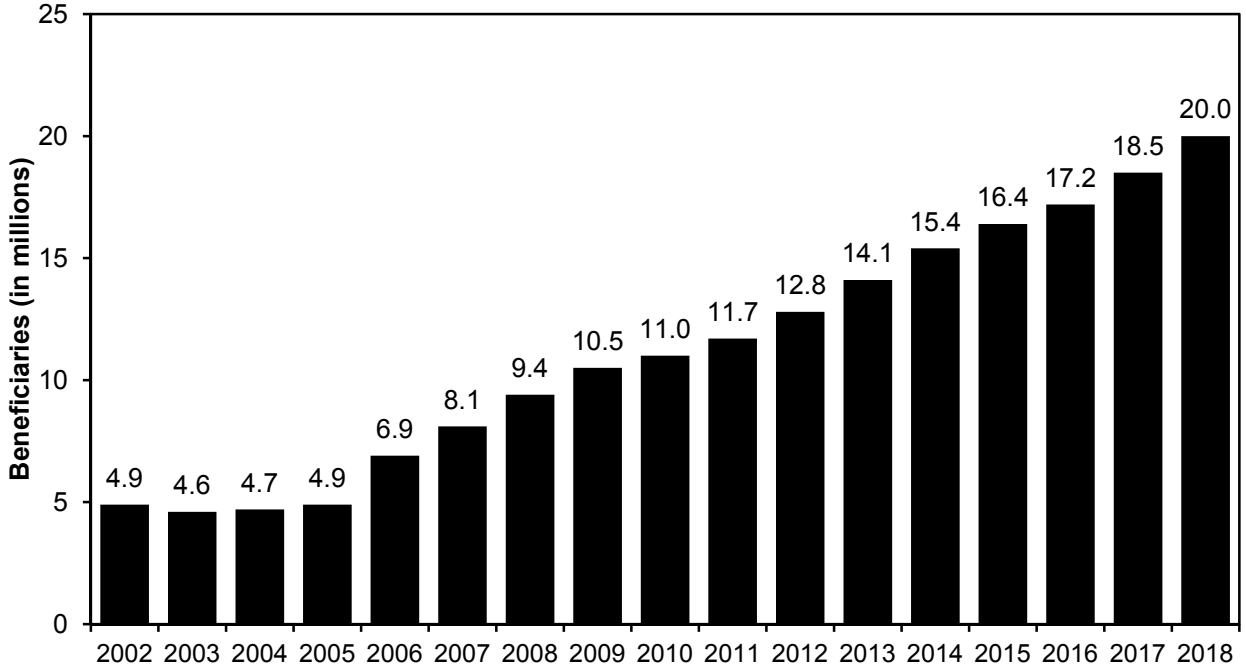
SECTION 9

Medicare Advantage

Chart 9-1. Enrollment in MA plans, 2002–2018



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 20.0 million enrollees (33 percent of all Medicare beneficiaries) in 2018. MA enrollment has grown steadily since 2003, increasing more than fourfold. The Medicare program paid MA plans about $210 billion in 2017 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

	Share of Medicare beneficiaries living in counties with plans available					
	CCPs					
	HMO or local PPO (local CCP)	Regional PPO	Any CCP	PFFS	Any MA plan	Average plan offerings per beneficiary
2012	93%	76%	99%	60%	100%	19
2013	95	71	99	59	100	19
2014	95	71	99	53	100	18
2015	95	70	98	47	99	17
2016	96	73	99	47	99	18
2017	95	74	98	45	99	18
2018	96	74	98	41	99	20

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).

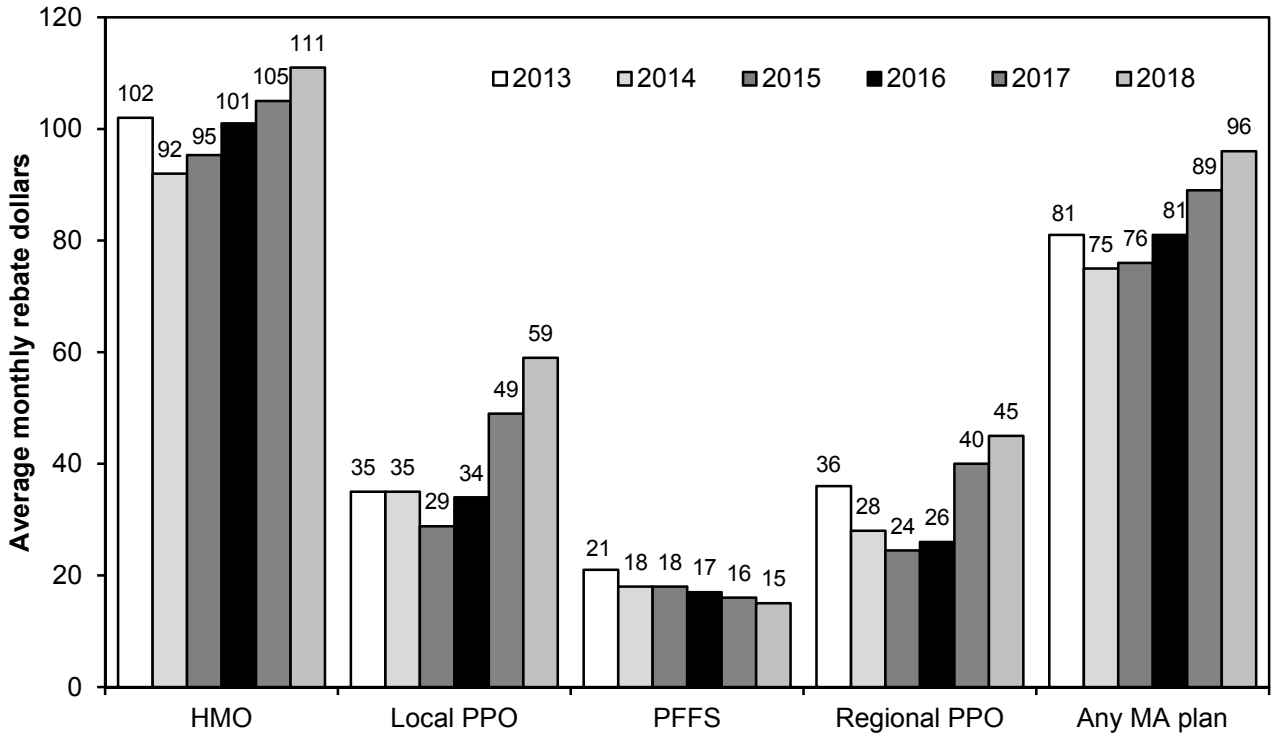
Source: MedPAC analysis of plan bid data from CMS.

- 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 96 percent of Medicare beneficiaries in 2018, and regional PPOs are available to 74 percent of beneficiaries; the availability of both plan types is as high as or higher than in any year since 2013. Since 2006, almost all Medicare beneficiaries have had MA plans available; 99 percent have an MA plan available in 2018.

- The number of plans from which beneficiaries may choose in 2018 is higher than any time since 2012. In 2018, beneficiaries can choose from an average of 20 plans operating in their counties.

Chart 9-3. Average monthly rebate dollars, by plan type, 2013–2018



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 $96 per month for 2018.

- 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 three years and are at a high of $111 per month for 2018.

- For both local and regional PPOs, the rebates declined through 2015 and then rose to levels higher than 2013 in 2018.

- Rebates for PFFS plans have declined steadily since 2011 (2011 and 2012 not shown in chart).

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

Plan type	Total enrollees (in thousands) February 2014	February 2015	February 2016	February 2017	February 2018	Percent change 2017–2018
Local CCPs	13,809	14,824	15,588	16,920	18,463	9%
Regional PPOs	1,221	1,237	1,315	1,353	1,327	–2
PFFS	309	260	238	190	154	–19

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.

- Enrollment in local CCPs grew by 9 percent over the past year. Enrollment in regional PPOs declined by 2 percent, while enrollment in PFFS plans continued to decline. Combined enrollment in the three types of plans grew by 8 percent from February 2017 to February 2018 (data not shown).

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2018

State or territory	Medicare eligibles (in thousands)	Distribution (in percent) of enrollees by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	60,463	21%	9%	2%	0%	1%	34%
Alabama	1,043	17	20	1	0	0	38
Alaska	94	0	1	0	0	0	1
Arizona	1,274	35	3	1	0	0	39
Arkansas	644	10	4	7	2	0	23
California	6,202	38	2	0	0	0	40
Colorado	907	30	4	0	0	2	36
Connecticut	677	23	11	1	0	0	35
Delaware	201	7	6	0	0	0	13
Florida	4,495	29	7	7	0	0	43
Georgia	1,714	11	17	8	0	0	36
Hawaii	268	17	27	2	0	0	45
Idaho	322	18	13	0	0	0	31
Illinois	2,233	10	11	0	0	0	23
Indiana	1,251	9	16	3	0	0	29
Iowa	622	6	11	0	0	2	19
Kansas	532	7	8	0	1	0	16
Kentucky	929	7	16	5	0	1	30
Louisiana	865	29	3	2	0	0	34
Maine	335	17	11	0	1	0	30
Maryland	1,030	3	4	0	0	4	12
Massachusetts	1,322	16	5	1	0	0	21
Michigan	2,059	14	22	1	0	0	37
Minnesota	1,014	12	5	0	0	40	57
Mississippi	605	10	3	5	0	0	18
Missouri	1,235	20	8	4	1	0	33
Montana	226	6	11	0	1	0	18
Nebraska	343	9	3	0	2	1	14
Nevada	517	30	5	0	0	0	35
New Hampshire	295	7	4	1	0	0	12
New Jersey	1,618	12	10	0	0	0	22
New Mexico	416	21	12	0	0	0	34
New York	3,600	28	8	3	0	0	39
North Carolina	1,959	14	17	2	0	0	33
North Dakota	129	0	3	0	0	15	18
Ohio	2,325	20	15	2	0	0	38
Oklahoma	741	11	6	1	0	0	19
Oregon	852	29	15	0	0	0	44
Pennsylvania	2,718	26	15	0	0	0	41
Puerto Rico	791	69	3	0	0	0	72
Rhode Island	219	34	2	1	0	0	37
South Carolina	1,048	7	5	13	0	0	26
South Dakota	173	0	6	0	0	14	20
Tennessee	1,347	24	12	1	0	0	37
Texas	4,074	19	12	4	0	1	36
Utah	388	29	6	0	0	0	36
Vermont	145	2	3	4	1	0	10
Virgin Islands	21	0	1	0	0	0	1
Virginia	1,506	8	5	2	1	2	19
Washington	1,340	27	4	0	0	0	31
Washington, DC	95	2	8	0	0	6	16
West Virginia	443	3	22	1	1	4	31
Wisconsin	1,157	21	12	1	1	4	40
Wyoming	107	0	1	0	1	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 2018.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2018

	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	107%	106%	110%	102%	107%
Bids/FFS	90	88	99	94	105
Payments/FFS	101	100	106	98	106

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 2017.

- 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. Plans with quality ratings of 4 or more stars may have their benchmarks raised by up to 10 percent of FFS spending 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 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.

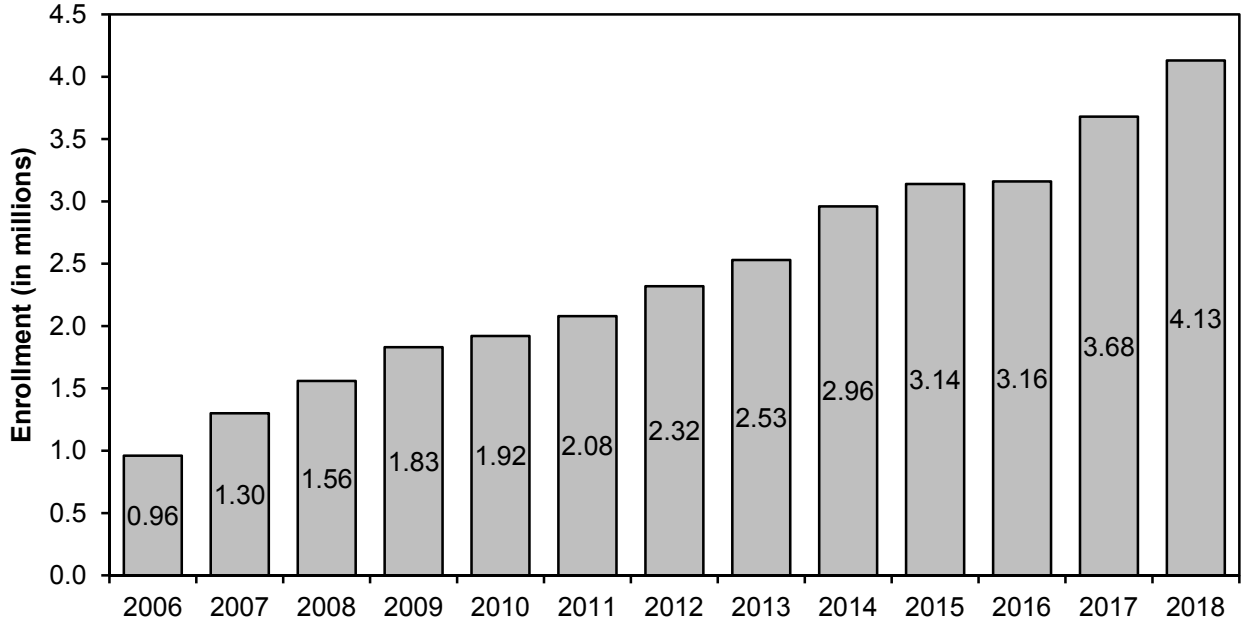
- We estimate that MA benchmarks average 107 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type because different types of plans tend to draw enrollment from different types of geographical areas.

- Plans' enrollment-weighted bids (excluding employer plans, which no longer submit bids) average 90 percent of FFS spending in 2018. 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 2018 MA payments will be 101 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 100 and 98 percent of FFS, respectively, while payments to PFFS and local PPOs average 106 percent of FFS.

Chart 9-7. Enrollment in employer group MA plans, 2006–2018



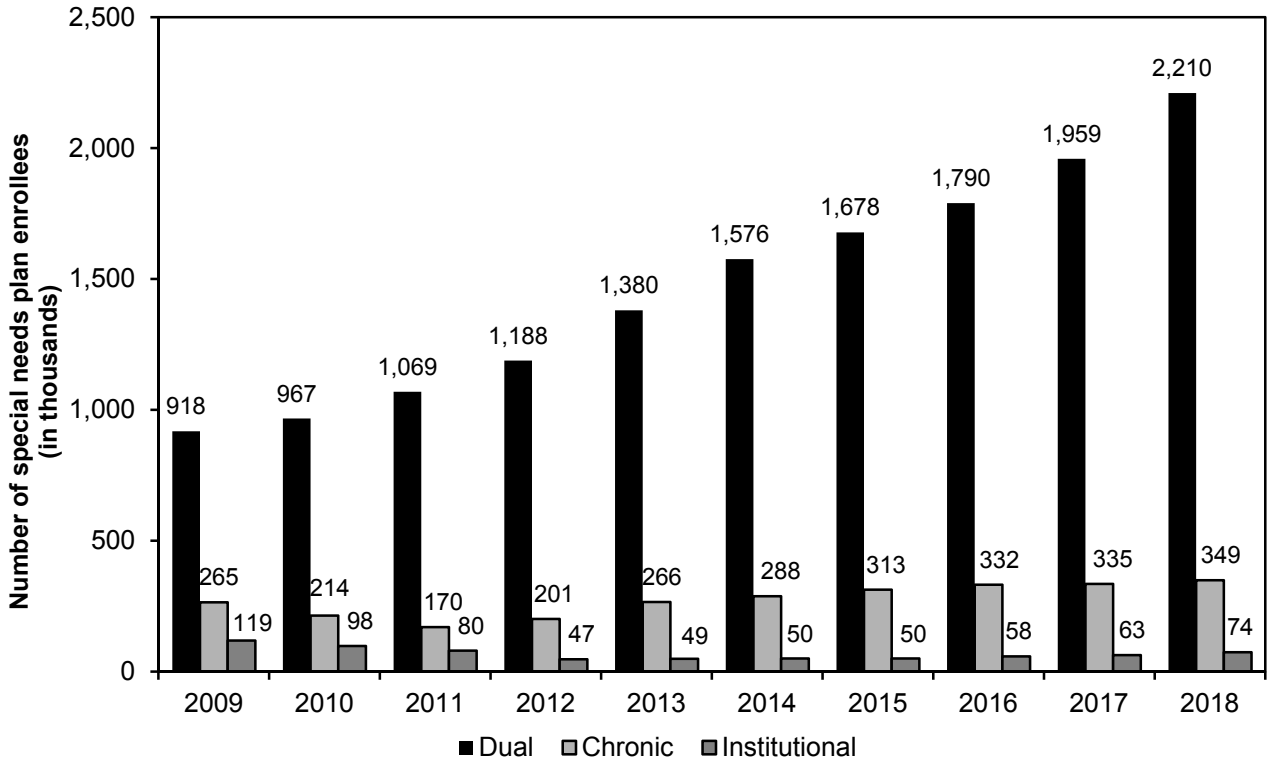
Note: MA (Medicare Advantage). Enrollment numbers are as of May for 2006, November for 2007, and February for 2008 through 2018.

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 2018, about 4.1 million enrollees were in employer group plans, or about 21 percent of all MA enrollees. Employer plan enrollment grew by 12 percent from 2017 and has doubled since 2011.

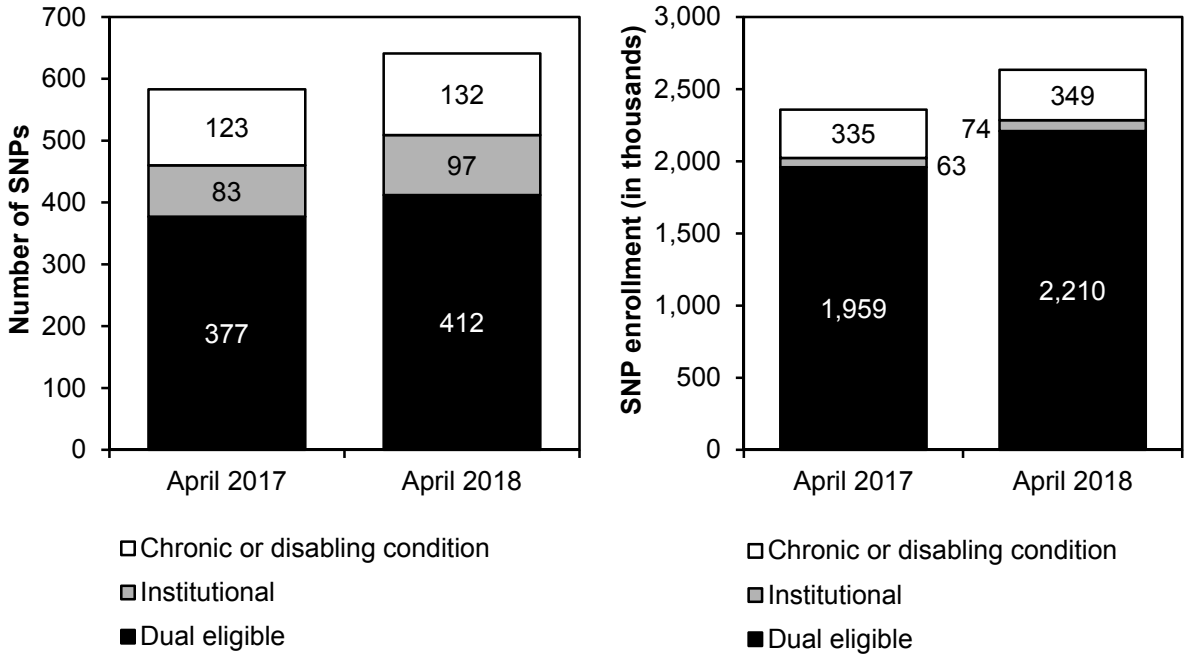
Chart 9-8. Number of special needs plan enrollees, 2009–2018



Source: CMS special needs plans comprehensive reports, April 2009–2018.

- 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 2 million in 2018, doubling since 2011.
- 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 stabilized, then increased beginning in 2016.

Chart 9-9. Number of SNPs and SNP enrollment rose from 2017 to 2018



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2017 and 2018.

- The number of SNPs increased by 10 percent from April 2017 to April 2018, and the number of SNP enrollees increased by 12 percent. All three types of SNPs showed increases in the number of plans and enrollment.
- In 2018, most SNPs (64 percent) are for dual-eligible beneficiaries, while 15 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need), and 21 percent are for beneficiaries with chronic conditions.
- Enrollment in SNPs has grown from 0.9 million in May 2007 (not shown) to 2.6 million in April 2018.
- The availability of SNPs varies by type of special needs population served (data not shown). In 2018, 86 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (the same as in 2017), 56 percent live where SNPs serve institutionalized beneficiaries (up from 52 percent in 2017), and 47 percent live where SNPs serve beneficiaries with chronic conditions (up from 44 percent).

Chart 9-10. Twenty most common condition categories among MA beneficiaries, as defined in the CMS–HCC model, 2016

Conditions (defined by HCC)	Percent of beneficiaries with listed condition	Percent of beneficiaries with listed condition and no others
Vascular disease	17.9%	2.1%
Diabetes with chronic complications	17.3	3.1
COPD	14.2	1.8
CHF	11.4	0.5
Specified heart arrhythmias	11.2	1.3
Diabetes without complications	11.0	3.9
Major depressive, bipolar, and paranoid disorders	10.2	1.7
Morbid obesity	7.6	0.9
Rheumatoid arthritis and inflammatory connective tissue disease	6.0	1.0
Breast, prostate, colorectal, and other cancers and tumors	5.1	1.4
Coagulation defects and other specified hematological disorders	4.3	0.4
Angina pectoris	3.7	0.3
Other significant endocrine and metabolic disorders	3.2	0.3
Acute renal failure	3.2	0.1
Ischemic or unspecified stroke	2.9	0.2
Drug/alcohol dependence	2.5	0.2
Seizure disorders and convulsions	2.5	0.3
Cardio-respiratory failure and shock	2.4	0.0
Septicemia, sepsis, systemic inflammatory response syndrome/shock	1.7	0.0
Chronic ulcer of skin, except pressure	1.7	0.1

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 2016

	As percent of Medicare population	Percent of category in FFS	Percent of category in private plans
All beneficiaries	**100%**	**68%**	**32%**
Aged (65 or older)	84	67	33
Under 65	16	73	27
Non–dual eligible	**81**	**69**	**31**
Aged (65 or older)	74	68	32
Under 65	8	72	28
Dual eligible	**18**	**66**	**34**
Aged (65 or older)	11	61	39
Under 65	8	73	27
Dual-eligible beneficiaries by category (all ages)			
Full dual eligibility	**13**	**70**	**30**
Beneficiaries with partial dual eligibility			
QMB only	3	61	39
SLMB only	2	54	46
QI	1	51	49

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 2016, Puerto Rico had 568,000 Medicare Advantage enrollees. Dual-eligible special needs plans in Puerto Rico had 283,000 enrollees in December 2016. Figures may not sum due to rounding.

Source: MedPAC analysis of 2016 denominator and common Medicare environment files and CMS monthly MA reports.

- Medicare plan enrollment among the dually eligible continues to increase. In 2016, 34 percent of dual-eligible beneficiaries were in Medicare private plans, up from 23 percent in 2012.

- 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. Regardless of dual-eligibility status, beneficiaries under age 65 are less likely than aged beneficiaries to enroll in Medicare private plans (27 percent vs. 33 percent, respectively).

- 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 through 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 (46 percent and 49 percent, respectively) than any other category shown in this chart, and the rates are higher than the average rate (32 percent) across all Medicare beneficiaries.