores for established HMOs on individual HEDIS measures are generally higher than for each of the other plan categories (in part because of the inability of PPO and PFFS plans to use medical record information in reporting their scores for hybrid measures). However, for some measures PPO plans have scores equal to or higher than HMO plans, which may reflect the administrative capabilities of PPO plans in tracking claims data. We would also note that about half of the PPOs in the HEDIS data are operated by organizations that offer Medicare HMOs in the same geographic area or an overlapping area. As in past years, we also continue to see large variations in reported HEDIS scores across plans within plan types (not shown in Table 3-6).

There are three important caveats to consider when interpreting the overall performance of the MA program as measured by average HEDIS scores:

- First, there are many new plans in the 2008 data, and newer plans have poorer performance on many measures. For 2008, 69 plans reported Medicare HEDIS results for the first time, and another 119 plans began Medicare operations in 2004 or later, with the remaining 148 plans—less than half the total of 336—being established plans.
- Second, scores are not enrollment weighted. Almost all of the established plans are HMOs, and they continue to serve the majority of MA enrollees in 2008. Thus, enrollment weighting would raise the overall score. However, most of the enrollment growth is in newer plans, which again makes interpretation of overall score changes between years more complicated.
- Third, not all MA plans report HEDIS data. Plans must have participated in the program for a certain period of time and must meet a minimum enrollment threshold before they are required to report HEDIS measures. Almost half of current MA plans—280 out of 616 as of 2008—are not yet reporting HEDIS data, including 145 HMO plans. Thus, the overall scores do not represent the total picture of MA plan quality.

PFFS plans will not be required to report HEDIS results until 2010. However, PFFS plans currently may voluntarily report HEDIS results, and CMS has encouraged plans to do so. The 2008 HEDIS public use files from CMS contain PFFS reporting on many measures

from 14 PFFS contracts. The 14 PFFS plans account for about half of the total enrollment in PFFS. For each of 41 care-related HEDIS measures, on average about half of the 14 PFFS plans are reporting a score. HEDIS scores for PFFS are generally lower than scores for other plan types.

HOS results

The HOS measures changes in the health status of plan enrollees over a two-year period. It identifies which plans had better than expected improvement over the two years, which plans performed as expected, and which plans performed worse than expected.[9] Ninety percent of MA plans have outcomes within the expected range. Looking at the most recent cohort, which measured change in health status from 2005 to 2007, 7 plans had better than expected physical health outcomes and 11 were worse; 8 plans had better than expected mental health outcomes and 6 were worse. This result is an improvement over the 2004 to 2006 cohort for which the statistics were: 2 plans of 151 had better than expected physical health outcomes and 13 were worse; 5 plans had better than expected mental health outcomes and 7 were worse.

National Committee for Quality Assurance overall performance of health plans on quality measures

The National Committee for Quality Assurance (NCQA), in conjunction with *US News and World Report*, publishes a national ranking of health plans based on composite scores derived from HEDIS and other sources (NCQA 2008a). For 2008, the highest ranked Medicare plans tended to be long-established Medicare plans, with all having at least six years of Medicare contract experience. They all have commercial membership and generally are top-rated commercial plans as well. The top-ranked Medicare plans tended to be group models (10 of 15), with two staff model plans and three independent practice associations. This result is consistent with research showing that integrated models are more likely to provide higher quality care (Gillies et al. 2006).

There are 15 plans in the lowest decile of plan performance in the NCQA national ranking of Medicare plans. Of those plans, seven are Medicare-only plans and three others have no commercial enrollment, with only government-sponsored enrollees, such as Medicaid. Also 10 of these plans are new to the MA program—they have Medicare contracts dating from 2004 or later. This pattern of newer plans having worse performance than established plans is consistent with other measures we have discussed.

Implications of the findings on quality

These findings reinforce the Commission's recommendations related to quality in MA. The Commission has recommended that the MA payment system incorporate a pay-for-performance component. It will signal that the Medicare program expects MA plans to provide high-quality care and improve the quality of care over time. While payment policy in the MA program has led to growth in the number of plans available, growth in access to plans across the country, and increased enrollment, the additional funding has not necessarily resulted in cost containment or better quality of care for enrollees. Much of the enrollment growth is in new plans, which are not showing improvement in quality (NCQA 2008b).

The Commission also recommended that the Secretary collect data that enable a comparison of the MA sector with the Medicare FFS sector. Without these data, beneficiaries cannot factor in quality when choosing between enrolling in MA and staying in traditional FFS Medicare. These data are also important for evaluating both the MA program and FFS and establishing goals for improving each sector. As we have noted, this subject will be addressed in a separate report that responds to a congressional request in MIPPA.

High benchmarks increase payments and distort incentives

Currently, Medicare pays MA plans 14 percent more than it would spend for similar beneficiaries in FFS, pays a subsidy of $3.26 for each dollar of enhanced benefits a member receives in a PFFS plan, and has not seen a significant improvement in MA plan quality over the last couple of years (NCQA 2008b). Why is the MA program producing so little measurable improvement in quality for so much payment? The crucial factor is that the benchmarks that are used as bidding targets are set too high, and plan payments are not linked to performance. High benchmarks are the result of legislation that sought to increase plan participation and reflect a method for updating benchmarks that can only raise benchmarks but never lower them. High benchmarks lead to distorted incentives for the MA program.

Why benchmarks are high

By design, the statutorily set benchmarks in some localities exceeded FFS spending to encourage plans to

enter the MA program in areas they had not traditionally served. The process for setting benchmarks is rooted in a payment system for Medicare's private plan option established in 1997 legislation and modified through subsequent legislation. As a result, MA payment rates in the vast majority of counties are now higher than local per capita spending in the FFS program.

Payment floors set above FFS spending

Past legislative actions increased certain counties' benchmark rates. For example, legislation mandated benchmark floors—a minimum amount for a county's benchmark. By design, the floor rate exceeded FFS spending in many counties to attract plans to areas with lower than average FFS spending. There are two payment floors: a general floor applicable to all counties, and a higher "urban" floor, which applies only to counties in metropolitan areas with more than 250,000 residents.

The benchmark adjustment system never lowers benchmarks

CMS is required to make two adjustments to county benchmarks: updates and rebasing. Both can only raise county benchmarks, never lower them.[10]

CMS updates MA county-level benchmarks annually. By law, each county benchmark is increased from its previous level by the greater of 2 percent or the national per capita MA growth percentage. The national per capita MA growth percentage is CMS's estimate of total Medicare per capita spending growth for the coming year, adjusted to correct for past estimating errors. A benchmark can only be raised from its previous level; it cannot be decreased.

In "rebasing" years, benchmarks can be increased by even more than the update calculation. CMS calculates a rate equal to 100 percent of the per capita FFS spending for each county. If that new rate is higher than the updated rate, it becomes the new county benchmark. (CMS must rebase the estimates of county per capita FFS spending at least every three years but may rebase more frequently if it chooses. The last three rebasing years have been for the 2005, 2007, and 2009 MA payment rates.)

Rebasing goes only in one direction—it can only increase the benchmarks, which can result in an anomalous estimate that will affect all future rates for that county. An anomalous estimate could result because a spike may occur in FFS spending that is not representative of the long-term trend for the county. The reasons for an unusually high spending year could range from a particularly severe flu epidemic, to random year-to-year variation (an especially common occurrence in counties with small numbers of beneficiaries), to an unusual amount of inappropriate or fraudulent claims.

For example, Miami–Dade County's benchmark increase for 2009 was 13 percent. Miami received this increase because its FFS spending was projected to rise from previous levels by this amount. (Spending is projected by using a five-year rolling average of FFS spending for county residents. The 2009 rebasing included two new years of data.) Miami spending data, however, include millions of dollars in payments for claims that have since been proven inappropriate. One case alone generated more than $100 million in fraudulent claims (US Attorney 2008). The 2009 increase in the benchmark means that plans enrolling Miami beneficiaries will receive $150 million to $200 million more in MA payments in 2009 than they would have received if the benchmark had increased at the national growth rate.

Many counties have received benchmark updates based on FFS spending estimates that did not reflect their long-term trends. Regardless of the reason for the high FFS spending estimate, once a county's FFS spending level is rebased and increased, the county keeps its higher benchmark no matter how much subsequent FFS spending declines in that county. Currently, the Secretary of Health and Human Services does not have the authority to change either the update or the rebasing system. We plan to address this issue in a separate report the Congress has requested on the MA payment system.

High benchmarks distort incentives

In addition to increasing payments to MA plans, high benchmarks distort the incentives of the MA program and prevent it from achieving its true potential to innovate and achieve efficiencies.

Historically, private plans were included in Medicare to provide a mechanism for introducing innovation into the program while saving money for Medicare (the plans were paid 95 percent of FFS between 1982 and 1997). It was expected that private plans could achieve efficiencies by, for example, selectively contracting with efficient providers, managing the provision of services, and coordinating care—payment and delivery strategies that are not currently possible in traditional FFS Medicare. In addition, there was an expectation that more efficient MA practice patterns might eventually "spill over" into the FFS program, leading to greater efficiency there as

well. However, with payment levels significantly above traditional Medicare, the original concept of private plan efficiency linked to innovation has been lost. As a result, Medicare spending for the same care is considerably more in MA compared to FFS, and the enhanced benefits received by less than a quarter of all Medicare beneficiaries are, in aggregate, worth significantly less than the additional spending. At the extreme, instead of producing efficiency-enhancing innovation, MA's PFFS plans mimic FFS Medicare by design but cost 18 percent more.

The growth in less efficient plans heightens our concerns about equity issues that arise with MA relative to the traditional Medicare program, about equity for beneficiaries and taxpayers, and about ensuring a level playing field among the different MA plan types. The equity and efficiency issues are of particular concern when Medicare is not financially sustainable in the long run (described in depth in Chapter 1).

With MA benchmarks at their current levels, all beneficiaries, through their Part B premium—and all taxpayers, through general revenues—are subsidizing the MA enhanced benefits. The high MA benchmarks allow plans to be less efficient than they would be if they faced the financial pressure of benchmarks closer to Medicare FFS levels. As the Commission has stated in the past, organizations are more likely to be efficient when they face financial pressure, and the Medicare program needs to exert consistent financial pressure on the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance programs, to maximize the value it receives for the dollars it spends.

The Commission supports financial neutrality between payments in the traditional FFS program and MA program payments. Expressed in terms of the level of benchmarks for MA plans in the current bidding system, financial neutrality would mean that benchmarks should be set at 100 percent of Medicare FFS expenditures.

In our June 2005 report, the Commission made recommendations to address some of these problems, and recent law has embraced some of those recommendations (see text box, pp. 266–267).

Conclusion

Ideally, MA plans would provide enhanced benefits financed by their efficiency in providing the Medicare Part A and Part B benefit. If a private plan used savings from more efficient health care to provide lower cost sharing or enhanced benefits while maintaining quality, it would attract enrollees. Plans competing with each other based on furnishing health care at low cost and with high quality would promote efficiency. In a system in which plan payments are appropriately set and risk adjusted, a richer benefit package would generally signal that one plan was more efficient than a competing plan—and that a private plan offering enhanced benefits was more efficient than the traditional Medicare FFS program in the plan's market area. (We want to be clear that even though we use the FFS Medicare spending level as a measure of parity for the MA program, it should not be taken as a conclusion that the Commission believes FFS Medicare is an efficient delivery system in most markets. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements in the program.)

Our analysis finds that some plans are able to cover the same services as the traditional Medicare Part A and Part B benefit at a lower cost—namely, HMOs, which cover these services on average at 98 percent of Medicare FFS expenditures. Others, however, are much less efficient; for example, PFFS plan bids averaged 113 percent of FFS expenditures. High benchmarks and payment rules account for this misalignment with FFS spending.

Paying a plan more than FFS spending for delivering the same services is not an efficient use of Medicare funds in the absence of evidence that such payments result in better quality compared with FFS. We are concerned that the average MA bid for Medicare Part A and Part B services is above average FFS spending, which means that, on average, all enhanced benefits in the plan are funded by the Medicare program and not by plan efficiencies. In addition, a portion of the program payments used to fund enhanced benefits pay for plan administration and profits and not services for beneficiaries. ■

MedPAC's prior Medicare Advantage recommendations and Medicare Improvements for Patients and Providers Act of 2008 provisions

Medicare Advantage (MA) recommendations from the June 2005 *Report to the Congress: Issues in a Modernized Medicare Program* and subsequent legislation (in italics) are summarized below:

The Commission recommended that the Congress eliminate the stabilization fund for regional preferred provider organizations (PPOs). Authorization of the fund was one of several provisions intended to promote development of regional PPOs.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) eliminated $1.8 billion of the initial funding amount, leaving the initial funding level at $1.00 for the regional PPO stabilization fund through 2014.

The Commission recommended that the Congress remove the effect of payments for indirect medical education (IME) from the MA plan benchmarks. MA rates set at 100 percent of fee-for-service (FFS) include medical education payments, but Medicare makes separate IME payments to hospitals treating MA enrollees.

MIPPA, beginning in 2010, reduces each county benchmark by 0.6 percent annually until the total percentage reduction equals the percentage of total FFS spending in the county attributable to IME payments to hospitals. The phaseout will be gradual, with some counties (e.g., in New York City, Boston, and Philadelphia) having phase-out periods lasting more than a decade. In the first year, however, the reduction will be broad based, as 92 percent of MA enrollees live in counties where the benchmark would be reduced by 0.6 percent. Including IME spending in the benchmarks in 2009 raised them by about 2.5 percent.

The Commission recommended that the Secretary calculate clinical measures for the FFS program that would permit CMS to compare the FFS program with MA plans. The Commission believes that more can be done to facilitate beneficiary choice and decision making by enabling a direct comparison between the quality of care in private plans and quality in the FFS system.

MIPPA mandated that the Commission should report on measures and methods for comparing Medicare FFS and MA plans on quality.

The Commission recommended that the Congress set the benchmarks CMS uses to evaluate MA plan bids at 100 percent of FFS costs. The Commission has consistently supported the concept of financial neutrality between payment rates for the FFS program and private plans.

MedPAC's prior Medicare Advantage recommendations and Medicare Improvements for Patients and Providers Act of 2008 provisions (cont.)

The Commission recognizes that changing MA plan payment rates to achieve financial neutrality too quickly may cause disruptions for beneficiaries and may have other unintended consequences. This recommendation would lower payments to plans in some areas, which may cause some plans to reduce the enhanced benefits they offer and their level of participation in the MA program—and reduce plan choice for some beneficiaries. The Congressional Budget Office (CBO) estimates that there would primarily be reductions in future MA growth rates rather than a loss of current members (Orszag 2007). The timing of the transition to a plan payment system that is financially neutral needs to take into account the effect on beneficiaries.

The Commission recommended that the Congress redirect the amounts retained in the Trust Funds for bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures. Pay-for-performance should apply in MA to reward plans that provide higher quality care.

The Commission recommended that the Congress clarify that regional plans should submit bids that are standardized for the region's MA-eligible population. There can be distortions in competition between regional and local plans because of the different method used to determine benchmarks for regional PPOs in relation to the method used for other plans.

Additional provision in MIPPA

The Commission was concerned that rapid enrollment growth in private FFS (PFFS) plans was a manifestation that the benchmarks were high enough to allow inefficient plans to thrive, although they cost the Medicare program significantly more than the program would have paid if their enrollees had remained in FFS Medicare. In addition, the lack of a network limited the plans' ability to influence quality of care.

MIPPA imposes two new requirements on PFFS plans. Beginning in 2011, MIPPA requires that PFFS plans maintain a contracted network of providers, except in areas where there were fewer than two networked plans offered the previous year. (Regional PPOs do not count as networked providers in areas where they have been granted network exemptions by CMS.) MIPPA also requires PFFS plans to report on quality beginning in 2010. ■

Endnotes

1 We define urban counties as those counties classified as being in a metropolitan statistical area; all other counties we classify as rural counties. To match more closely the designation of nonfloor and floor counties (including the urban floor), we use the metropolitan statistical area status of counties as of 2002, before changes in the designation of counties in 2003.

2 The availability of PFFS plans will likely drop substantially in 2011 when certain Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provisions become effective. (See text box on MA provisions in MIPPA, pp. 266–267.)

3 There is some interaction between FFS and MA that can affect the comparisons. The MA program can reduce expenditures in the Part D program, as we discuss in Chapter 4. Since bids for both stand-alone prescription drug plans and MA drug plan bids make up the overall national average Part D bid and affect Medicare's payments to drug plan sponsors, lower average bids by MA plans somewhat reduce federal program spending for Part D. Second, CMS has observed differences in coding of diagnoses between MA and the FFS sector. Because MA plan payments are adjusted for the health status of each enrollee based on these codes, to the extent that there is "undercoding" in FFS relative to MA, our ratios of MA payments in relation to FFS expenditures may be understated. (See CMS 2009.)

4 A plan can also choose to offer benefits beyond the traditional Medicare benefit package funded by beneficiary premiums. The following discussion of enhanced benefits does not include premium-funded benefits.

5 A plan's administrative costs include items such as member service activities, provider contracting, provider relations, medical management, quality improvement activities, information systems, claims processing, marketing, and other nonmedical costs. Administrative costs vary from plan to plan. PFFS plans are likely to have high administrative costs associated with claims processing but little if any costs associated with provider contracting. Generally, an HMO with salaried physicians that owns its own hospitals has little in the way of claims processing costs, while a PPO has both claims processing and provider contracting costs. Plans that serve employer-group enrollees exclusively generally have much lower marketing costs than plans that enroll Medicare beneficiaries individually.

6 Because we do not take into account the loading factor for Part D benefits that is determined through the Part D bid, the $79 net figure is slightly higher than if we had applied the Part D loading factor to the benefit enhancements of drug coverage. If the Part D loading factor is similar to the MA bid loading factor, the net value of enhanced benefits would be in the range of $77 across all plans.

7 HEDIS is a registered trademark of the National Committee for Quality Assurance.

8 No plan received the full five-star rating for 2008, but 10 plans received a 4.5 rating. The 10 plans have the following characteristics: The plans are established plans including three cost-reimbursed HMO contracts dating from the 1980s. Six of the 10 plans are group model plans, 1 is a staff model, 1 is a mixed model, and 2 are independent practice associations.

These plans offer fewer enhanced benefits than some of their competitors, yet beneficiaries choose them anyway. Cost-reimbursed plans, for example, must charge a premium for any benefit enhancement, including the reduction of cost sharing for Medicare-covered services. The top-ranked MA plans do not have zero-premium benefit packages even when competing Medicare plans in their markets offer such plans. Because the most highly ranked plans are not in the most competitive markets, it may also suggest that plan competition does not necessarily guarantee improved quality (as shown by Scanlon and colleagues (2008)), though an alternative explanation may be that the highly ranked plans are competing on the basis of quality more than on cost.

9 In reporting HOS results, plans are classified as performing within expected ranges unless (1) there are statistically significant differences among plans in the measures for improvement or decline in physical or mental health, and (2) there are plans in which the difference exceeds a certain threshold. Plans will be designated as "outliers" if the first condition is met, and if a given plan's results differ from the national average results across all plans by a certain order of magnitude (specifically, when the result of dividing the plan deviation by the standard error of the deviation is greater than 2 or less than –2 (Rogers et al. 2004).)

10 Two factors lead to reductions in benchmarks: the phasing out of the indirect medical education amounts in the benchmarks that we discuss in this chapter, and the phasing out of the budget-neutrality adjustment that has served to increase benchmarks. The last year in which the budget-neutrality adjustment will apply is 2010. However, even taking these two factors into account, benchmarks would always be expected to rise because of the statutory provision requiring an increase of at least 2 percent each year in county benchmarks.

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