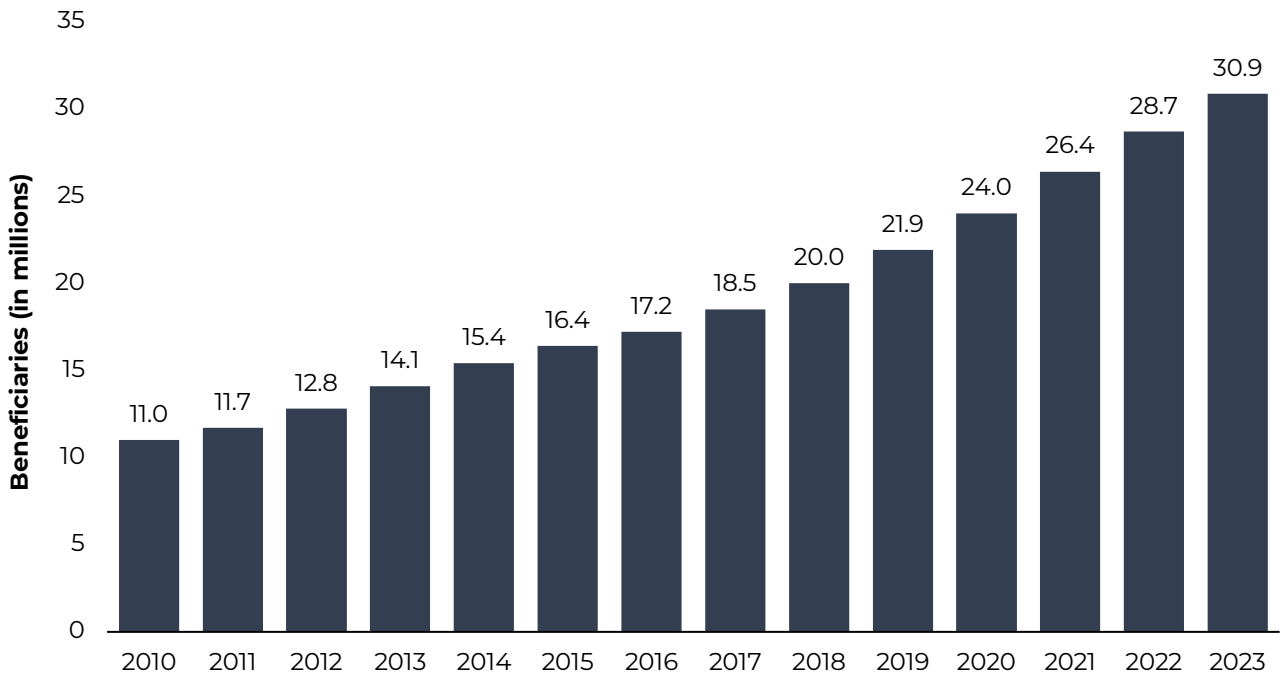
SECTION

9

Medicare Advantage

Chart 9-1 Enrollment in MA plans, 2010–2023



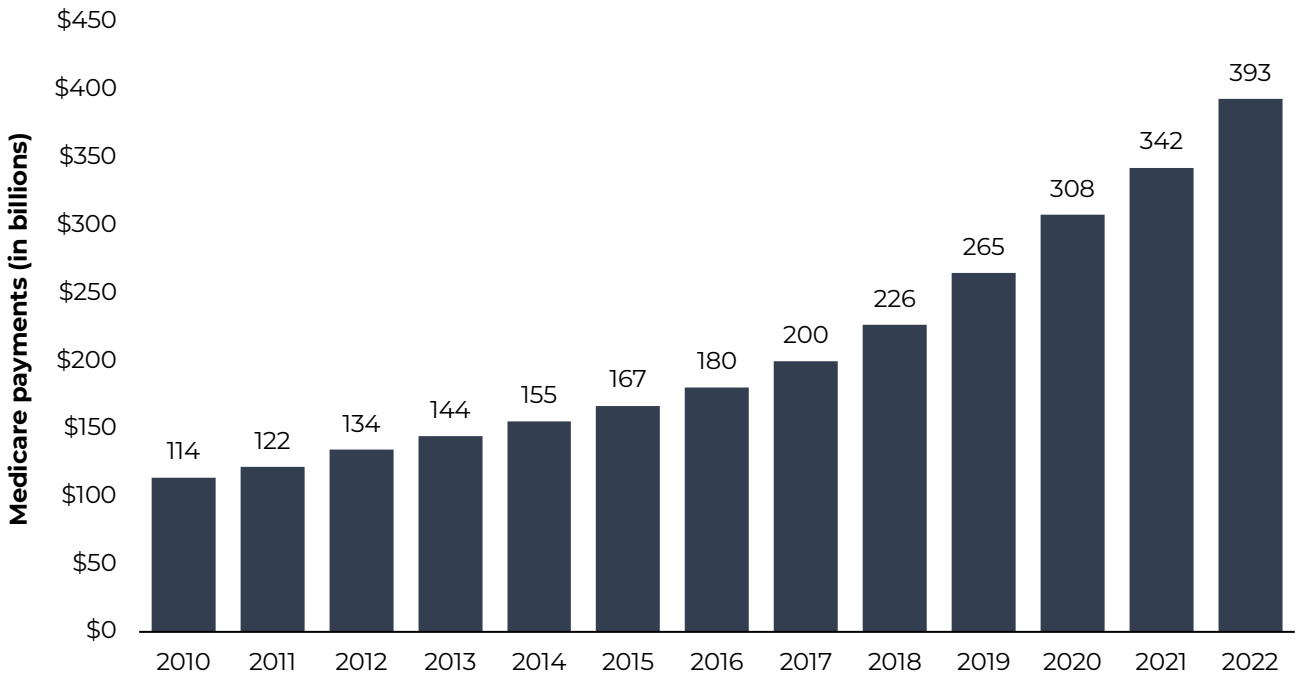
Note: MA (Medicare Advantage).

Source: CMS Medicare managed care contract reports and monthly summary reports, February 2010–2023.

> In February 2023, enrollment in MA plans, which are paid on an at-risk capitated basis, reached 30.9 million, or 52 percent of all eligible Medicare beneficiaries (only beneficiaries enrolled in both Part A and Part B are eligible to enroll in an MA plan). An additional 1 percent of all Medicare beneficiaries with both Part A and Part B coverage are enrolled in other private plans such as cost plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid plans participating in CMS's financial alignment demonstration (data not shown).

> MA enrollment has grown steadily since 2010, increasing nearly threefold. Enrollment growth has been particularly rapid in recent years, climbing by at least 8 percent in each of the last six years.

Chart 9-2 Medicare payments to MA plans, 2010–2022



Note: MA (Medicare Advantage). In contrast with prior MedPAC estimates, the figures above do not include Medicare MSA plans, cost-reimbursed plans, Medicare-Medicaid demonstration plans, and the Program of All-Inclusive Care for the Elderly.

Source: MedPAC estimate based on the Reports of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust funds, 2020-2023.

> The Medicare program paid MA plans an estimated $393 billion in 2022 to cover Part A and Part B services for MA enrollees.

> The rapid growth in MA enrollment (Chart 9-1) coincided with rapid growth in total Medicare payments to MA plans. From 2017 to 2022, total payments to MA plans nearly doubled.

Chart 9-3 MA plans available to almost all Medicare beneficiaries, 2016–2023

	Share of Medicare beneficiaries living in counties with plans available					Average plan offerings per beneficiary
	CCPs					
	HMO or local PPO (local CCP)	Regional PPO	Any CCP	PFFS	Any MA plan	
2016	96	73	99	47	99	18
2017	95	74	98	45	99	18
2018	96	74	98	41	99	20
2019	97	74	98	38	99	23
2020	98	73	99	36	99	27
2021	98	72	99	34	99	32
2022	99	74	99	35	99	36
2023	99	74	99	29	>99.5	41

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). These data do not include plans that have restricted enrollment (special needs plans, employer plans) or are not paid based on MA rates (cost plans and certain demonstration plans). For 2015 through 2021, "share of Medicare beneficiaries" includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). As of 2022, the share of Medicare beneficiaries includes only beneficiaries with both Part A and Part B coverage (i.e., MA-eligible beneficiaries).

Source: MedPAC analysis of plan bid data from CMS, 2016–2023.

> There are four types of MA plans, three of which are CCPs. Local CCPs include HMOs and local PPOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional PPOs cover one or more entire states and have networks that may be looser than those of local PPOs. CCPs accounted for 98 percent of Medicare private plan enrollees as of February 2023 (data not shown). Since 2011, PFFS plans are required to have networks in areas with two or more CCPs. In other areas, PFFS plans are not required to have networks, and enrollees are free to use any Medicare provider.

> Local CCPs are available to 99 percent of eligible Medicare beneficiaries in 2022, and regional PPOs are available to 74 percent of beneficiaries. Since 2006, almost all Medicare beneficiaries have had MA plans available (data not shown); Nearly 100 percent have an MA plan available in 2023.

> The number of plans from which beneficiaries may choose in 2023 is higher than at any time during the years examined. In 2023, beneficiaries can choose from an average of 41 plans operating in their counties.

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

Plan type	Total enrollees (in thousands)					Percent change 2022–2023
	2019	2020	2021	2022	2023	
Local CCPs	20,502	22,704	25,325	27,878	30,291	9%
Regional PPOs	1,255	1,170	1,003	756	534	–29
PFFs	118	87	61	48	37	–23

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

Source: CMS health plan monthly summary reports, February 2019–2023.

> Almost all MA enrollees (98 percent) choose local CCPs (HMOs or local PPOs), which limit or discourage use of out-of-network providers. Though network requirements may be looser in regional PPOs and PFFS plans, enrollment in both types of plans has been declining for several years and dropped sharply in 2023, with enrollment in regional PPOs falling by 29 percent and enrollment in PFFS plans falling by 23 percent.

> Combined enrollment in the three types of plans grew by 8 percent from February 2022 to February 2023 (data not shown). Enrollment in local CCPs grew by 9 percent over the past year, and special needs plans (SNPs) accounted for 45 percent of this growth (data not shown). Local PPOs grew by 14 percent over the past year and accounted for nearly two-thirds (64 percent) of the growth in local CCP enrollment (data not shown). Most enrollment growth among HMOs (92 percent) occurred within SNPs (data not shown). The growth in SNP and local PPO enrollment may be driven by increases in Medicare payments for extra benefits of MA enrollees (data not shown).

Chart 9-5 MA and cost plan enrollment by state and type of plan, 2023

State or territory	All MA-eligible beneficiaries (in thousands)	Distribution (in percent) of beneficiaries by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	59,914	30%	21%	1%	0%	0%	52%
Alabama	1,011	29	32	0	0	0	61
Alaska	100	0	2	0	0	0	2
Arizona	1,330	38	15	0	0	0	53
Arkansas	616	19	24	2	1	0	46
California	6,018	49	5	0	0	0	54
Colorado	910	36	19	0	0	0	55
Connecticut	660	20	35	0	0	0	56
Delaware	216	14	18	0	0	0	32
Florida	4,668	37	19	2	0	0	58
Georgia	1,722	16	38	3	0	0	57
Hawaii	260	22	39	0	0	0	61
Idaho	351	32	18	0	0	0	50
Illinois	2,133	14	25	0	0	0	40
Indiana	1,245	21	28	1	0	0	50
Iowa	623	16	18	0	0	2	37
Kansas	528	11	21	1	0	0	34
Kentucky	893	26	27	1	0	0	55
Louisiana	854	44	12	1	0	0	57
Maine	340	33	26	0	0	0	59
Maryland	961	14	11	0	0	0	25
Massachusetts	1,276	18	15	1	0	0	33
Michigan	2,052	23	37	0	0	0	60
Minnesota	1,030	17	39	0	0	6	62
Mississippi	588	22	18	1	0	0	41
Missouri	1,203	28	25	1	0	0	55
Montana	234	8	21	0	0	0	30
Nebraska	343	16	15	0	0	3	34
Nevada	524	44	10	0	0	0	54
New Hampshire	297	13	22	0	0	0	36
New Jersey	1,519	13	30	0	0	0	43
New Mexico	412	26	26	0	0	0	52
New York	3,464	32	19	3	0	0	54
North Carolina	2,011	27	26	1	0	0	54
North Dakota	131	0	16	0	0	17	33
Ohio	2,284	34	20	1	0	0	55
Oklahoma	716	18	22	0	0	0	41
Oregon	854	35	22	0	0	0	57
Pennsylvania	2,641	30	25	0	0	0	55
Puerto Rico	674	94	1	0	0	0	95
Rhode Island	211	44	13	0	0	0	57
South Carolina	1,102	12	30	3	0	0	45
South Dakota	177	2	16	0	0	18	35
Tennessee	1,336	36	18	0	0	0	54
Texas	4,187	32	21	3	0	0	56
Utah	405	38	16	0	0	0	54
Vermont	148	5	25	2	0	0	33
Virgin Islands	19	1	29	0	0	0	30
Virginia	1,468	25	13	1	0	0	39
Washington	1,348	34	15	0	0	0	49
Washington, D.C.	79	12	21	0	0	0	32
West Virginia	417	8	42	0	0	4	54
Wisconsin	1,193	30	23	1	0	4	58
Wyoming	113	0	10	0	1	1	13

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports rather than bids to CMS. U.S. total includes beneficiaries in U.S. territories but does not include beneficiaries residing in foreign areas. Component percentages and U.S. total may not sum to totals due to rounding. We report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage).

Source: CMS enrollment and population data, February 2023.

Chart 9-6 MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2023

	All plans	HMOs	Local PPOs	Regional PPOs	All plans after coding estimate
Benchmarks/FFS	109%	109%	110%	95%	114%
Bids/FFS	83	82	85	82	87
Payments/FFS	101	100	102	91	106

Note: MA (Medicare Advantage), FFS (fee-for-service), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Employer plans do not submit plan bids and generally receive payment based on the bidding behavior of PPOs. Thus, employer plans are included only in "Payments/FFS." We estimate FFS spending by county using the 2023 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals. To account for our most recent coding estimate of 4.9 percent (after accounting for the mandatory coding adjustment which reduces MA risk score by 5.9 percent), we estimated overall benchmarks, bids, and payments if coding differences between MA and FFS were fully reflected (i.e., if the risk-adjusted differences between MA and FFS did not include coding differences). We assume, conservatively, that the coding differences for 2023 are the same as for 2021 (the most recent year of data available). We did not estimate coding differences between MA and FFS by plan type. Although MA enrollees must be enrolled in both Part A and Part B, the FFS spending denominator used in the table includes all Part A and Part B spending. Overall MA payments relative to actual historical spending for FFS enrollees with both Part A and Part B have been historically similar to our estimates using all FFS enrollees. MA benchmarks, bids, and payments assume this level of FFS spending. All numbers in this table have been risk adjusted and reflect quality bonuses but have not been adjusted for favorable selection of beneficiaries in MA plans, and only aggregate numbers for all plans have been adjusted for coding intensity differences between MA and FFS.

Source: MedPAC analysis of CMS FFS spending projections and plan bid data from CMS, October 2022.

> Since 2006, plan bids have partly determined the Medicare payments that plans receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.

> The benchmark is a bidding target in each county that is set by means of a statutory formula based on percentages (ranging from 95 percent to 115 percent) of each county's per capita Medicare FFS spending. Plans with quality ratings of 4 or more stars typically have their benchmarks raised by 5 percent (and up to 10 percent in some counties).

> If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it is typically 65 percent or 70 percent. After accounting for administrative expenses and profit, plans must return rebates to enrollees in the form of lower cost sharing, supplemental benefits, or lower premiums.

> We estimate that MA benchmarks average 109 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type, as they draw enrollment from different geographic areas.

> Plans' enrollment-weighted bids average 83 percent of CMS's FFS spending projections for 2023.

> After accounting for risk-coding differences between FFS and MA plans that have not been resolved through the coding intensity factor, we estimate that MA payments are 6 percent higher than spending for similar beneficiaries in FFS. This estimate would be higher if we included an adjustment for the effect of favorable selection—where payments to plans are systemically greater than plans' spending for their enrollees.

Chart 9-7 Impact of coding intensity on MA risk scores was larger for enrollees eligible for partial or full Medicaid benefits, 2021

Medicaid eligibility	Coding intensity relative to FFS Medicare
All MA enrollees	10.8%
No Medicaid benefits	10.2
Partial Medicaid benefits	14.5
Full Medicaid benefits	11.3

Note: MA (Medicare Advantage), FFS (fee-for-service). Analysis is based on retrospective cohorts of 2021 enrollees, tracked backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007. The analysis compares risk scores for MA and FFS beneficiaries with the same Medicaid eligibility (e.g., MA enrollees eligible for full Medicaid benefits are compared with FFS beneficiaries eligible for full Medicaid benefits) and accounts for differences in age, sex, and length of enrollment between the MA and FFS populations.

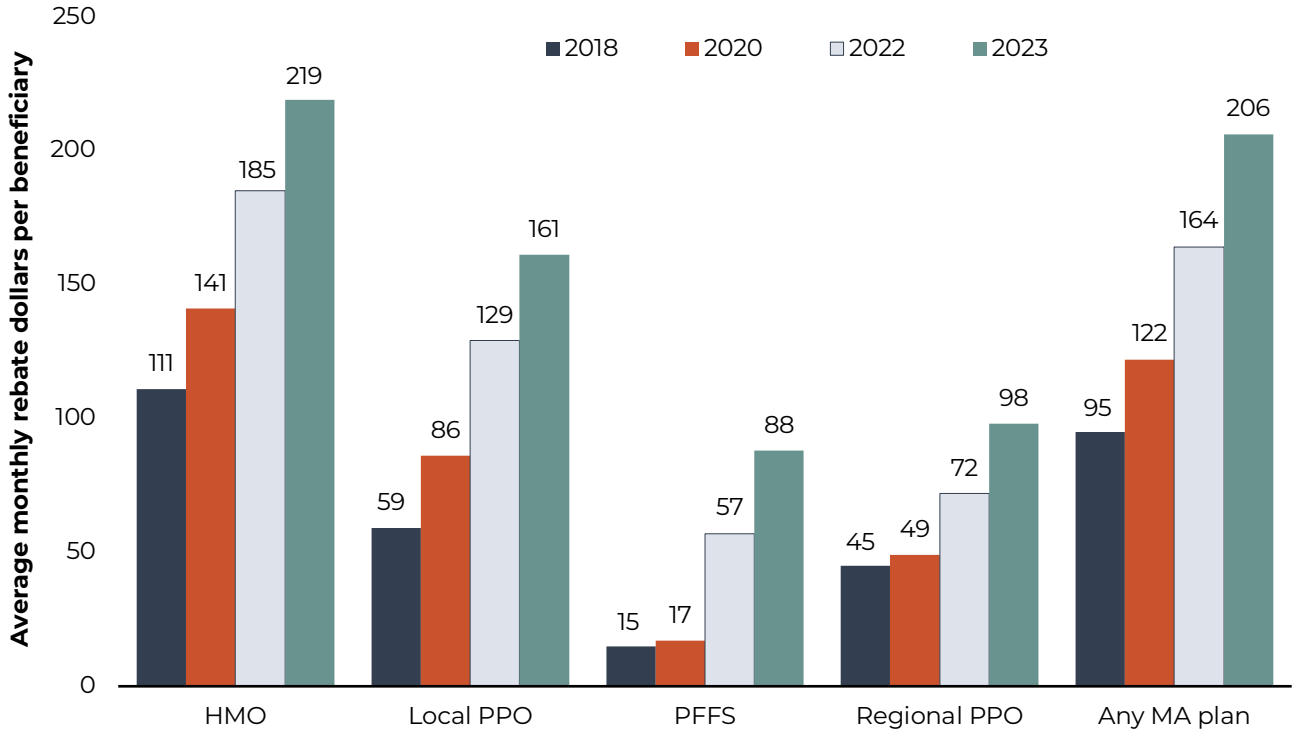
Source: MedPAC analysis of CMS enrollment and risk score files, 2007 through 2021.

> Payments to MA plans are risk adjusted to account for differences in health status. Higher risk scores increase payments to plans for enrollees with higher expected Medicare spending. Risk scores are based on demographic information and diagnoses that plans submit to CMS. Documenting additional diagnosis codes raises plan enrollees' risk scores, generating two distinct benefits for MA plans: (1) increasing plans' monthly payments and (2) increasing the rebates plans use to provide extra benefits to enrollees. Plans that document relatively more diagnosis codes have a competitive advantage over other plans. In contrast, the payment policies in FFS Medicare offer relatively little incentive to code all diagnosis codes. This difference in coding incentives causes beneficiary risk scores to be higher when a beneficiary enrolls in MA than if the same beneficiary enrolls in FFS Medicare. As a result of higher MA coding intensity, the Medicare program pays MA plans more than the program would have paid for services provided through FFS Medicare.

> In 2021, MA risk scores on average were 10.8 percent higher than risk scores for comparable FFS beneficiaries.

> MA enrollees who were eligible for full or partial Medicaid benefits had higher coding intensity relative to FFS than enrollees who were not eligible for Medicaid. Risk scores for MA enrollees eligible for partial Medicaid benefits were 14.5 percent higher than the scores for FFS beneficiaries eligible for partial Medicaid benefits, and risk scores for MA enrollees eligible for full Medicaid benefits were 11.3 percent higher than the scores for FFS beneficiaries eligible for full Medicaid benefits. By contrast, risk scores for MA enrollees who were not eligible for Medicaid were 10.2 percent higher than the scores for their FFS counterparts,

Chart 9-8 Average monthly rebate dollars, by plan type, 2018–2023



Note: HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), MA (Medicare Advantage). Employer group waiver and special needs plans are excluded.

Source: MedPAC analysis of bid data from CMS.

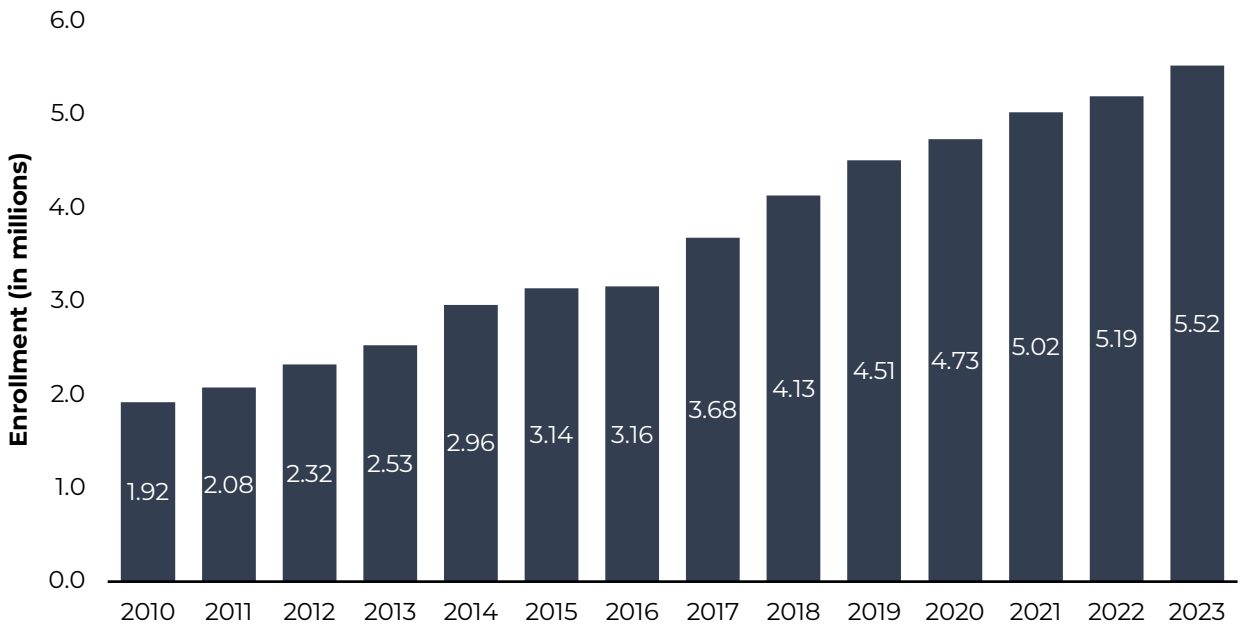
> Perhaps the best summary measure of plan benefit value is the average rebate, which plans receive to provide additional benefits that are not covered under Medicare Part A and Part B. Plans are awarded rebates for bidding under their benchmarks. The rebates must be returned to the plan members in the form of extra benefits (after accounting for plan margins and administrative costs). The extra benefits may be lower cost sharing, supplemental benefits, or lower premiums. The average rebate for all nonemployer, non–special needs plans rose to a high of $206 per month per beneficiary for 2023.

> HMOs have had, by far, the highest rebates because they tend to bid lower than other types of plans. Average rebates for HMOs have risen sharply over the past few years and are at a historical high of $219 per month per beneficiary for 2023.

> For local PPOs, rebates have risen sharply in recent years, more than doubling since 2019.

> While the availability of PFFS plans is relatively low, rebates for PFFS plans rose sharply in 2023 among the relatively small number of PFFS plans.

Chart 9-9 Enrollment in employer group MA plans, 2010–2023



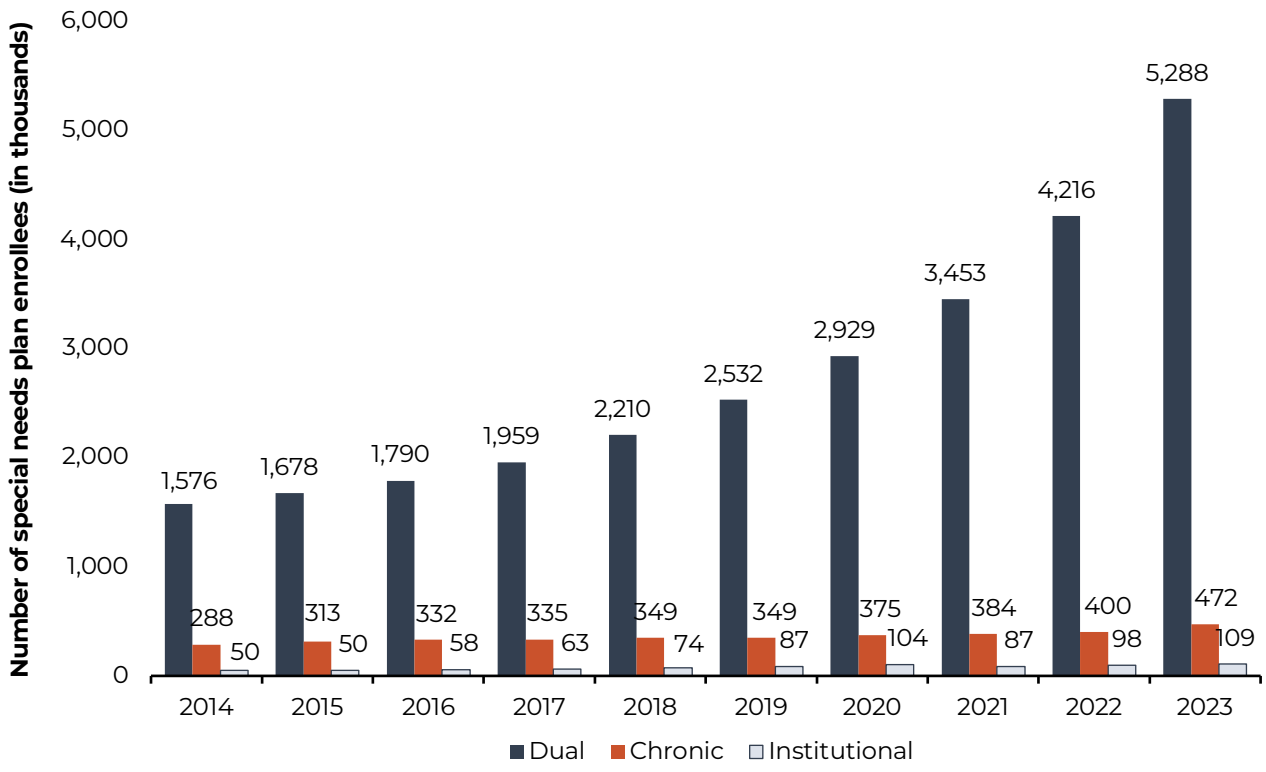
Note: MA (Medicare Advantage).

Source: CMS enrollment data, February 2010–2023.

> While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.

> As of February 2023, about 5.5 million enrollees were in employer group plans, or about 18 percent of all MA enrollees. Employer plan enrollment grew by 6 percent from 2022 and has more than doubled since 2013.

Chart 9-10 Number of special needs plan enrollees, 2014–2023



Source: CMS special needs plans comprehensive reports, April 2014–2023.

> The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.

> SNPs were originally authorized for five years, but SNP authority was extended several times. The Bipartisan Budget Act of 2018 made SNPs permanent.

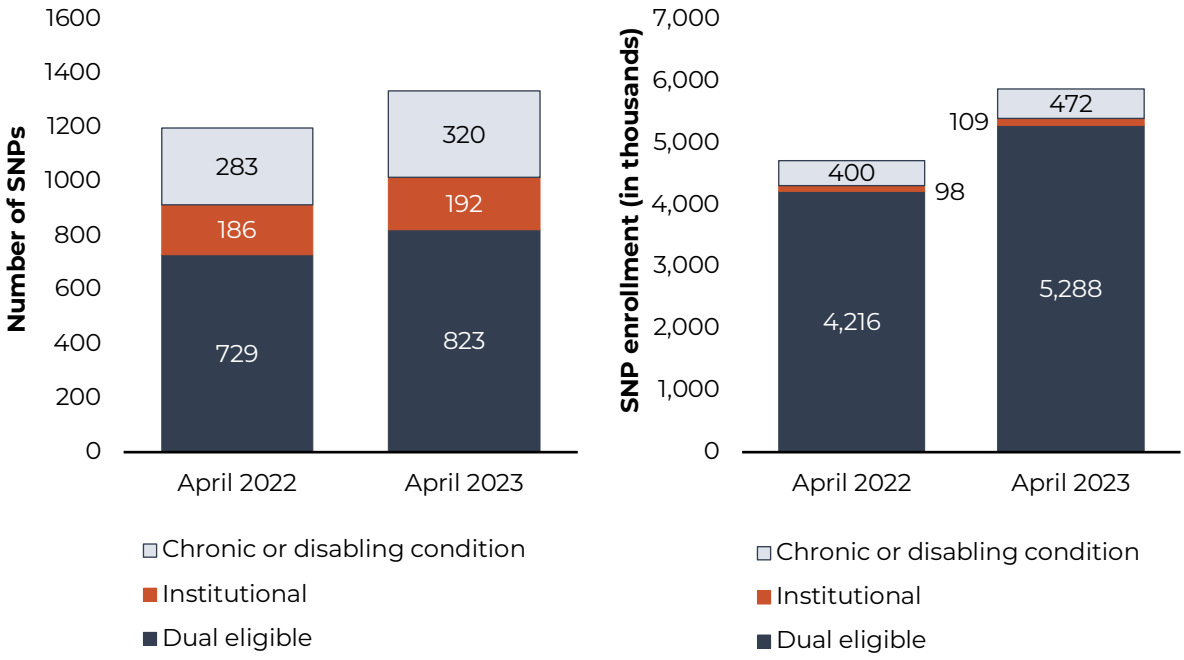
> CMS approves three types of SNPs: Dual-eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing-home certified.

> Enrollment in dual-eligible SNPs has grown continuously and exceeds 5.2 million in 2023, tripling since 2014.

> Enrollment in chronic condition SNPs has grown at varying rates as plan requirements have changed, but it has generally risen annually since 2014.

> Enrollment in institutional SNPs increased to its highest level ever in 2023.

Chart 9-11 Number of SNPs and SNP enrollment rose from 2022 to 2023



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2022 and 2023.

> The number of SNPs increased by 11 percent from April 2022 to April 2023. Dual-eligible SNPs increased by 13 percent, institutional SNPs increased by 3 percent, and the number of chronic condition SNPs increased by 13 percent.

> In 2023, most SNPs (61 percent) are for dual-eligible beneficiaries, while 16 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need), and 24 percent are for beneficiaries with chronic conditions.

> From April 2022 to April 2023, the number of SNP enrollees increased by 24 percent. Enrollment in SNPs for dual-eligible beneficiaries grew by 25 percent, enrollment in SNPs for institutionalized beneficiaries increased by 11 percent, and enrollment in SNPs for beneficiaries with certain chronic conditions grew by 18 percent. Enrollment in all SNPs has grown from 0.9 million in May 2007 (data not shown) to 5.9 million in April 2023.

> The availability of SNPs varies by type of special needs population served (data not shown). In 2022, 94 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (unchanged from 2022), 74 percent live where SNPs serve institutionalized beneficiaries (up from 77 percent in 2022), and 66 percent live where SNPs serve beneficiaries with chronic conditions (up from 59 percent in 2022).

Chart 9-12 MA enrollment patterns, by age, dual-eligible status, and ESRD status, June 2022

	All MA-eligible beneficiaries		FFS		MA		MA enrollment as a share of all MA-eligible category
	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	
Total	57.6	100%	29.2	100%	28.4	100%	49%
Aged (65 or older)	50.3	87	25.7	88	24.6	87	49
Under 65	7.2	13	3.5	12	3.7	13	52
Non–dual eligible	46.2	80	24.4	84	21.8	77	47
Aged (65 or older)	43.2	75	23.0	79	20.3	71	47
Under 65	3.0	5	1.4	5	1.6	5	52
Full dual eligibility	8.0	14	3.8	13	4.1	15	52
Aged (65 or older)	4.9	8	2.1	7	2.7	10	56
Under 65	3.1	5	1.7	6	1.4	5	46
Partial dual eligibility	3.4	6	1.0	3	2.4	8	71
Aged (65 or older)	2.2	4	0.6	2	1.7	6	74
Under 65	1.1	2	0.4	1	0.8	3	66
Enrollment subcategories, all ages							
ESRD	0.5	1	0.3	1	0.2	1	42
Beneficiaries with partial dual eligibility							
QMB only	1.7	3	0.5	2	1.2	4	70
SLMB only	1.0	2	0.3	1	0.8	3	73
QI	0.6	1	0.2	1	0.4	2	73

Note: MA (Medicare Advantage), ESRD (end-stage renal disease), FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualified individual). Data exclude cost plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid Plans participating in CMS's financial alignment demonstration. MA-eligible beneficiaries are Medicare beneficiaries with both Part A and Part B coverage. Dual-eligible beneficiaries are eligible for Medicare and Medicaid. Data exclude Puerto Rico because enrollment data undercount dual-eligible categories. As of June 2022, Puerto Rico had about 630,000 Medicare beneficiaries enrolled in MA plans, and about 288,000 were enrolled in dual-eligible special needs plans. Figures may not sum to totals due to rounding.

Source: MedPAC analysis of 2022 common Medicare environment files.

> Medicare beneficiaries with Medicaid benefits who have full dual eligibility (i.e., those who have coverage of their Medicare out-of-pocket costs (premiums and cost sharing) as well as coverage for services such as long-term care services and supports) are less likely to enroll in MA plans than beneficiaries with "partial" dual eligibility. Fully dual-eligible beneficiaries have coverage through state Medicaid programs, including certain QMBs (i.e., QMB-Plus) and certain SLMBs (i.e., SLMB-Plus) who also have Medicaid coverage for services. Beneficiaries with partial dual eligibility (such as QIs or SLMBs) have coverage for Medicare premiums or premiums and Medicare cost sharing (such as QMBs).

> Medicare plan enrollment among the dually eligible continues to increase. In 2021, 52 percent of fully dual-eligible beneficiaries were in MA plans (up from 46 percent in 2021; data not shown), and 71 percent of partial dual-eligible beneficiaries were in MA plans (up from 66 percent in 2021; data not shown). QI beneficiaries have the highest rates of MA enrollment among partial duals (73 percent).

> A substantial share of the dually eligible (37 percent; data not shown) are under the age of 65 and entitled to Medicare on the basis of disability or ESRD. Beneficiaries under age 65 who are fully dual eligible are less likely than aged fully dual-eligible beneficiaries to enroll in MA (46 percent vs. 56 percent, respectively). A higher share of MA enrollees are fully dual eligible compared with FFS enrollees (15 percent vs. 13 percent, respectively).

> ESRD beneficiaries had higher rates of plan enrollment in 2022 (42 percent) compared with 2021 (35 percent; data not shown).