

SECTION

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**Medicare Advantage**

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

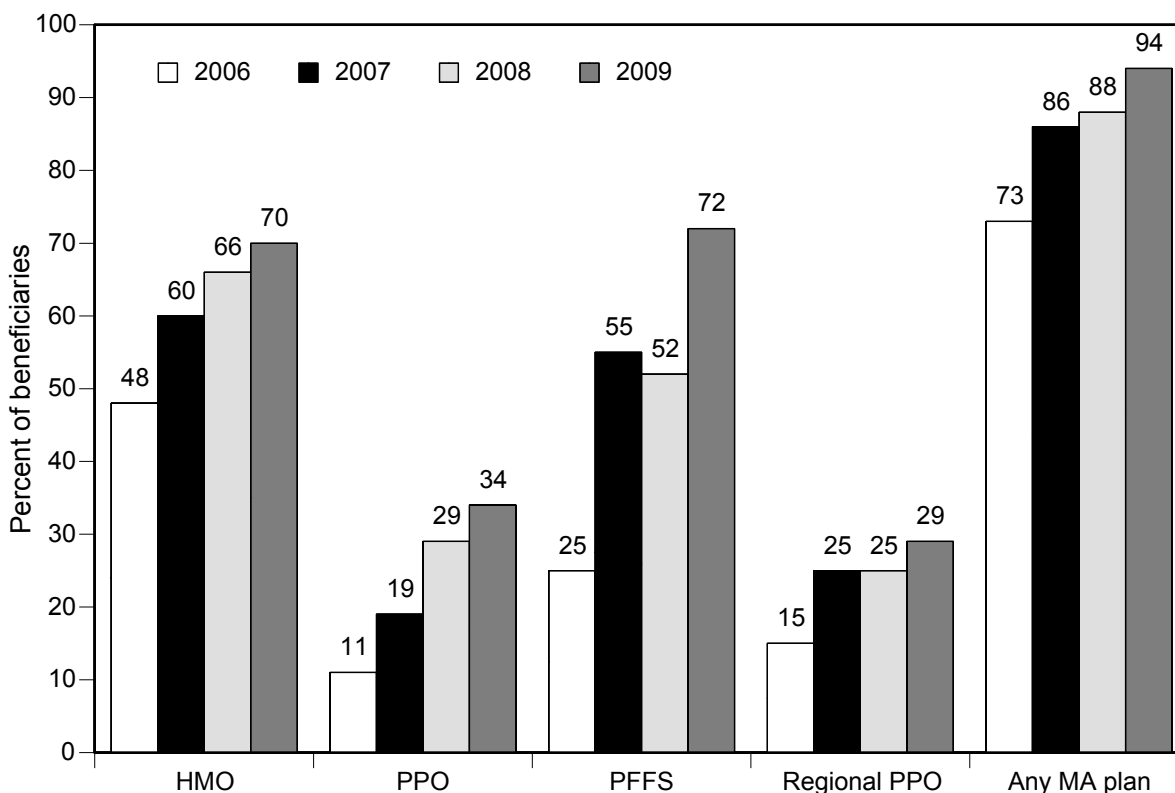
	CCPs			PFFS	Any MA plan	Average plan offerings per county
	HMO or local PPO	Regional PPO	Any CCP			
2005	67%	N/A	67%	45%	84%	5
2006	80	87	98	80	100	12
2007	82	87	99	100	100	20
2008	85	87	99	100	100	35
2009	88	91	99	100	100	34

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 or are not paid based on the MA plan bidding process (special needs plans, cost-based plans, employer-only plans, and certain demonstration plans).

Source: MedPAC analysis of plan finder data from CMS.

- There are four types of plans, three of which are coordinated care plans (CCPs). Local CCPs include local preferred provider organizations (PPOs) and health maintenance organizations (HMOs), which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional CCPs (regional plans are required by statute to be PPOs) cover entire state-based regions and have networks that may be looser than the ones required of local PPOs. Regional PPOs were only available beginning in 2006. PFFS plans, which are not CCPs, are not required to have networks and members may go to any willing Medicare provider.
- Local CCPs are available to 88 percent of Medicare beneficiaries in 2009—up from 67 percent in 2005. Regional PPOs are available to 91 percent of beneficiaries. Virtually all beneficiaries live in a county where MA PFFS plans are available in 2009—up from 45 percent in 2005. For the past four years, 100 percent of Medicare beneficiaries have had MA plans available, up from 84 percent in 2005.
- The number of plans from which beneficiaries may choose has increased. In 2009, beneficiaries can choose from an average of 34 plans operating in their counties, up from a choice of 20 plans in 2007 and 5 plans in 2005.

**Chart 10-2. Access to zero-premium plans with MA drug coverage, 2006–2009**

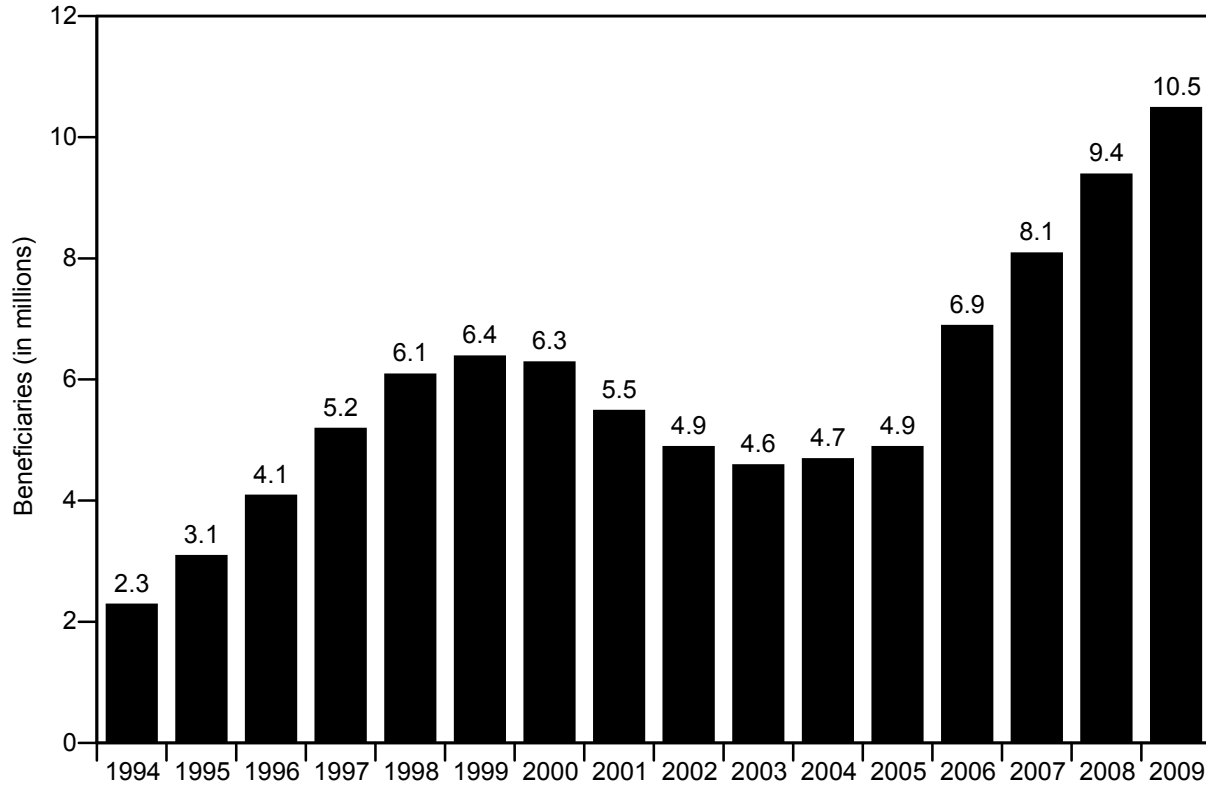


Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

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

- Across all plan types, in 2009 there is increased availability of “zero-premium” plans—plans with no premium payments other than the Medicare Part B premium. More beneficiaries can obtain an MA plan with Part D drug coverage (an MA–PD plan) for which the enrollee pays no premium for either the drug coverage or the coverage of Medicare Part A and Part B services. In 2009, 94 percent of Medicare beneficiaries have access to at least one MA–PD plan with no premium (beyond the Medicare Part B premium) for the combined coverage (and no premium for any non-Medicare-covered benefits included in the benefit package), compared with 73 percent in 2006 and 88 percent in 2008.
- Seventy percent of beneficiaries have zero-premium MA–PD HMOs available, while MA–PD PPOs without premiums are much less widely available. Particularly noteworthy is the increased availability of private fee-for-service (PFFS) plans offering zero premiums. In 2006, 25 percent of beneficiaries had access to a PFFS plan with no plan premium for Part C and Part D coverage—a figure that grew to 72 percent in 2009.
- In most cases, enrollees of MA plans continue paying their Medicare Part B premium, but some MA–PD plans use rebate dollars to reduce or eliminate their enrollees’ Part B premium obligation.

**Chart 10-3. Enrollment in MA plans, 1994–2009**



Note: MA (Medicare Advantage).

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

- Medicare enrollment in private health plans paid on an at-risk capitated basis is at an all-time high at 10.5 million enrollees (23 percent of all Medicare beneficiaries). Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999, then declined to a low of 4.6 million enrollees in 2003. MA enrollment has increased steadily since 2003.

## Chart 10-4. Enrollment in local coordinated care plans grew slower than in other major plan types

Plan type	Total enrollees (in thousands)				Percentage change 2008–2009
	July 2006	February 2007	February 2008	February 2009	
Local CCPs	5,480	6,065	6,830	7,625	12%
Regional PPOs	82	121	257	377	47
PFFS	774	1,328	2,057	2,353	14

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

Source: CMS health plan monthly summary reports.

- Growth in enrollment in local coordinated care plans (CCPs) was slower than growth in regional preferred provider organizations (PPOs) or private fee-for-service (PFFS) plans over the past year. Combined enrollment in the three types of plans grew by 13 percent from February 2008 to February 2009.
- While still the dominant form of enrollment, local CCP enrollment grew 12 percent over the past year, while enrollment in regional PPOs grew by 47 percent and PFFS enrollment grew by 14 percent.
- More than half of the growth in PFFS plans from February 2008 to February 2009 can be attributed to employer-group plans (see Chart 10-8). As of February 2009, 30 percent of PFFS enrollees are enrolled through employer groups.

**Chart 10-5. MA and cost plan enrollment by state and type of plan, 2009**

State	Medicare eligibles (in thousands)	Distribution (in percent) of enrollees by plan type					Total
		HMO	Local PPO	Regional PPO	PFFS	Cost	
Alabama	805	11%	7%	0%	2%	0%	21%
Alaska	55	0	0	0	1	0	1
Arizona	853	31	2	1	4	0	38
Arkansas	506	3	1	2	8	0	14
California	4,475	33	0	1	1	0	35
Colorado	576	24	1	0	5	4	34
Connecticut	547	13	1	0	1	0	16
Delaware	140	1	1	0	3	0	5
District of Columbia	75	2	2	0	1	6	11
Florida	3,176	23	1	3	2	0	29
Georgia	1,148	3	2	2	8	0	15
Hawaii	194	13	4	1	2	19	39
Idaho	213	10	4	0	13	1	27
Illinois	1,770	5	1	0	3	0	10
Indiana	959	1	3	2	9	1	15
Iowa	570	2	1	1	6	1	11
Kansas	463	2	3	0	4	1	9
Kentucky	725	3	2	2	7	1	15
Louisiana	654	18	0	0	4	0	22
Maine	253	3	1	0	6	0	9
Maryland	742	3	1	0	1	3	7
Massachusetts	1,016	14	1	0	3	0	19
Michigan	1,574	5	0	1	18	0	24
Minnesota	748	13	0	2	9	13	37
Mississippi	477	3	0	1	6	0	9
Missouri	962	12	3	0	4	0	20
Montana	160	0	2	0	15	0	17
North Carolina	1,395	8	1	0	9	0	18
North Dakota	106	0	0	0	6	1	8
Nebraska	271	3	0	1	7	1	12
Nevada	328	27	1	1	2	0	31
New Hampshire	204	0	0	0	6	0	6
New Jersey	1,279	10	1	0	2	0	12
New Mexico	293	17	4	0	4	0	24
New York	2,879	23	3	1	2	0	29
Ohio	1,831	13	1	1	10	1	27
Oklahoma	576	10	1	0	3	0	14
Oregon	581	23	15	0	5	0	42
Pennsylvania	2,210	26	6	0	6	0	38
Puerto Rico	620	55	7	0	0	0	62
Rhode Island	177	34	1	0	1	0	36
South Carolina	716	1	1	3	10	0	15
South Dakota	132	0	0	1	6	0	7
Tennessee	997	15	1	0	6	0	22
Texas	2,784	12	1	2	3	1	18
Utah	263	7	13	0	10	1	31
Vermont	105	0	0	0	3	0	4
Virginia	1,073	1	1	0	10	1	14
West Virginia	372	1	3	0	15	3	23
Washington	899	15	3	0	6	0	24
Wisconsin	872	8	2	0	14	2	27
Wyoming	76	0	0	0	4	1	6
U.S. Total	44,871	15	2	1	5	1	24

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

Source: CMS enrollment and population data, 2008.

- Medicare private plans attract more beneficiaries in some areas than in others. At the state level, private plans attract only 1 percent of beneficiaries in Alaska. The highest penetrations of Medicare private plans are in Oregon and Puerto Rico, with 42 percent and 62 percent of beneficiaries, respectively, enrolled in plans.
- The popularity of different types of plans varies as well. For example, some states have all their plan enrollment in private fee-for-service (PFFS) plans, while other states have little or none of their enrollment in PFFS plans.

## Chart 10-6. Different requirements and provisions apply to different types of MA plans

	PFFS	MSA	HMO/Local PPO	Regional PPO	SNP
Must build networks of providers			✓	✓	✓
Must report quality measures			✓	✓	✓
Must have CMS review and approve bids and premiums			✓	✓	✓
Must return to the Trust Funds 25 percent of the difference between bid and benchmark	✓		✓	✓	✓
Must offer individual MA plan if offering employer group plan*			✓	✓	✓
Must offer Part D coverage			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures		✓		✓	
Can limit enrollment to targeted beneficiaries					✓

Note: MA (Medicare Advantage), PFFS (private fee-for-service), MSA (medical savings account), HMO (health maintenance organization), PPO (preferred provider organization), SNP (special needs plan).

\*Effective as of 2008 contract year; requirement does not apply to PFFS and MSA plans.

Source: MedPAC analysis of MA statutory and regulatory requirements.

- Different requirements apply to different plan types in Medicare Advantage (MA). Private fee-for-service (PFFS) plans and medical savings account (MSA) plans are exempt from many requirements that apply to coordinated care plans (CCPs). PFFS and MSA plans are not required to build networks, report on all CCP-required quality measures, offer the Part D drug benefit, or have the level of their premiums approved by CMS. Also, beginning in 2008, non-network PFFS plans and MSA plans will not be subject to the requirement that they offer nongroup MA plans if they offer employer group MA plans.
- MSA plans have a payment advantage over other types of MA plans (though currently only three MSA plans are in operation). When an MSA plan bids below the benchmark, its enrollees retain the full difference in their accounts, while non-MSA plans receive only 75 percent of the difference between the bid and benchmark to provide extra benefits to their enrollees (Medicare retains the other 25 percent of the difference).
- Only regional preferred provider organizations and MSA plans are required to have benefit structures that include an out-of-pocket limit on enrollee expenditures. The plans are allowed to determine their own level of the out-of-pocket limits. Special needs plans are allowed to limit their enrollment to one of three special populations: Medicare/Medicaid dual eligibles, institutionalized beneficiaries, and beneficiaries with chronic or disabling conditions.

## Chart 10-7. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2009

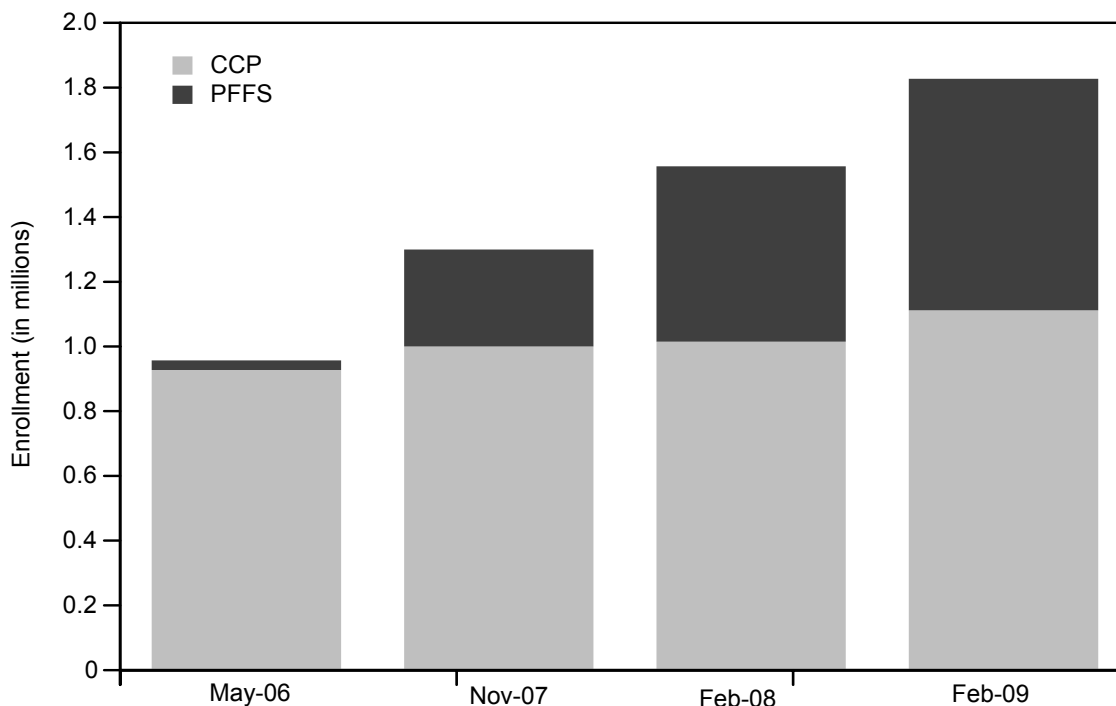
	All Plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	118%	118%	121%	114%	120%
Bids/FFS	102	98	108	106	113
Payments/FFS	114	113	118	112	118

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

Source: MedPAC analysis of plan bid data from CMS, November 2008.

- Since 2006, plan bids have partially determined the Medicare payments they receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is handled separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.
- The benchmark is an administratively determined bidding target. Legislation in 1997 established benchmarks in each county, which included a floor—a minimum amount below which no county benchmarks could go. By design, the floor rate exceeded fee-for-service (FFS) spending in many counties. Benchmarks are updated yearly by the national growth in FFS spending.
- If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid, plus a "rebate," defined by law as 75 percent of the difference between the plan's bid and its benchmark. The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.
- We estimate that Medicare Advantage (MA) benchmarks average 118 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type, because different types of plans tend to draw enrollment from different types of areas.
- Plans' enrollment-weighted bids average 102 percent of FFS spending. We estimate that HMOs bid an average of 98 percent of FFS spending, while bids from other plan types average at least 106 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS, while other plan types tend to charge more.
- We project that 2009 MA payments will be 114 percent of FFS spending. That means that in 2009 the Medicare program is paying about \$12 billion more for the 23 percent of beneficiaries enrolled in MA plans than if they remained in FFS Medicare.
- The ratio of payments relative to FFS spending varies by the type of MA plan. HMOs and regional preferred provider organization (PPO) payments are estimated to be 113 percent and 112 percent of FFS, while payments to PFFS and local PPOs will average 118 percent.

**Chart 10-8. Enrollment in employer group MA plans, 2006–2009**

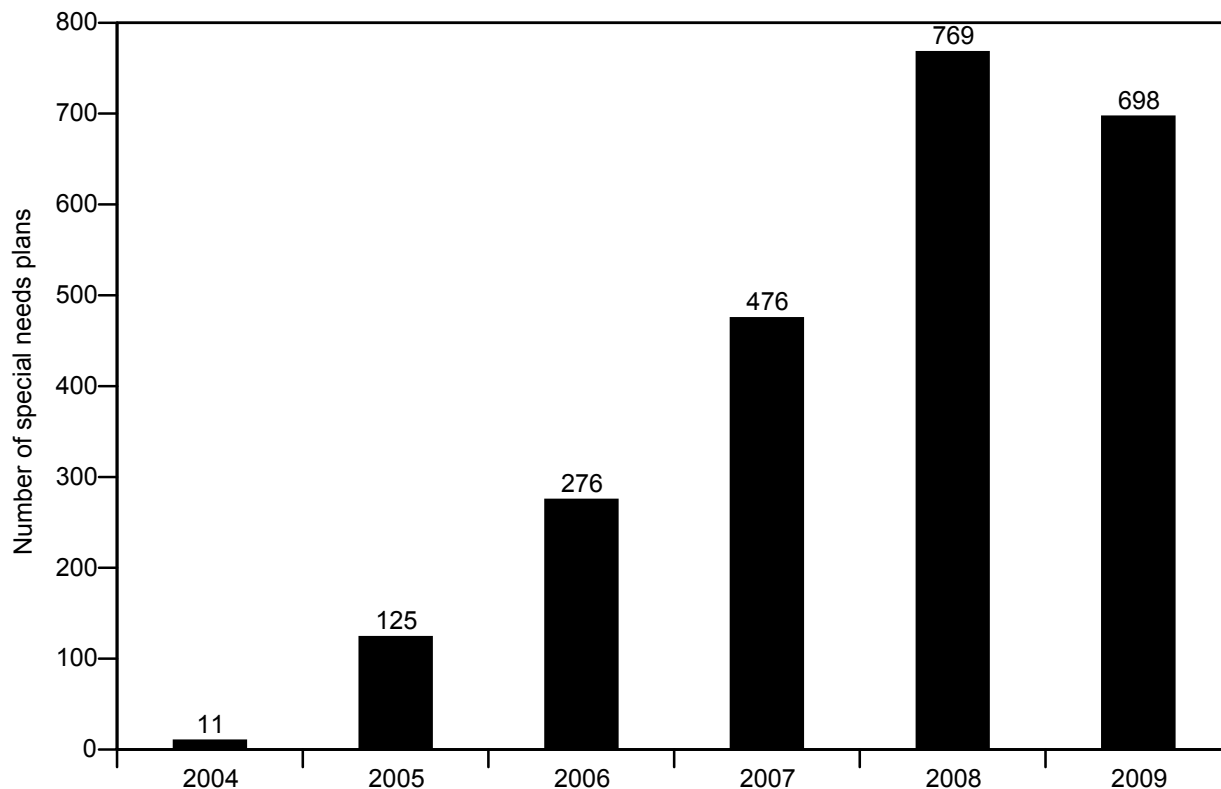


Note: MA (Medicare Advantage), CCP (coordinated care plan), PFFS (private fee-for-service).

Source: CMS enrollment data.

- While most Medicare Advantage (MA) plans are available to any Medicare beneficiary, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.
- In the last 3 years, enrollment in employer group plans has grown by more than 90 percent, while overall MA enrollment grew by about 50 percent. As of February 2009, there were about 1.8 million enrollees in employer group plans compared with about 8.5 million enrollees in individual MA plans. Thus, about 18 percent of all enrollees in MA plans were employer group enrollees.
- As in the individual MA market, the growth has been concentrated in private fee-for-service (PFFS) plans. About 80 percent of the growth in employer group enrollment over the past three years has come from private fee-for-service enrollment. There are now more than 700,000 enrollees in employer group PFFS plans. PFFS plans now have about 40 percent of the enrollment in the MA employer group market, and employer group enrollment is now about 30 percent of all PFFS enrollment.
- Our analysis of MA bid data shows that employer group plans on average have bids that are higher relative to fee-for-service (FFS) spending than individual plans, meaning that group plans appear less efficient than individual market MA plans. Employer group plans bid an average of 109 percent of FFS, compared with 100 percent of FFS for individual plans.
- We estimate that Medicare pays employer group plans 115 percent of average FFS Medicare spending, compared with 114 percent of FFS for individual market MA plans.

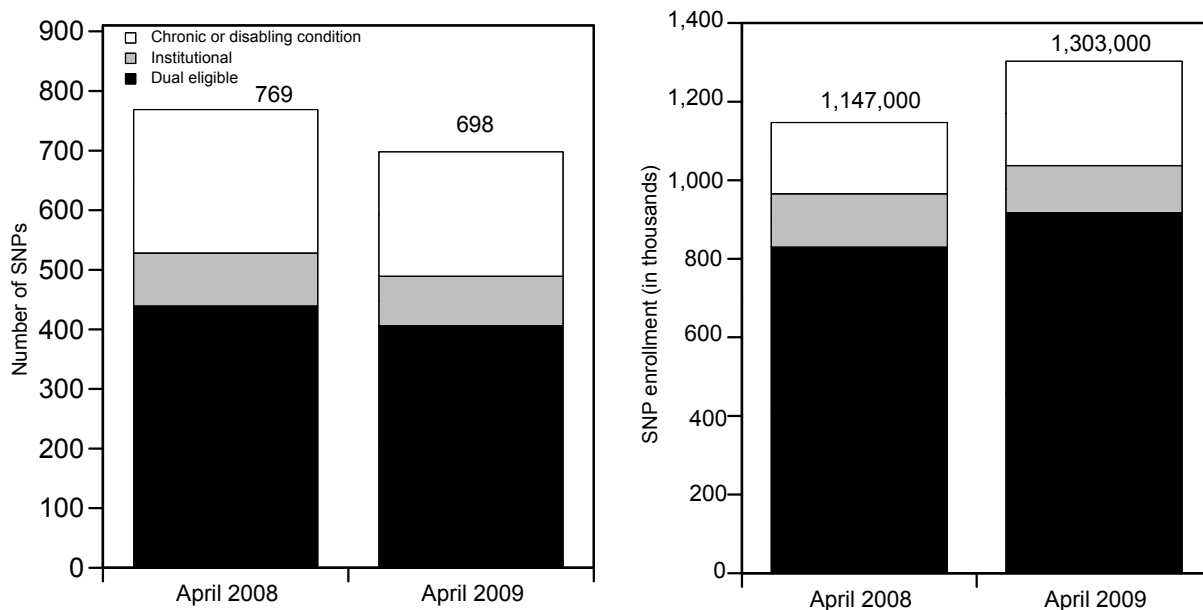
**Chart 10-9. Special needs plans decreased in 2009 after growing quickly for several years**



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

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.
- In 2009, there are 698 SNPs; this is the first decrease in the number of SNPs since they were created.
- SNPs were originally authorized for five years. SNP authority was extended, subject to new requirements, by the Medicare, Medicaid, and SCHIP Extension Act of 2007 and the Medicare Improvements for Patients and Providers Act of 2008. Absent additional congressional action, SNP authority will expire at the end of 2010.

**Chart 10-10. The number of SNPs decreased while SNP enrollment increased from 2008 to 2009**



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2008 and 2009.

- Although the number of SNP plans decreased by 9 percent from April 2008 to April 2009, the number of SNP enrollees increased by 14 percent.
- In 2009, most special needs plans (SNPs) (58 percent) are for dual-eligible beneficiaries, while 30 percent are for beneficiaries with chronic conditions, and 12 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need).
- Enrollment in SNPs has grown from 843,000 in March 2007 (not shown) to 1,147,000 in April 2008, to 1,303,000 in April 2009.
- 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.

## Web links. Medicare Advantage

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

[http://www.medpac.gov/chapters/Jun09\\_Ch07.pdf](http://www.medpac.gov/chapters/Jun09_Ch07.pdf)

- Chapter 3 of MedPAC's March 2009 Report to the Congress provides information on Medicare Advantage plans.

[http://www.medpac.gov/chapters/Mar09\\_Ch03.pdf](http://www.medpac.gov/chapters/Mar09_Ch03.pdf)

- More information on the Medicare Advantage program payment system can be found in MedPAC's Medicare Payment Basics series.

[http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_08\\_MA.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_MA.pdf)

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

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

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

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

