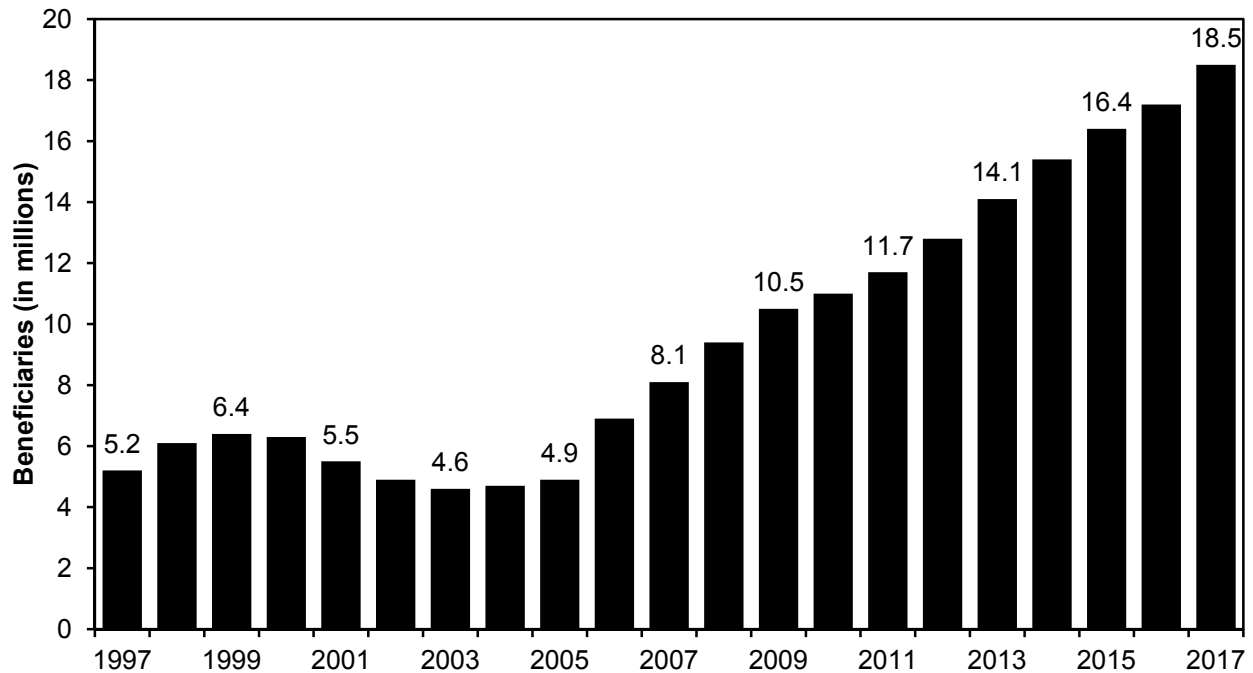


SECTION

9

Medicare Advantage

Chart 9-1. Enrollment in MA plans, 1997–2017



Note: MA (Medicare Advantage).

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

- Medicare enrollment in MA plans that are paid on an at-risk capitated basis reached 18.5 million enrollees (32 percent of all Medicare beneficiaries) in 2017. Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999, but then declined to a low of 4.6 million enrollees in 2003. MA enrollment has increased steadily since 2003. The Medicare program paid MA plans about \$190 billion in 2016 to cover Part A and Part B services for MA enrollees (data not shown).

Chart 9-2. MA plans available to almost all Medicare beneficiaries

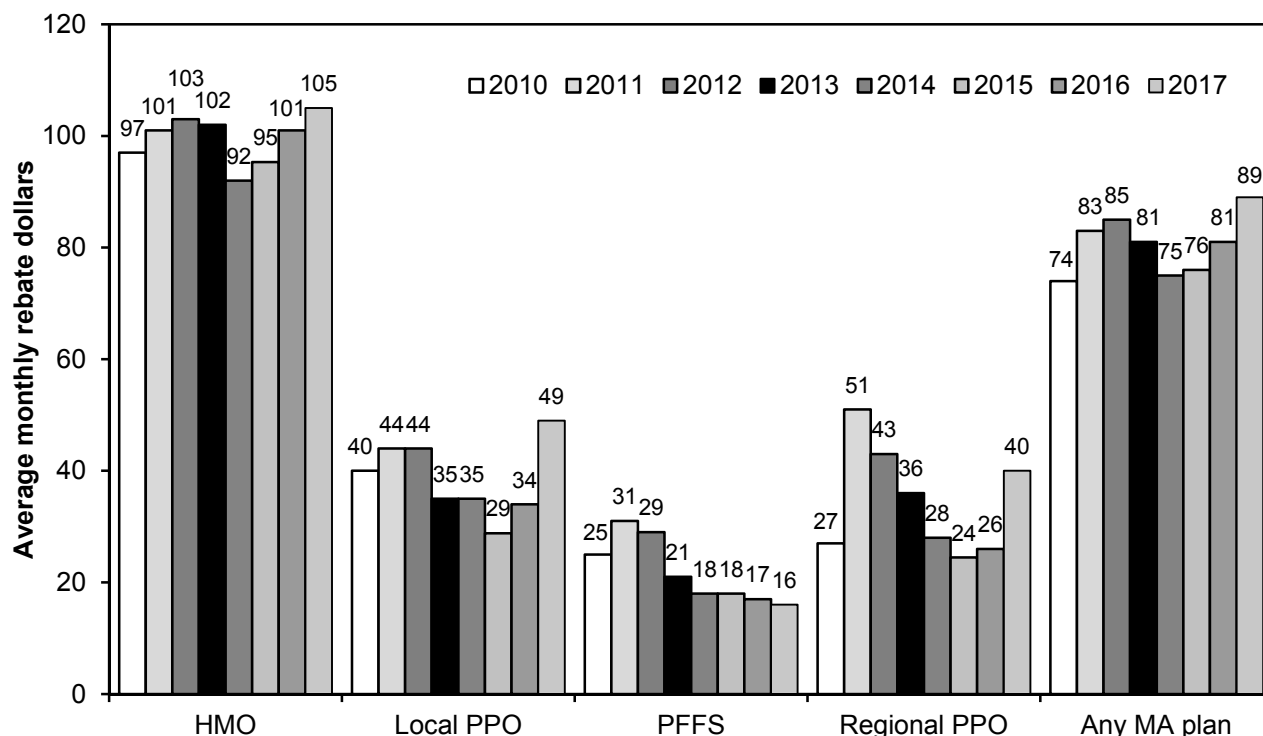
	CCPs			PFFS	Any MA plan	Average plan offerings per county
	HMO or local PPO	Regional PPO	Any CCP			
2009	88%	91%	99%	100%	100%	34
2010	91	86	99	100	100	21
2011	92	86	99	63	100	12
2012	93	76	99	60	100	12
2013	95	71	99	59	100	12
2014	95	71	99	53	100	10
2015	95	70	98	47	99	9
2016	96	73	99	47	99	9
2017	95	74	98	45	99	10

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 plans, employer-only plans, and certain demonstration plans).

Source: MedPAC analysis of plan bid data from CMS.

- 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 entire state-based regions and have networks that may be looser than those required of local PPOs. Since 2011, PFFS plans (but not CCPs) 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 95 percent of Medicare beneficiaries in 2017, and regional PPOs are available to 74 percent of beneficiaries; the availability of both plan types is the same or higher than in 2013. Since 2006, almost all Medicare beneficiaries have had MA plans available; 99 percent had an MA plan available in 2017.
- The number of plans from which beneficiaries may choose in 2017 is higher than last year. In 2017, beneficiaries can choose from an average of 10 plans operating in their counties (this figure is the simple average of plans per county; if counties were enrollee weighted, the average would be 18). This availability has decreased from the peak in 2009, reflecting network requirements for PFFS plans and CMS's 2010 effort to reduce the number of duplicative plans and plans with low enrollment. The decrease in plan choices from 2010 to 2017 was due to the reduction in the number of PFFS plans.

Chart 9-3. Average monthly rebate dollars, by plan type, 2010–2017



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 and plan finder data from CMS.

- Perhaps the best summary measure of plan benefit value is the average rebate, which plans receive to provide additional benefits. Plans are awarded rebates for bidding under their benchmarks. The rebates must be returned to the plan members in the form of extra benefits. The extra benefits may be supplemental benefits, lower cost sharing, or lower premiums. The average rebate for all non-employer, non-SNP plans rose to a high of \$89 per month for 2017.
- 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 two years and are at a high of \$105 per month for 2017.
- For both local and regional PPOs, the rebates rose from 2010 to 2011, declined through 2015, and rose to levels higher than 2010 in 2017.
- Rebates for PFFS plans have declined steadily since 2011.

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

Plan type	Total enrollees (in thousands)					Percent change 2016–2017
	February 2013	February 2014	February 2015	February 2016	February 2017	
Local CCPs	12,580	13,809	14,824	15,588	16,920	9%
Regional PPOs	1,060	1,221	1,237	1,315	1,353	3
PFFS	417	309	260	238	190	–20

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

Source: CMS health plan monthly summary reports.

- Enrollment in local CCPs grew by 9 percent over the past year. Enrollment in regional PPOs grew by 3 percent, while enrollment in PFFS plans continued to decline. Combined enrollment in the three types of plans grew by 8 percent from February 2016 to February 2017.

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2017

State or territory	Medicare eligibles (in thousands)	Distribution (in percent) of enrollees by plan type					Total
		HMO	Local PPO	Regional PPO	PFFS	Cost	
U.S. total	57,481	21%	9%	2%	0%	1%	33%
Alabama	1,001	16	19	1	0	0	36
Alaska	88	0	1	0	0	0	1
Arizona	1,196	35	3	1	0	0	39
Arkansas	615	9	4	6	3	0	22
California	5,904	38	2	0	0	0	40
Colorado	842	30	4	0	0	3	37
Connecticut	649	24	3	1	0	0	28
Delaware	190	6	5	0	0	0	11
Florida	4,229	29	6	8	0	0	43
Georgia	1,609	10	16	8	0	0	35
Hawaii	256	18	26	1	0	0	46
Idaho	300	18	13	0	0	0	32
Illinois	2,142	10	11	0	0	0	22
Indiana	1,194	7	15	4	0	0	27
Iowa	595	6	11	0	0	2	18
Kansas	506	6	8	0	1	0	16
Kentucky	891	6	16	6	0	1	29
Louisiana	828	28	3	2	0	0	33
Maine	319	17	10	0	1	0	28
Maryland	976	3	4	0	0	4	11
Massachusetts	1,263	15	5	1	0	0	21
Michigan	1,968	13	20	1	0	0	34
Minnesota	961	13	5	0	0	40	57
Mississippi	580	9	3	5	0	0	17
Missouri	1,179	20	7	4	1	0	32
Montana	213	2	18	0	1	0	21
Nebraska	327	8	3	0	2	1	13
Nevada	482	31	5	0	0	0	36
New Hampshire	277	5	3	1	1	0	10
New Jersey	1,545	11	10	0	0	0	21
New Mexico	392	22	11	0	0	0	33
New York	3,453	27	7	4	1	0	38
North Carolina	1,854	14	16	2	0	0	32
North Dakota	123	0	2	0	0	16	18
Ohio	2,233	20	13	2	0	0	36
Oklahoma	706	12	5	1	1	0	18
Oregon	798	29	16	0	0	0	45
Pennsylvania	2,619	25	15	0	0	0	41
Puerto Rico	775	72	3	0	0	0	75
Rhode Island	210	34	2	1	0	0	37
South Carolina	991	7	5	12	0	0	25
South Dakota	163	0	5	0	0	16	21
Tennessee	1,284	24	11	1	0	0	37
Texas	3,834	19	9	4	0	1	34
Utah	365	29	6	0	0	0	36
Vermont	138	2	2	4	1	0	9
Virgin Islands	20	0	1	0	0	0	1
Virginia	1,420	7	5	2	2	2	17
Washington	1,258	26	4	0	0	0	31
Washington, DC	91	2	7	0	0	7	15
West Virginia	428	3	21	1	1	4	30
Wisconsin	1,100	20	12	1	1	5	39
Wyoming	100	0	1	0	2	1	4

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. Component percentages may not sum to totals due to rounding.

Source: CMS enrollment and population data February 2017.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2017

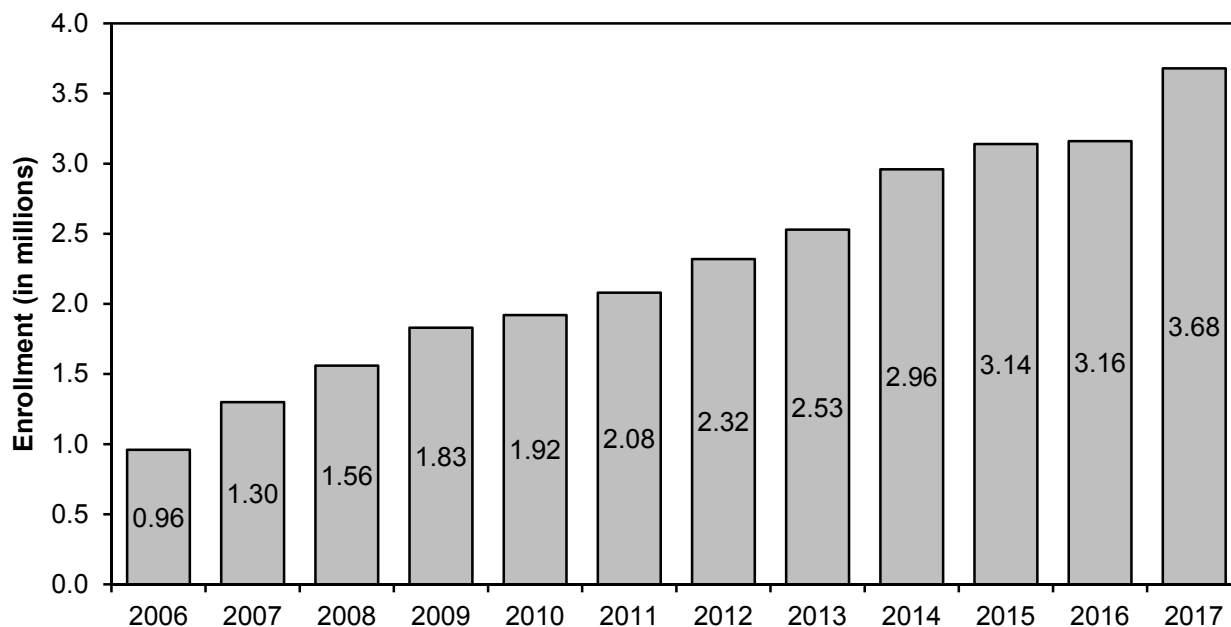
	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	106%	106%	111%	101%	110%
Bids/FFS	90	88	101	94	108
Payments/FFS	100	99	107	98	109

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 October 2016.

- Since 2006, plan bids have partly determined the Medicare payments they 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 an administratively determined bidding target. Benchmarks for each county are set by means of a statutory formula based on percentages (ranging from 95 percent to 115 percent) of each county's per capita Medicare 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 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 ranges from 50 percent to 70 percent. The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.
- We estimate that MA benchmarks average 106 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 geographical areas.
- Plans' enrollment-weighted bids (excluding employer plans, which no longer submit bids) average 90 percent of FFS spending in 2017. We estimate that HMOs bid an average of 88 percent of FFS spending, while bids from other plan types average at least 94 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS in the areas where they bid.
- We project that 2017 MA payments will be 100 percent of FFS spending. This figure does not include employer plans and does not account for risk coding differences between FFS and MA plans that have not been resolved through the coding intensity factor.
- The ratio of payments relative to FFS spending varies by the type of MA plan. HMO and regional PPO payments are estimated to be 99 and 98 percent of FFS, respectively, while payments to PFFS and local PPOs average 109 percent and 107 percent of FFS, respectively.

Chart 9-7. Enrollment in employer group MA plans, 2006–2017

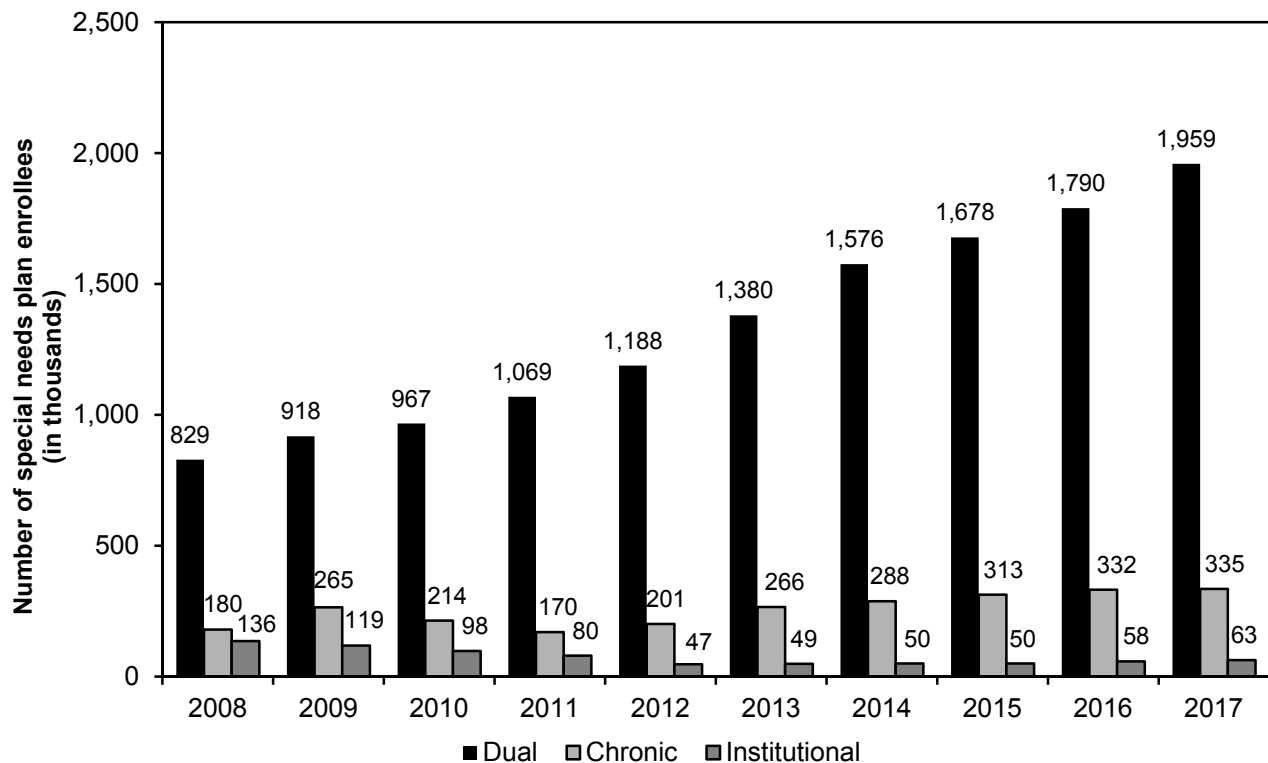


Note: MA (Medicare Advantage). Enrollment numbers are as of May for 2006, November for 2007, and February for 2008 through 2017.

Source: CMS enrollment data.

- 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 2017, about 3.7 million enrollees were in employer group plans, or about 20 percent of all MA enrollees. Employer plan enrollment grew by 16 percent from 2016 and has doubled since 2009.

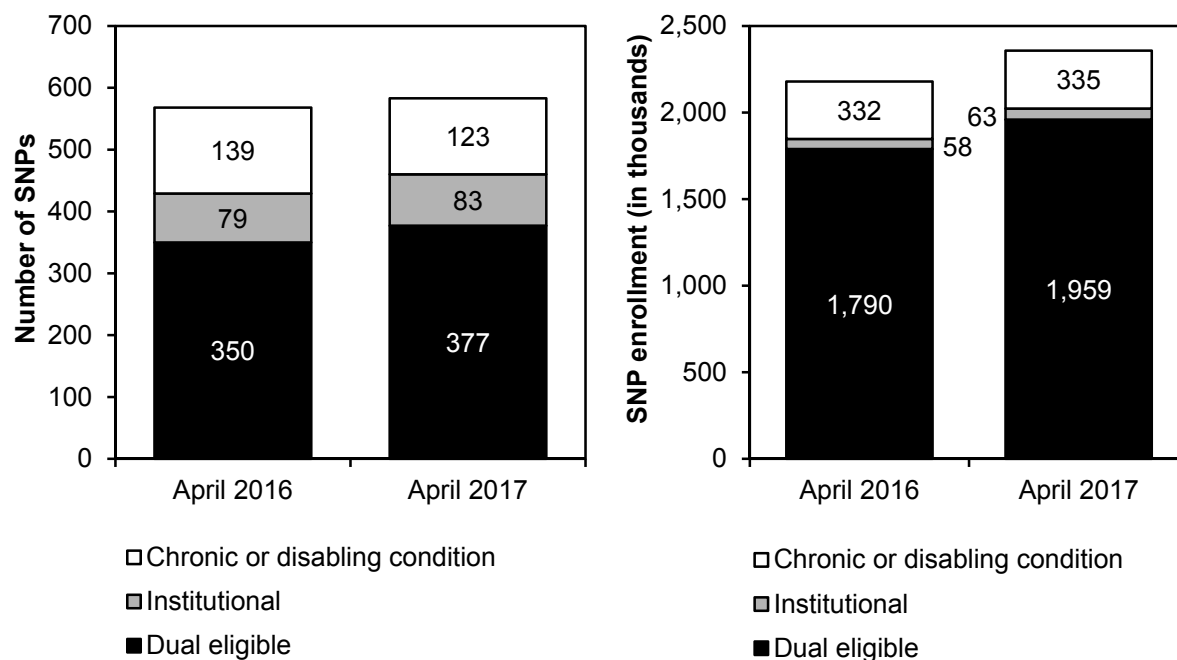
Chart 9-8. Number of special needs plan enrollees, 2008–2017



Source: CMS special needs plans comprehensive reports, April 2008–2017.

- 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. SNP authority was extended several times, often subject to new requirements. Absent further congressional action, SNP authority will expire at the end of 2018.
- 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 is about 2 million in 2017.
- Enrollment in chronic condition SNPs has fluctuated as plan requirements have changed, but has risen annually since 2011.
- Enrollment in institutional SNPs declined steadily through 2012 but has held steady over the last few years and increased in 2016 and 2017.

Chart 9-9. Number of SNPs and SNP enrollment rose from 2016 to 2017



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2016 and 2017.

- The number of SNPs increased by 3 percent from April 2016 to April 2017, and the number of SNP enrollees increased by 8 percent. All three types of SNPs showed increases in enrollment. The number of institutional and dual-eligible SNPs increased, while chronic disease SNPs decreased by about 9 percent. The direction of these changes is the same as it was last year; enrollment in all three types increased and the number of dual SNPs and institutional SNPs increased, from 2016 to 2017, while the number of chronic condition SNPs decreased.
- In 2017, most SNPs (65 percent) are for dual-eligible beneficiaries, while 21 percent are for beneficiaries with chronic conditions and 14 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need).
- Enrollment in SNPs has grown from 0.9 million in May 2007 (not shown) to almost 2.4 million in April 2017.
- The availability of SNPs varies by type of special needs population served (data not shown). In 2017, 86 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 83 percent in 2016), 52 percent live where SNPs serve institutionalized beneficiaries (up from 50 percent in 2016), and 44 percent live where SNPs serve beneficiaries with chronic conditions (down from 54 percent).

Chart 9-10. Twenty most common condition categories among MA beneficiaries, as defined in the CMS–HCC model, 2015

Conditions (defined by HCC)	Percent of beneficiaries with listed condition	Percent of beneficiaries with listed condition and no others
Vascular disease	17.7%	2.1%
Diabetes with chronic complications	15.2	2.6
COPD	14.4	1.9
Diabetes without complications	13.0	4.5
CHF	11.5	0.5
Specified heart arrhythmias	11.4	1.3
Major depressive, bipolar, and paranoid disorders	9.6	1.7
Morbid obesity	7.0	0.8
Rheumatoid arthritis and inflammatory connective tissue disease	5.8	1.0
Breast, prostate, colorectal, and other cancers and tumors	5.2	1.4
Coagulation defects and other specified hematological disorders	4.1	0.4
Angina pectoris	3.7	0.3
Acute renal failure	3.1	0.1
Other significant endocrine and metabolic disorders	3.0	0.3
Ischemic or unspecified stroke	2.7	0.2
Drug/alcohol dependence	2.7	0.2
Seizure disorders and convulsions	2.6	0.3
Cardio-respiratory failure and shock	2.3	0.0
Chronic ulcer of skin, except pressure	1.8	0.1
Colorectal, bladder, and other cancers	1.7	0.3

Note: MA (Medicare Advantage), CMS–HCC (CMS–hierarchical condition category), COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure).

Source: MedPAC analysis of Medicare data files from Acumen LLC.

- CMS uses the CMS–HCC model to risk adjust capitated payments to MA plans so that payments better reflect the clinical needs of MA enrollees given the number and severity of their clinical conditions. The CMS–HCC model uses beneficiaries’ conditions, which are collected into HCCs, to adjust the capitated payments.
- Vascular disease is the most common HCC, but two diabetes HCCs combined are more common than vascular disease. Over 28 percent of MA enrollees are in one of those two diabetes HCCs.

Chart 9-11. Medicare private plan enrollment patterns, by age and Medicare–Medicaid dual-eligible status, December 2015

	As percent of Medicare population	Percent of category in FFS	Percent of category in plans
All beneficiaries	100%	69%	31%
Aged (65 or older)	84	68	32
Under 65	16	74	26
Non–dual eligible	82	69	31
Aged (65 or older)	73	69	31
Under 65	9	74	26
Dual eligible	18	68	32
Aged (65 or older)	10	63	37
Under 65	8	75	25
Dual-eligible beneficiaries by category (all ages)			
Full dual eligibility	13	72	28
Beneficiaries with partial dual eligibility			
QMB only	3	63	37
SLMB only	2	56	44
QI	1	53	47

Note: FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualified individual). Dual-eligible beneficiaries are eligible for Medicare and Medicaid. See accompanying text for an explanation of the categories of dual-eligible beneficiaries. "Plans" include Medicare Advantage plans as well as cost-reimbursed plans. Data exclude Puerto Rico because of the inability to determine specific dual-eligible categories. As of December 2015, Puerto Rico had 565,000 Medicare Advantage enrollees. Dual-eligible special needs plans in Puerto Rico had 279,000 enrollees in December 2015.

Source: MedPAC analysis of 2015 denominator and common Medicare environment files and CMS monthly MA reports.

- Recent levels of Medicare plan enrollment among the dually eligible represent a significant increase over earlier years. In 2004, only 1 percent of dual-eligible beneficiaries were enrolled in plans, compared with 16 percent of non-dual-eligible beneficiaries. At the end of 2012, 23 percent of dual-eligible beneficiaries were in Medicare private plans, compared with 32 percent at the end of 2015.
- A substantial share of dual-eligible beneficiaries (42 percent (not shown in table)) are under the age of 65 and entitled to Medicare on the basis of disability or end-stage renal disease. Beneficiaries under age 65 are less likely than aged beneficiaries to enroll in Medicare private plans (26 percent vs. 32 percent).
- Dual-eligible beneficiaries who have full dual eligibility—that is, those who have coverage for 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 private Medicare plans than beneficiaries with “partial” dual eligibility. Full dual-eligibility categories consist of beneficiaries with coverage through state Medicaid programs as well as certain QMBs and SLMBs who also have Medicaid coverage for services. The latter two categories are referred to as QMB-Plus and SLMB-Plus beneficiaries. Beneficiaries with partial dual eligibility have coverage for Medicare premiums (through the QI or SLMB program) or premiums and Medicare cost sharing, in the case of the QMB program. SLMB-only and QI beneficiaries have higher rates of plan enrollment (44 percent and 47 percent, respectively) than any other category shown in this chart, and the rates are higher than the average rate (31 percent) across all Medicare beneficiaries.

Chart 9-12. Distribution of MA plans and enrollment by CMS overall star ratings, March 2017

Plans and enrollment	Year 2017 star ratings: Number of stars						Any star rating
	5	4.5	4	3.5	3	2.5	
All plan types							
Number of plans	14	67	97	107	67	11	363
As share of rated plan enrollees	9%	23%	38%	21%	8%	1%	100%
HMOs							
Number of plans	13	55	66	74	55	11	274
As share of HMO enrollees	14%	30%	31%	18%	6%	1%	100%
Local PPOs							
Number of plans	1	12	29	22	10	0	74
As share of local PPO enrollees	<1%	14%	60%	25%	2%	N/A	100%
Regional PPOs							
Number of plans	0	0	1	5	2	0	8
As share of regional PPO enrollees	N/A	N/A	33%	27%	40%	N/A	100%
PFFS							
Number of plans	0	0	0	1	0	0	1
As share of PFFS enrollees	N/A	N/A	N/A	100%	N/A	N/A	100%

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service). For purposes of this table and the accompanying text, a plan is an MA contract, which can consist of several options with different benefit packages that are also referred to as "plans." Cost-reimbursed HMO plans are included in the data. No plan had an overall star rating below 2.5. Numbers may not sum to 100 percent due to rounding; enrollment totals are rounded results of the sum of unrounded numbers.

Source: MedPAC analysis of CMS star ratings and enrollment data, 2016.

- The star rating system is a composite measure of clinical processes and outcomes, patient experience measures, and measures of a plan's administrative performance. The overall star rating measures performance on Part C measures and Part D measures.
- The average overall star rating across all plans is 3.75, or 4.01 on an enrollment-weighted basis. There are 107 plans, with nearly 244,000 enrollees, that do not have a star rating because they are too new to be rated or there is insufficient information on which to base a rating (data not shown in chart). In addition, the 58 Medicare–Medicaid plans participating in the financial alignment demonstration, with nearly 400,000 enrollees, are not included in the star rating system.

(Chart continued next page)

Chart 9-12. Distribution of MA plans and enrollment by CMS overall star ratings, March 2017 (continued)

- Under the statutory provisions that introduced quality bonus payments beginning in 2012, plans with ratings of 4 stars or more receive bonus payments in the form of an increase in their benchmarks. Plan star ratings also determine the level of rebate dollars, with higher rated plans able to use a higher proportion of the difference between the plan bid and benchmark amounts to provide extra benefits to enrollees.
- Plans with a 5-star rating are able to enroll beneficiaries outside of the annual election period, on a year-round basis. The 5-star status of such plans is highlighted in the Medicare.gov website's Medicare Plan Finder. The year 2017 is the first year in which a plan type other than HMO has received a 5-star rating, as one local PPO is at 5 stars. Plans with ratings below 3 stars have an indicator of their low-performing status in the Medicare Plan Finder.
- The criteria for determining plan star ratings change from year to year. Therefore, plan ratings across years are not entirely comparable. Beginning in 2012, a weighting approach was used that assigns greater weight to outcome measures (weighted 3) and patient experience and access measures (weighted 1.5), with less weight assigned to process and administrative measures (weighted 1). In 2017, excluding two composite improvement measures (each weighted 5), 60 percent of the weight of measures reflects Part C and Part D clinical quality measures (outcomes as well as clinical process measures); 20 percent of the weight represents patient experience measures; and the remaining 20 percent are administrative measures.
- The two year-over-year composite improvement measures—one each for Part C and Part D—account for 13 percent of the total weight for determining a Medicare Advantage Prescription Drug plan's overall star rating in 2017. For high-performing plans that have little room for improvement in their measures, the plan's overall star rating can be computed without including the improvement measure.
- Another factor that can increase a plan's overall star rating is a reward factor that CMS adds to the overall star rating for plans that "have both high and stable relative performance."
- An organization can consolidate plans that previously had separate ratings into combined plans with a single rating. The star rating in such a case is the star rating of the surviving plan, regardless of the star ratings of the other plans being combined. This practice affects the enrollment shares by star category shown in this table and affects the ability to compare current year data with data for prior years. (See the Commission's March 2017 report to the Congress for additional information about this practice.)

