CHAPTER 3

Update on the Medicare Advantage program and implementing past recommendations

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Chapter summary

This chapter provides an update on plan participation and beneficiary enrollment in the Medicare Advantage (MA) program as of early 2007, paying special attention to private fee-for-service (PFFS) plans and special needs plans (SNPs). The Commission supports the participation of private health plans in Medicare. Beneficiaries should be able to choose health plans that seek greater efficiency in the delivery of health care and improved outcomes for enrollees. Private plans have the flexibility to use care management techniques that fee-for-service (FFS) Medicare does not encourage. If paid appropriately, they have greater incentives to undertake innovations in care delivery and management and to negotiate with providers over levels and methods of payment.

MA plans can use the savings they achieve through efficiency to provide enrollees with extra benefits—reduced cost sharing and coverage of items and services not covered by Medicare. In a system in which plan payments are no higher than those in FFS and are appropriately risk adjusted, a richer benefit package would generally signal that one plan is more efficient than a competing plan—and that

In this chapter

a private plan offering extra benefits is more efficient than the traditional Medicare FFS program in the plan's market area. However, for most MA plans the current approach to payment does not promote efficiency, primarily because county benchmarks—the basis of payment for MA plans—exceed Medicare FFS expenditures.

Our analysis of 2006 benchmarks and program payments in MA showed that benchmarks and payments significantly exceeded Medicare FFS expenditures. The benchmarks averaged 116 percent of the expected FFS spending, and Medicare payments on behalf of MA enrollees averaged 112 percent of what payments would have been under the traditional FFS program. High benchmarks have enabled plans to offer generous extra benefits to attract enrollees, resulting in significant enrollment growth in MA.

The original design of the Medicare private health plan program envisioned that extra benefits would be available to enrollees only when plans achieved efficiencies. Some MA plans have payments that are lower than FFS Medicare, and those payments finance the cost of the Medicare benefit as well as extra benefits. However, in many cases (and for PFFS plans in particular), the sole source of financing for extra benefits is Medicare payments that are significantly above FFS expenditure levels.

The continuing growth in enrollment in counties with the highest payments relative to FFS spending and in the least efficient types of plans heightens our concerns about the MA program. Enrollment growth has been greater in PFFS than in coordinated care plans. PFFS enrollment experienced the fastest growth through 2007, with membership expanding 72 percent between July 2006 and February 2007.

The current MA payment policy is inconsistent with MedPAC's principles of payment equity between MA and the traditional FFS program. Moreover, the program applies standards and rules inequitably among different types of MA plans. Equity and efficiency issues are of particular concern with

Medicare facing long-run issues of financial sustainability, discussed in our March 2007 report to the Congress (MedPAC 2007).

Beginning with our March 2001 report to the Congress and in subsequent years, the Commission recommended payment equity between Medicare's private plans and the FFS program (MedPAC 2001a). In the context of MA, Medicare could achieve such equity by setting benchmarks at 100 percent of FFS payment levels. However, the Commission recognizes that changing MA plan payment rates to achieve financial neutrality too quickly will cause disruptions for beneficiaries in some markets, and thus the Congress may want a transition period. We discuss possible approaches for moving toward benchmarks at 100 percent of FFS expenditure levels:

- Freeze benchmarks at current levels to arrive at 100 percent of FFS rates over time, with a possible minimum yearly update.
- Cap the percentage by which benchmarks can exceed FFS expenditures and gradually lower the cap.
- Use a blend of 100 percent of FFS rates and historical benchmarks and gradually increase the portion attributable to 100 percent of FFS in the blend.
- Use plan bids as a factor in determining benchmarks.

We also discuss the large differences among plans in their performance on quality measures, highlighting the importance of the Commission's recommendation to institute a pay-for-performance system in MA and the importance of having all plans report on quality measures (PFFS plans currently are exempt from most quality measurement requirements).

Two issues of concern provide advantages to particular types of MA plans. Medical savings account (MSA) plans consist of a high-deductible health plan combined with a savings account with funds deposited by Medicare that enrollees can use on a tax-advantaged basis to cover health care costs. Unlike other plan types, MSA plans do not have to return 25 percent of

the difference between the plan bid and the benchmark to the trust funds. Instead, the program deposits the full difference between the benchmark and a bid below the benchmark to the enrollee's savings account. Another recently enacted provision allows MA-only plans (i.e., that do not offer Part D drug coverage) to have year-round open enrollment. The provision provides an advantage to PFFS plans because enrollees choosing other types of MA plans must give up their Part D coverage when they enroll in the MA-only plan.

We provide an update on SNP availability and participation. The number of SNPs and enrollment in SNPs increased from 2006 to 2007. We intend to continue studying what the proper role for SNPs in the MA program should be and what criteria to establish for these plans. ■

The Commission has examined enrollment patterns and plan payments for the Medicare Advantage (MA) program for different geographic areas and types of plans. In this chapter, we pay particular attention to the fastest-growing plan type, private fee-for-service (PFFS). We also provide an update on special needs plans (SNPs). Our March 2007 report to the Congress repeated the Commission's past recommendations for the MA program.

The Commission's views on private plans in Medicare

The Commission supports the participation of private health plans in the MA program. Beneficiaries should be able to choose alternatives to traditional fee-for-service (FFS) Medicare in which health plans use practices that promote greater efficiency in the delivery of health care and improved outcomes for enrollees. Private plans have the flexibility to use care management techniques that FFS Medicare does not encourage. Moreover, if paid appropriately, plans have greater incentive to undertake innovations in the delivery and management of care and to negotiate with providers over levels and methods of payment.

The Commission supports financial neutrality between payments in the traditional FFS program and the MA program and, beginning with the March 2001 report to the Congress, has recommended changing the program to achieve neutrality (MedPAC 2001a). Financial neutrality means that the Medicare program pays the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. Financial neutrality would set benchmarks for MA plans in the current bidding system at 100 percent of average Medicare FFS expenditures. The Commission also recommended that the Congress use the 25 percent difference between the benchmark amount and bids below 100 percent of the benchmark (now retained in the Medicare trust funds) for a pay-for-performance program in MA (MedPAC 2005). The Commission has also discussed premium support as an approach to neutrality. Under premium support, competition between health plans and the FFS system would determine the contribution Medicare makes on behalf of the beneficiary. Although MA is a bidding system, plans bid against administratively set benchmarks, which have a strong influence on the payments to plans.

Efficiency in Medicare Advantage and extra benefits

Over many years of experience with private plans in Medicare, the Congress has looked to private plans to provide a source of efficiency in the program. To the extent that MA plans provide Medicare benefits at a lower cost than the traditional program, they are required to return some of the efficiency to the program and to the beneficiary. Recent analysis of efficiency in MA shows that some types of plans are efficient while others are not. High benchmarks used in the bidding formula work against the program's objectives in getting the most for the program dollar. We also see differences in the quality that plans bring to beneficiaries.

Private plans, efficiency, and benefits

From the time that full risk contracting for HMOs became a feature of Medicare through the Tax Equity and Fiscal Responsibility Act of 1982, policymakers have tried to structure the Medicare private plan program so that efficient plans can provide extra benefits to enrollees. To the extent that a private plan can provide care more efficiently than FFS Medicare (or, prior to the current MA program, for less than 95 percent of Medicare FFS costs), the program was designed so that plans could use their efficiency gains to finance extra benefits.[1] Extra benefits include reduced out-of-pocket costs for enrollees and services not covered by Medicare, such as dental, hearing, and vision services; rebates of the Part B premium (as of 2001); and (before the advent of Part D) outpatient prescription drugs.

Extra benefits should attract beneficiaries to enroll in efficient plans. Having plans compete against each other should also promote efficiency. In a system in which plan payments are no higher than those in FFS and are appropriately risk adjusted, a richer benefit package generally signals that one plan is more efficient than a competing plan—and that a private plan offering extra benefits is more efficient than the traditional Medicare FFS program in the plan's market area.[2]

In the program's current design—in which plans bid against a benchmark set in law—for bids below the benchmark, the law requires that 75 percent of the difference (referred to as the rebate) be used to fund extra benefits for enrollees. The program keeps the remaining 25 percent in the Medicare trust funds (for regional plans,

Calculating Medicare's payments to plans

The benchmark is a bidding target under the bidding system for Medicare Advantage (MA) plans that began in 2006. The local MA benchmarks come from the county-level payment rates used to pay MA plans before 2006. Those payment rates were at least as high as per capita fee-for-service (FFS) Medicare spending in each county. Some counties had rates significantly higher than FFS because of specific statutory changes. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 called for updating county benchmarks from one year to the next in one of three ways, using whichever method results in the greatest increase:

- Generally, local MA benchmarks are updated by the national growth rate in per capita Medicare spending (subject to certain adjustments that could increase or decrease eventual plan payments).

- A second possibility is that, if the national growth rate is less than 2 percent, MA benchmarks are increased by 2 percent (subject to certain adjustments). This minimum increase provision (contained in the Balanced Budget Act of 1997 (BBA)) applies each year, regardless of the economic circumstances and of the expected cost growth for an efficient provider. In 1998, for example, the year when the 2 percent provision went into effect, the provision applied to MA payment rates at the same time that overall Medicare expenditures declined slightly for the year.

- A third possibility is to set the benchmark of a given county equal to the FFS expenditure for the county. That is, 100 percent of FFS becomes the benchmark for a county if it yields the highest benchmark amount.

To implement the 100 percent of FFS provision, CMS determines FFS rates for each county at least every three years, a procedure referred to as "rebasing." Once a county benchmark is set at 100 percent of FFS in a given year, even if FFS payments fall, the benchmark for plans does not. For example, if in the following year CMS finds the FFS rate for the county was far below that of the preceding year, the county capitation rate would be the preceding year's FFS rate increased by either the minimum increase of 2 percent or, if greater, the national growth rate in per capita Medicare spending. This policy creates, in effect, an additional type of "floor."

Another source of higher benchmarks is Medicare's treatment of indirect medical education (IME) payment to hospitals. See our June 2005 report to the Congress for discussion of our recommendation to remove the effect on benchmarks of Medicare's double payment for IME for MA enrollees.

MA benchmarks are higher than Medicare per capita FFS spending in almost all counties (other than for regional plans, which have a different basis for determining benchmarks applicable across an entire region). One source of the difference is statutory provisions that introduced minimum county payment rates, or floors, intended to attract or retain private plans in Medicare. Floor rates are no longer a basis of plan payment, but what were historically floor counties generally continue to have higher payment rates than nonfloor counties in relation to FFS expenditure levels.

The BBA initially established a payment floor for counties with relatively low FFS expenditures. The BBA floor is often called the rural floor because it applies mainly to rural counties and was primarily intended to attract plans to rural areas. The "large urban floor," which applies to counties within large metropolitan statistical areas, was introduced in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and was effective as of March 2001. BIPA also provided an increase in the BBA floor rate. The counties that had been floor counties have very high relative benchmarks compared with other geographic areas; on average, they are 121 percent of FFS for the large urban floor counties and 134 percent of FFS—the highest average benchmark level—for the floor established in the BBA. ■

TABLE 3–1 **Program payments exceed FFS expenditures but vary by plan type, 2006**

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Percentage relative to FFS expenditures					
Benchmark	116%	115%	120%	112%	122%
Bid (for Medicare Part A and Part B benefits)	99	97	108	103	109
Rebate	13	13	9	7	10
Payment (bid + rebates)	112	110	117	110	119
Enrollment as of July 2006 (in thousands)	6,877	5,195	285	82	774

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service). When a bid is below the benchmark, 75 percent of the difference—referred to as the "rebate" amount—is paid to the plan to provide extra benefits and reduced premiums; 25 percent of the difference is retained by the Medicare trust funds and, in the case of regional PPOs, half of the 25 percent is deposited in the benefit stabilization fund. Enrollment increased rapidly after July 2006.

Source: MedPAC analysis of CMS data on plan bids, benchmarks, and enrollment.

half of the 25 percent is retained in the benefit stabilization fund for possible use in 2012 or thereafter to promote participation by regional plans).

Comparing payments to plans with the amounts spent under the fee-for-service program

As stated in the March 2007 report to the Congress, our analysis of plan benchmarks shows that they are well above FFS levels (116 percent of FFS expenditures as of 2006), with variations by geographic area and type of plan that reflect the enrollment patterns of the different plan types (Table 3-1).[3] The Congressional Budget Office independently arrived at a similar finding for 2007: Benchmarks are at 117 percent of FFS and program payments for MA enrollees are at 112 percent of FFS (CBO 2007).

MedPAC has not estimated the bid-to-benchmark ratio for 2007. One factor that should, all else equal, lead to a decline in plan payments for 2007 is the phasing out of the hold-harmless provision that determines the extent to which MA payments are adjusted to reflect the health status of enrollees. MA plans are enrolling beneficiaries who are healthier than average. A payment system incorporating risk adjustment based on health status would lower payments for healthier enrollees. However, the hold-harmless provision protects plans from the effect of full implementation of payments based on health status. This provision is phasing out over several years, ending in 2011. However, other factors—primarily the trend in enrollment toward areas of the country with high benchmarks in relation to FFS—will increase the benchmark-to-FFS ratio for 2007.

Some have criticized the accuracy of our estimated ratios in connection with three issues: (1) administrative costs in the Medicare program, (2) the use of Department of Veterans Affairs (VA) facilities by Medicare beneficiaries, and (3) the treatment of indirect medical education (IME) payments (AHIP 2007a). At the national level, these issues would not materially change our findings; that is, the ratios would remain unchanged. For example, factoring in certain CMS administrative costs and MA user fees would result in a change of at most 0.5 percentage point.[4] In a few geographic areas, beneficiaries' use of VA facilities to receive Medicare-covered care may understate the average cost of providing Medicare-covered services in the area. That is, CMS estimates of county-level FFS expenditures (and thus the benchmarks) do not account for some Medicare beneficiaries using VA facilities to obtain care that otherwise would be covered and paid for by Medicare.[5] However, if MA enrollees continued to use VA facilities to the same extent as FFS beneficiaries, a benchmark adjustment might not be appropriate. Another issue is whether our calculations account for IME payments. We correctly account for IME dollars by removing them from each sector in calculating the ratio of MA benchmarks and payments to FFS expenditures.

Recent findings on differences in efficiency by type of plan

Our analysis of plan payments and benchmarks showed that, for 2006, program payments to plans averaged 112 percent of FFS expenditures across all plans.Those figures vary by plan type, with HMO benchmarks and program payments at 115 percent and 110 percent of FFS, respectively, on average, and PFFS at 122 percent and 119 percent of FFS, respectively (Table 3-1, p. 63). These differences reflect the areas where these types of plans locate as well as variations in efficiencies in care delivery.

Efficient plans operate in the MA program. They provide the traditional Medicare Part A and Part B benefit at a lower cost than the FFS program, although plans receive additional Medicare payments that are used for extra benefits. On average in 2006, HMO plans provided the traditional Medicare benefit for 97 percent of Medicare FFS expenditure levels (Table 3-1, p. 63). Because HMOs had such a large share of the overall enrollment in 2006, across all plan types the bid for Medicare Part A and Part B services averaged 99 percent of Medicare FFS expenditures. However, some plan types were much less efficient; for example, PFFS plan bids averaged 109 percent of FFS expenditures. That is, on average they cost Medicare 9 percent more than the traditional FFS program to provide Medicare Part A and Part B benefits. For each plan type, the numbers we cite are averages; not all plans of a particular type (HMOs, preferred provider organizations (PPOs), PFFS) operate with the same efficiency in relation to FFS in their market areas.

Plan bids for the Medicare Part A and Part B benefit package include costs for administration, marketing, and profit or retained earnings. Similarly, the extra benefits provided through the additional payments include the administrative and marketing costs and profit or retained earnings associated with extra benefits.[6]

Effects of high benchmarks

The high MA benchmarks allow plans to be less efficient than they would otherwise be if they faced the financial pressure of lower 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. The Medicare program needs to exert consistent financial pressure on both the FFS program (as detailed in our March 2007 report to the Congress) and the MA program, coupled with meaningful quality measurement and pay-for-performance programs, to maximize the value the Medicare program receives for the dollars it spends. MA payment policy is actively shaping the market for Medicare health plans. The current policy conveys the message that Medicare values private plans that cost more than FFS, and Medicare is willing to subsidize beneficiary enrollment in MA.

MA enrollment is growing particularly fast in PFFS plans and in counties where the benchmarks are highest in relation to FFS. PFFS enrollment tends to be concentrated in counties where benchmarks are significantly higher than FFS expenditures. This explains why PFFS plan benchmarks and payments are so high in relation to FFS. Growth in enrollment in less efficient plans heightens our concerns about payment equity for MA. The program is paying more for MA enrollees than for those in the traditional Medicare FFS program, with beneficiaries and taxpayers financing those higher payments. The Commission also has concerns about an uneven playing field among the different types of MA plans. The equity and efficiency issues we discuss here are of particular concern in an era when Medicare faces long-run sustainability challenges.

With MA benchmarks at their current levels, the MA program results in higher average costs than FFS Medicare and added costs for taxpayers and beneficiaries who finance the Medicare program. However, with respect to the cost of the Part D program, because MA–Prescription Drug (MA–PD) plan bids on average are lower than the bids of stand-alone plans, MA–PD bids bring down the national average bid for Part D (see discussion in the March 2007 report to the Congress on relative premium levels in Part D by plan type). For Medicare Part A and Part B, while some of the MA payments above FFS expenditures are used to finance extra benefits for MA enrollees, all beneficiaries, through their Part B premium—and all taxpayers, through general revenues—are paying for those benefits. Most Medicare beneficiaries are not MA enrollees, but all beneficiaries pay for benefits the 18 percent of beneficiaries enrolled in MA plans use.

Low-income and minority beneficiaries are more likely to enroll in MA plans (AHIP 2007b, Atherly and Thorpe 2005), and a reduction in benchmarks may disproportionately affect their benefits. Although we cannot be certain about the impact on different populations (e.g., urban enrollees of MA plans would be more likely than rural enrollees to continue to receive generous extra benefits if benchmarks were brought closer to FFS levels), the benefits do not go exclusively to a subgroup

of enrollees. All MA enrollees receive the same level of benefits. Some are concerned that low-income individuals should receive extra help with their cost sharing and other expenses for medical care. However, other programs target this population more efficiently. Examples are the Medicare savings programs and the low-income subsidy approach used for the Medicare drug benefit.

The PFFS option

The high MA benchmarks have allowed PFFS plans to attract enrollment in areas with limited competition from other plan types. PFFS plans essentially mimic FFS Medicare in their structure and in their payment and contracting arrangements with providers.

Design and history of the PFFS option

The existing PFFS plans are generally not network plans (they do not provide care through a network of contracted providers) and do not use many of the techniques that network plans can use to encourage the provision of better health care at a reduced cost. PFFS plans pay providers the same rates as Medicare FFS.[7] Although PFFS plans may form networks to make payment arrangements with providers, to date PFFS plans have relied mainly on "deemed" participation of providers to provide care to their enrollees. Under this policy, the plan deems a provider to be in the PFFS plan if the beneficiary states that he or she is a PFFS plan enrollee and the provider treats the patient after learning about the plan's terms and conditions of payment. A provider also is deemed if he or she has had reasonable opportunity to obtain information about terms and conditions (e.g., being provided with an Internet source for the terms and conditions).

The program does not require PFFS plans to meet the same quality standards as network plans because, as non-network plans, one might argue that they are not accountable for the quality of care practiced by physicians and other providers that enrollees choose to see.

The Balanced Budget Act of 1997 (BBA) introduced the PFFS option to guarantee access to all Medicare providers without imposing utilization controls. Policymakers developed this option because, in the 1990s, during the period of greatest growth in managed care enrollment, they feared that rationing of care would occur because of a general movement toward managed care, utilization management, and restrictive provider networks. Policymakers wanted an option without limitations on enrollees' ability to obtain care through the providers of their choice.

TABLE 3–2 **Enrollment in PFFS plans grew faster than in other major plan types**

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

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

Source: CMS health plan monthly summary reports.

While including the PFFS option in the BBA, the Congress also intended that enrollees bear the added cost of a private health plan offering free access to providers. As noted in the BBA conference report, "the private fee-for-service Medicare+Choice option authorized by this agreement represents the first defined contribution plan in which beneficiaries may enroll in the history of the program" (House of Representatives 1997). PFFS was a defined contribution plan under Medicare+Choice (the predecessor to MA) because, unlike other plans, a PFFS plan could charge a premium for its cost of providing the Medicare Part A and Part B benefit package in excess of the actuarial value of Part A and Part B cost sharing in FFS Medicare.

The current benchmarks are high enough to permit PFFS plans to finance extra benefits through program payments even when such plans are less efficient at providing the Medicare Part A and Part B benefit package. In our June 2001 report to the Congress, we anticipated the possibility that PFFS plans would be providing extra benefits solely because of the higher payment rates and noted that this "would not appear to be paying the cost of an efficient provider—the basic axiom of Medicare payment policy. Paying PFFS plans at … [higher] rate[s] is an expensive way to get extra benefits for Medicare beneficiaries in some counties" (MedPAC 2001b).

Recent growth in PFFS plans

PFFS plans and enrollment continue to grow rapidly (Table 3-2). While local coordinated care plans grew

TABLE 3–3

PFFS enrollment comes primarily from floor counties and rural areas

	July 2006 distribution		February 2007 distribution		
	Enrollees (in thousands)	Percent	Enrollees (in thousands)	Percent	Percent growth in enrollment
By historical county payment status					
BBA floor counties	284	37%	399	31%	40%
MSA floor counties	390	50	630	49	62
Nonfloor counties	99	13	260	20	162
By rural/urban status					
Rural	304	39	451	35	48
Urban	470	61	838	65	78

Note: PFFS (private fee-for-service), BBA (Balanced Budget Act of 1997), MSA (metropolitan statistical area). Sums of figures in each group may not be the same due to rounding. The number of enrollees for July 2006 includes counties with 10 or fewer enrollees; the number of enrollees for February 2007 in this table does not. BBA floor counties are generally rural counties with a payment set by the BBA at a minimum level. The MSA floor, applicable to counties within an MSA with a population of over 250,000, was introduced in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and was effective as of March 2001. BIPA also provided an increase in the BBA floor rate.

Source: MedPAC analysis of CMS data on plan-level enrollment.

about 11 percent between July 2006 and February 2007, enrollment in PFFS plans accounted for nearly half the growth in MA, rising from about 774,000 to 1.3 million—a 72 percent increase.[8] The number of entities with PFFS contracts nearly doubled, from 25 in 2006 to 47 in 2007. In addition, for 2007, a direct-contract employer group plan (an option authorized in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)) started operating as a PFFS plan, with 10,000 enrollees. Under this option, the employer is an MA contractor, assuming risk for providing Medicare services to its retirees.

The more common option is for an employer to offer retiree coverage through an MA organization that designs a plan available only to that employer group or to multiple employer groups. The PFFS option is particularly attractive for employers and unions covering retirees when they retire and move away from their place of work. While plans can cover active workers through network plans in a specific geographic area, an HMO, for example, would need to have a very wide network to provide access to retirees. A PFFS plan, on the other hand, because it does not need to have a network, can make its service area the entire country. This solves the employer's or union's concerns about ensuring access to care, and PFFS plans do not have to form networks in each county where they have enrollment.

Enrollment in PFFS continues to come primarily from counties where benchmarks reflect statutorily set payment floors (Table 3-3). In February 2007, 80 percent of PFFS enrollment comes from such counties (31 percent from BBA floor counties and 49 percent from metropolitan statistical area floor counties (the text box on p. 62 provides an explanation of floor counties)). The percentage of the total PFFS enrollment coming from rural counties has decreased slightly, from 39 percent in 2006 to 35 percent in 2007.[9] However, enrollment grew most rapidly in nonfloor counties between 2006 and 2007.

SNPs (discussed separately at the end of this chapter) and employer-sponsored plans were the only source of growth in local HMO plans between 2006 and 2007. Between July 2006 and February 2007, the number of HMO enrollees who were not in SNP plans and not enrolled through an employer-sponsored plan declined by about 2 percent.

Differences among MA plans on quality measures

In addition to differences in efficiency among MA plans, we see wide differences in plan performance on quality measures (Table 3-4, reflecting results for 2005). For example, on the quality measure for the percentage of enrollees with diabetes who receive eye exams, the currently reported scores among HMO plans range from 14 percent to 87 percent. The rate for providing flu shots

TABLE 3–4 **Quality measures show significant variation across plans**

Quality measure, by plan type	Number of plans with data	Rate			
		Average	Median	Lowest	Highest
Eye exams for members with diabetes					
All plans	175	64%	66%	8%	87%
ALL HMO plans	138	65	66	14	87
PPOs	12	53	57	8	74
PFFS plans	4	37	37	28	45
Flu shots					
All plans	247	68	73	15	89
ALL HMO plans	206	67	71	16	88
PPOs	3	72	73	68	75
PFFS plans	0	N/A	N/A	N/A	N/A
Beta blockers after heart attack					
All plans	127	93	97	28	100
ALL HMO plans	112	94	97	59	100
PPO plans	3	69	80	28	100
PFFS plans	1*	N/A	N/A	N/A	N/A

Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable). All plans include cost plans (plans contracting with Medicare on a cost reimbursement basis) and demonstration plans.
*One plan reported, with a rate of 65 percent.

Source: MedPAC analysis of data from Medicare personal plan finder downloadable database reflecting 2005 results.

to members ranged from 16 percent to 88 percent among HMOs. CMS reported no data on PFFS performance on the flu shot measure; for the three PPOs that reported data, flu shot rates ranged from 68 percent to 75 percent.[10]

The measure on which plans register their best performance is the provision of beta blockers after a heart attack. Among the 127 plans of any type for which there are reported data, the scores range from 28 percent to 100 percent, with the median at 97 percent and with 22 plans having a score of 100 percent. Plans have also shown improvement in measures over the years. For example, the National Committee for Quality Assurance reports that, in Medicare plans, the measure for controlling high blood pressure among those with hypertension increased from 47 percent in 2000 to 66 percent in 2005 (NCQA 2006).

In the past, the Commission has called for two policies on quality (MedPAC 2005). One is for CMS to calculate measures of quality in the FFS program so that we can compare the performance of MA to the traditional program. The other is for a pay-for-performance program within the MA program that would pay more to plans with superior quality and to those that improved their quality over time and would pay less to other plans.

Options for moving to benchmarks at 100 percent of FFS expenditures

Since benchmarks remain high, MA plans are able to offer extra benefits, subsidized by the Medicare program, to attract enrollees. This has resulted in significant growth in MA enrollment. While the Commission supports plans as an option for Medicare beneficiaries, it also supports the concept of setting benchmarks at 100 percent of FFS. The Commission recognizes that changing MA plan payment rates to achieve financial neutrality too quickly will cause disruptions for beneficiaries in some markets. The

history of private plan participation in Medicare provides a precedent for understanding the possible consequences of a change in MA payment policy. Following the payment changes in the BBA and because of other market factors affecting managed care plans, a large number of plans withdrew from Medicare in 1999 and thereafter, and enrollment declined significantly (Hurley et al. 2003, GAO 2000). On the other hand, the more beneficiaries who receive extra benefits subsidized by the Medicare program, and the longer beneficiaries have such benefits, the more difficult it will be to reduce MA benchmarks. In 2006, county benchmarks in counties with any MA enrollment ranged from about 104 percent to about 166 percent of FFS (excluding Puerto Rico).

Possible approaches might be to:

- freeze all county benchmark rates at their current levels until each county's rate is at the FFS level, while possibly providing for a minimum update;
- differentially reduce benchmark rates by setting a cap on the amount by which benchmarks could exceed FFS in a county, thereby having a higher reduction in the highest benchmark counties; or
- use a blend of FFS rates and MA rates that would apply to a particular county, increasing the weight of the FFS portion over time.

Other transition strategies are also possible, such as using local plan bids as a factor in determining benchmarks.

Freeze benchmarks

The Congress could freeze benchmarks until FFS spending catches up to that level. This policy would address all areas with benchmarks above FFS immediately, but it would take many years for FFS levels to catch up in some areas (e.g., in counties with benchmarks at 166 percent of FFS). This approach has the disadvantage of freezing benchmarks in counties where rates are close to FFS, which are likely to be the areas with the highest concentration of MA enrollment (currently and historically) and areas where competitive plans have bids that are low in relation to FFS expenditures or are in fact below FFS. Therefore, a better option might be to allow a minimum yearly update in MA benchmarks (e.g., 2 percent each year, which is the current minimum), but this would lengthen the time it takes benchmarks to reach FFS levels in many counties.

Under this option, with a minimum increase, for the first few years beneficiaries would not be likely to see big changes in their benefits and program savings would be lower. However, this policy has the effect of keeping benchmarks high in areas with the highest benchmarks in relation to FFS. Counties with the highest relative benchmarks would be the last to reach FFS levels.

Cap allowable percentage above FFS for benchmark and gradually lower cap

The cap option would set a maximum for the benchmark equal to some percentage above FFS and gradually reduce the percentage. For example, assume the cap was set at 140 percent and reduced by 10 percentage points each year until all benchmarks were set at local FFS spending. In year 1, all benchmarks higher than 140 percent of FFS would be reduced to 140 percent. In year 2, all benchmarks would be limited to 130 percent of FFS, and so on.

This policy would first address areas with the largest discrepancies between benchmarks and FFS costs. All benchmarks eventually would be brought down to FFS levels. Depending on how quickly the benchmarks come down, many areas with benchmarks above FFS would not see any reductions for several years, and program savings would be gradual for the first few years. While there would not be an extreme reduction in benefits immediately, there would likely be significant reductions annually.

Blend 100 percent of FFS and historical benchmarks and gradually increase the blend

The blend option would blend an area's FFS rate with its historical benchmark (perhaps increased by a national growth percentage), and the historical benchmark would be weighted lower each year until it was eliminated. For example, in the first year the blend could be 80 percent historical and 20 percent FFS. In year 2, the weighting could be changed to 60/40, and so on.

Advantages of this policy include that reductions would begin immediately and would be proportional to the discrepancies between benchmarks and FFS costs. There would be more certainty in the timing because all counties would be at FFS levels by a certain year. For areas where the benchmarks were not relatively high, the annual reductions would not be large. All benchmarks would be reduced toward FFS. Those areas with relatively high benchmarks would see large reductions each

year. As with other transitions, the savings would build gradually, and certain counties would see changes in benefits and plan options.

Competitive bidding to set rates

Medicare could use plan bids to help determine the benchmarks. There could be several versions of this option. We focus on an approach that would operate somewhat like the bidding system used to set the regional benchmarks. Plan bids in an area would be averaged and blended with the area's FFS spending or the MA county benchmarks to calculate a benchmark for a particular market area (e.g., a county or an area larger than one county). Under this type of policy, Medicare would use competition to influence plan payments, which then would be more likely to reflect the costs of efficient providers. Average bids for the Medicare Part A and Part B benefit package are currently well below the benchmarks and are often below FFS costs. Therefore, the resulting benchmarks may approach FFS spending, although it is unlikely that program costs would end up at exactly 100 percent of FFS. This option would also be complicated to design and implement. For example, not all plans in a given market may include every county of a multicounty market area or some counties may have only one plan.

Equity between sectors and among plan types

The Commission supports equity between MA plans and the traditional Medicare program. Supporting the principle of equity between the sectors takes many forms. For example, most private plans participating in Medicare are required to report various types of quality measures. The Commission believes the same approach should apply in the traditional FFS program. That is, CMS should report quality information for FFS Medicare that allows Medicare beneficiaries to compare FFS Medicare with private plans in terms of their performance on quality measures. To that end, the Commission has specifically recommended that the Secretary of Health and Human Services calculate clinical measures for the FFS program that would permit CMS to compare the FFS program with MA plans (MedPAC 2006a).

The Commission also supports the concept of equity in the treatment of different plan types within the private plan sector. For example, the Commission recommended that the Congress eliminate the benefit stabilization fund introduced in the MMA, which provided an unfair advantage to the regional PPOs. (In the Deficit Reduction Act of 2005, the Congress reduced the stabilization fund by $6.5 billion, to $3.5 billion, and restricted the availability of the funds to 2012 or thereafter.)

Table 3-5 (p. 70) shows how different requirements apply to different plan types in MA. In general, the Commission favors a level playing field for all plan types, unless special circumstances dictate otherwise. The Commission believes, for example, that PFFS plans and medical savings account (MSA) plans should be required to report on the quality of care for their enrollees so that beneficiaries can use quality as a factor in judging these plans. The Congress should eliminate payment rules that give one plan an advantage over another—as in the case of regional PPO plans.

In 2008, PFFS plans and MSA plans will have another advantage over other plan types. Other types of organizations with network plans that wish to offer plans tailored for employer-group-sponsored retirees will continue to be required to have plans that are available to individual, non-group-sponsored beneficiaries. However, non-network PFFS plans and MSA plans will not be subject to this requirement (CMS 2006).

In the March 2007 report to the Congress, the Commission noted its concern about how MA MSA plans are paid. The report pointed specifically to the statutory provision which required all funds to be used for the enrollee deposit when the equivalent of an MSA plan bid is below the benchmark. For other MA plans, the trust fund retains 25 percent of the difference. This provides MSA plans with an unfair advantage over other types of MA plans (though currently only three MSA plans are in operation).

In a similar vein, we are concerned about a recent provision that gives an unfair advantage to certain types of plans. The Tax Relief and Health Care Act of 2006 added section 1851(e)(2)(E) of the Social Security Act, effective only for 2007 and 2008, which allows a beneficiary who is not an MA enrollee (i.e., is in FFS Medicare) to enroll in an MA-only (nondrug) plan outside of the open enrollment period. MA-only plans then have an advantage over other plans. These MA-only plans have year-round enrollment, while other plans may accept new enrollees only during the open enrollment period (or if a person is newly entitled to Medicare, for example). In

TABLE 3–5 **Certain requirements and provisions vary by type of MA plan**

	PFFS	MSA	HMO/ Local PPO	Regional PPO	SNP
Requirements					
Build networks of providers[a]			✓	✓	✓
Report quality measures			✓	✓	✓
Have CMS review and negotiate bids			✓	✓	✓
Return to the trust funds 25 percent of the difference between bid and benchmark[b]	✓		✓	✓	✓
Offer Part D coverage[c]			✓	✓	✓
Have an out-of-pocket limit on enrollee expenditures		✓		✓	
Offer individual MA plan if offering employer group plan[d]			✓	✓	✓
Other provisions					
Protected from some risk through risk corridors[e]				✓	
Can limit enrollment to targeted beneficiaries[f]					✓

Note: MA (Medicare Advantage), PFFS (private fee-for-service), MSA (medical savings account), PPO (preferred provider organization), SNP (special needs plan).
[a]PFFS plans are exempted from other MA plans' network adequacy requirements if they pay providers Medicare fee-for-service rates.
[b]This provision applies when bids are under the benchmark. For regional PPO plans, one-half of the 25 percent amount is retained by the trust funds, and the remainder is included in the stabilization fund that, as of 2012, may be used to retain or attract such plans.
[c]MSA plans are prohibited from offering Part D coverage. PFFS plans may offer Part D coverage, but special rules apply to such plans (e.g., it is not required that an enrollee receive drugs at a discounted rate when the deductible applies or the person is in the Part D coverage gap).
[d]As of 2008, only non-network PFFS plans can operate exclusively as plans limited to employer group enrollees.
[e]Risk corridors are available only in 2006 and 2007.
[f]MA plans must allow all Medicare beneficiaries in their service area to enroll with few exceptions (e.g., beneficiaries with end-stage renal disease). Other exceptions apply to MSA plans (e.g., Medicaid beneficiaries may not enroll in an MSA). SNPs are permitted to limit their enrollment to their targeted beneficiary population (i.e., dual eligibles, beneficiaries who reside in an institution, or those with a chronic or disabling condition). SNPs can be local or regional coordinated care plans. They cannot be MSAs or PFFS plans.

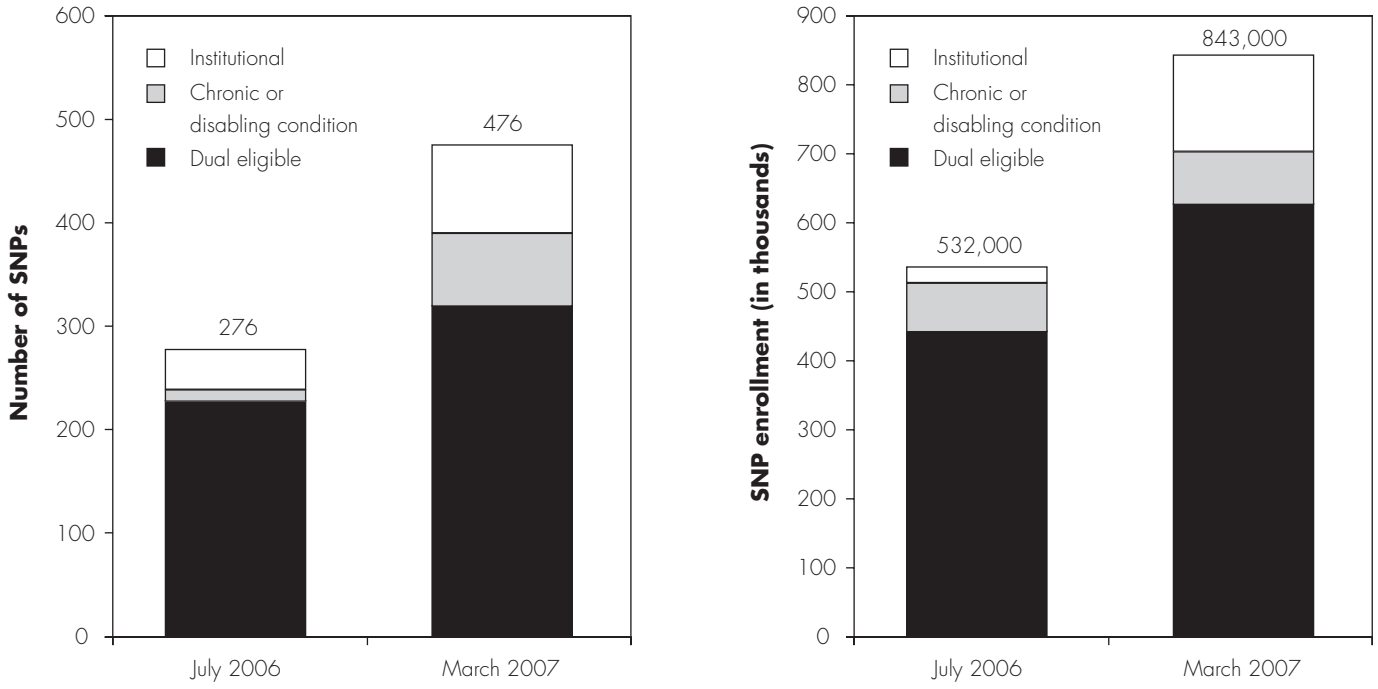
Source: MedPAC analysis of MA statutory and regulatory requirements.

particular, the provision affords an advantage to PFFS plans. The CMS guidance on this provision states that "if an individual in Original Medicare and a stand-alone prescription drug plan elects to enroll in an MA-only coordinated care plan, such as an HMO, PPO, or Regional PPO, his or her enrollment in the PDP [prescription drug plan] will be automatically cancelled as of the effective date of enrollment in the MA-only plan" (CMS 2007a). Beneficiaries without drug coverage may enroll in any MA-only plan, but a beneficiary's Part D coverage continues only if the person enrolls in a PFFS MA-only plan. In addition to giving an advantage to PFFS plans, beneficiaries with Part D coverage can use this provision as a way to discontinue their Part D enrollment outside of the open enrollment period.

Special needs plans

The Congress created a new MA plan type known as a SNP in the MMA to provide a common framework for existing plans for special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans. SNPs function essentially like any other MA plan but must also provide the Part D drug benefit. In exchange, they are allowed to limit their enrollment to their targeted populations—a provision that will lapse at the end of 2008, absent action by the Congress to extend the provision. Targeted populations include dual (Medicare and Medicaid) eligibles, the institutionalized, and beneficiaries with severe or disabling chronic conditions.

FIGURE 3–1 **The number of SNPs and SNP enrollment increased from 2006 to 2007**



Note: SNP (special needs plan).

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

This year again marked a significant increase in the number of SNPs available to beneficiaries. In 2004, there were just 11 SNPs.[11] By 2005, the number grew to 125. In 2006, the number of SNPs more than doubled to 276 with the entry of 151 new SNPs. In 2007, there are 476 SNPs. Organizations entering the SNP market include those with experience with Medicaid and special needs populations, such as Evercare, but also include MA organizations that chose to add SNPs to their menu of plans.

The Commission has sought creative ways to deliver high-quality health care to special needs beneficiaries. SNPs offer the potential to improve care coordination for dual eligibles and other special needs beneficiaries through unique benefit design and delivery systems.

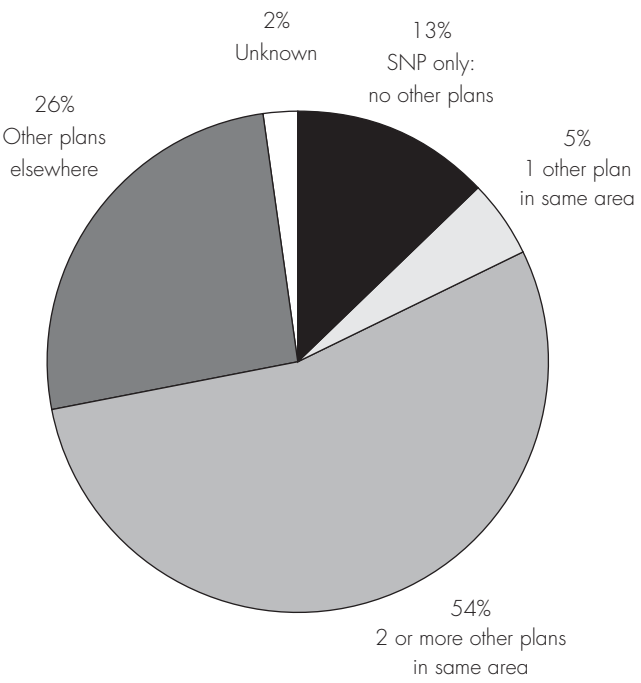
However, as described in the June 2006 report to the Congress, we see that many SNPs are not taking advantage of the opportunity to better coordinate care for special needs beneficiaries. SNPs, even dual-eligible SNPs, are not required to contract with states to provide Medicaid benefits. Based on site visits and additional discussions with experts, we do not see how dual-eligible SNPs that do not integrate Medicaid could fulfill the opportunity to coordinate the two programs. We also are unsure whether SNP designation is necessary to allow plans to furnish the sorts of benefits targeted at beneficiaries in institutions and with chronic conditions. For 2008 applications, CMS instructed SNPs to describe how they plan to meet their enrollees' special needs but has not specified minimum expectations or established an enforcement mechanism.

SNP availability and enrollment: July 2006 and March 2007

Since the June 2006 report to the Congress, we have further analyzed the availability of and enrollment in SNPs. Most SNPs (82 percent) available in 2006 were for dual-eligible beneficiaries (Figure 3-1). In 2007, dual-eligible plans still account for the largest share of

FIGURE 3–2

Most SNPs' parent organizations offered other MA plans in 2006



Note: SNP (special needs plan), MA (Medicare Advantage).

Source: CMS plan benefit packages, 2006.

SNPs (67 percent). However, institutional and chronic SNPs grew at faster rates, 127 percent and 446 percent, respectively (not shown).

In July 2006, most SNP enrollment (83 percent) was in dual-eligible plans (Figure 3-1, p. 71). Enrollment in chronic condition SNPs was almost entirely (98 percent) in a single plan—Medicare y Mucho Más in Puerto Rico. Enrollment in institutional SNPs was mostly (88 percent) in Evercare plans offered by United Healthcare. By 2007, most SNP enrollment was still in dual-eligible plans (74 percent). Enrollment in institutional SNPs grew as a share of total SNP enrollment from 4 percent to 17 percent. However, this growth is largely accounted for by the redefinition of the SCAN demonstration social-HMO as an institutional SNP. SCAN qualified as a SNP under the disproportionate share rule; approximately 26 percent of its enrollees are nursing home certifiable, living in the community. This change added 89,222 institutional SNP enrollees, 76 percent of institutional SNP enrollment growth.

Most SNPs were offered by parent organizations that also offer regular MA plans. Only 13 percent of SNPs were offered by parent organizations that focused exclusively on operating SNPs (Figure 3-2). The other 87 percent were offered by parent organizations that also offered regular MA plans, which suggests that these organizations offer SNPs as one choice in a menu of options. In fact, most SNPs (about 60 percent) existed alongside other MA plans offered by the same parent organization in the same service area.

Future work on Medicare Advantage

The Commission plans to continue monitoring the MA program. In addition to continuing our work in examining SNPs, we intend to look more closely at employer-sponsored plans in MA to learn more about their prevalence and where enrollment is concentrated. We would like to know more about the standards that apply to such plans (particularly in light of the broad waiver authority applicable to these plans), the bidding patterns compared with nongroup plans, and other issues that will permit us to evaluate these plans. Employer-sponsored plans appear to be growing in popularity, and more employers and groups are providing retiree coverage through the PFFS option. We will also be looking more closely at the MSA plans that began enrolling beneficiaries for 2007. MSA plans also appear to be focusing on the employer group market as a source of enrollment. ■

Endnotes

1 Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, plans with a bid below the benchmark (with the bid including administration and profit or retained earnings) are required to use 75 percent of the difference between the bid and the benchmark to finance extra benefits, with the remaining 25 percent (or half of that amount, for regional plans) retained by the Medicare trust funds. Previously, plans had the option of returning to the government all or a portion of the amount by which their needed revenue to provide the Medicare benefit package exceeded the Medicare payment—an option rarely chosen. Plans could also deposit any difference in a "stabilization fund" that financed extra benefits provided in a future year.

2 In the early years of the Medicare risk program, plan payments were set at 95 percent of projected FFS expenditures, but payments were not risk adjusted by enrollee health status.

3 For regional plans, within a given county the benchmark that applies to each county in the region may be lower than the local benchmark that applies to that county for local plans.

4 The user fee that is the MA plan contribution to the Medicare education campaign is 0.059 percent of plan payments (see www.cms.hhs.gov/MMAHelp/downloads/endofyearenrolpayletter07_final.pdf (downloaded 3/30/2007)). Benchmark amounts include CMS contractor administrative costs for claims processing. Noncontractor Medicare administrative costs incurred by CMS, after netting out administrative costs for the MA program apportioned by program expenditures, are in the range of 0.4 percent of program expenditures in Medicare (the CMS 2006 Financial Report is available at www.cms.hhs.gov/CFOReport/Downloads/2006_CMS_Financial_Report.pdf).

5 As required by the statute, CMS anticipates incorporating any VA effect in the 2009 MA rates (CMS 2007b).

6 For the range of benefits MA plans provided to enrollees in 2006, see Chart 10-4 of the June 2006 MedPAC data book (MedPAC 2006b).

7 At least one PFFS plan has a hospital network. The plan service area consists of two counties. Beneficiaries pay different levels of cost sharing for in-network versus out-of-network hospital care. We do not know whether the payment arrangements between the plan and the network hospitals call for payment at other than Medicare FFS rates.

8 The February 2007 numbers exclude counties with fewer than 11 enrollees because they are based on data released publicly by CMS, which suppresses such data for privacy reasons. For February 2007, about 39,000 enrollees live in counties with enrollment under 11. About 3 percent of PFFS enrollment comes from such counties. In the July 2006 data, about three-quarters of the under-11 enrollment in PFFS came from rural counties. Assuming a similar pattern in 2007, the rural and BBA floor percentages shown in the table for 2007 would increase by 1 percentage point.

9 Note that the February 2007 enrollment numbers of Table 3-3 are based on data publicly released by CMS and do not include counties with fewer than 11 enrollees. About 3 percent of PFFS enrollment is in counties with 10 or fewer enrollees in 2007. The 2006 numbers in the table include all counties with any PFFS enrollment.

10 The reported data are based on a MedPAC analysis of the 2007 Medicare Personal Plan Finder downloadable database available at the CMS website. Note that PFFS plans will no longer be reporting quality measures through the Health Plan Employer Data and Information Set but will have member satisfaction data reported based on the Consumer Assessment of Healthcare Providers and Systems. Medical savings account plans will have no reported quality or member satisfaction measures.

11 SNP plans, like other MA plans, are benefit packages offered by MA organizations, which sign contracts with CMS.

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