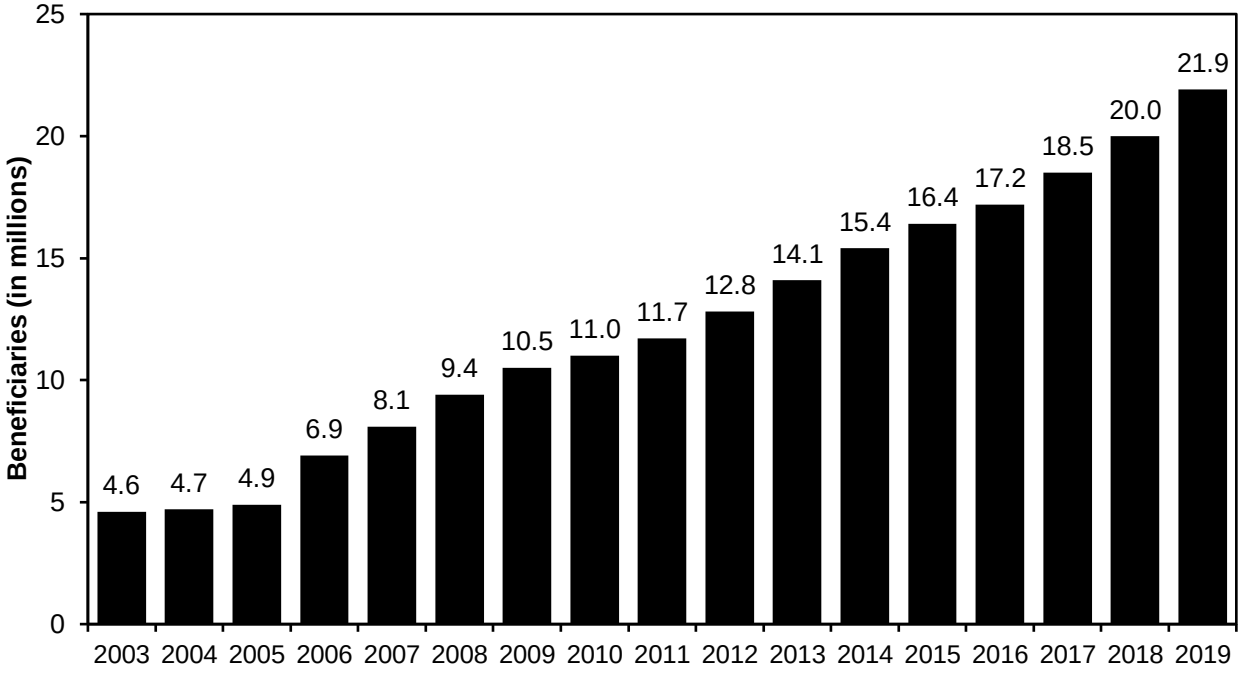
SECTION 9

Medicare Advantage

Chart 9-1. Enrollment in MA plans, 2003–2019



Note: MA (Medicare Advantage).

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

- Enrollment in MA plans that are paid on an at-risk capitated basis reached 21.9 million enrollees (34 percent of all Medicare beneficiaries) in 2019. MA enrollment has grown steadily since 2003, increasing almost fivefold. The Medicare program paid MA plans about $230 billion in 2018 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
2019	97	74	98	38	99	23

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).

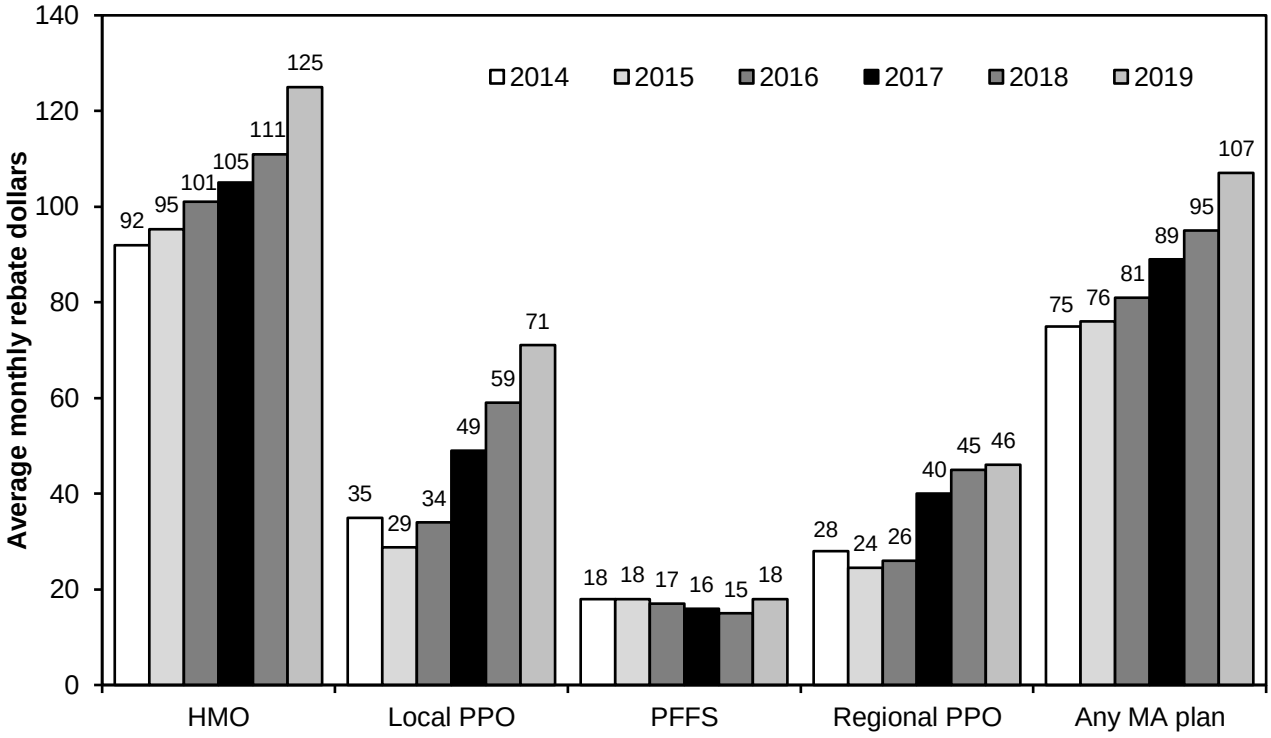
Source: MedPAC analysis of plan bid data from CMS.

- 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 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 97 percent of Medicare beneficiaries in 2019, 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 2019.

- The number of plans from which beneficiaries may choose in 2019 is higher than at any time since 2012. In 2019, beneficiaries can choose from an average of 23 plans operating in their counties.

Chart 9-3. Average monthly rebate dollars, by plan type, 2014–2019



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–special needs plans (SNPs) rose to a high of $107 per month for 2019.

- 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 high of $125 per month for 2019.

- For both local and regional PPOs, the rebates declined through 2015 and then rose sharply after 2016. Rebates for local PPOs have doubled since 2016.

- Rebates for PFFS plans had declined steadily since 2011 (2011–2013 not shown in chart) but increased for 2019.

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

Plan type	Total enrollees (in thousands) February 2015	February 2016	February 2017	February 2018	February 2019	Percent change 2018–2019
Local CCPs	14,824	15,588	16,920	18,463	20,502	11%
Regional PPOs	1,237	1,315	1,353	1,327	1,255	–5
PFFS	260	238	190	154	118	–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.

- Enrollment in local CCPs grew by 11 percent over the past year. Enrollment in regional PPOs declined by 5 percent, and enrollment in PFFS plans dropped by 23 percent. Combined enrollment in the three types of plans grew by 10 percent from February 2018 to February 2019 (data not shown).

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2019

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	63,678	21%	11%	2%	0%	1%	35%
Alabama	1,088	18	20	1	0	0	40
Alaska	99	0	1	0	0	0	1
Arizona	1,364	33	5	1	0	0	38
Arkansas	675	12	4	6	2	0	24
California	6,523	37	2	0	0	0	40
Colorado	977	29	8	0	0	1	38
Connecticut	707	21	17	1	0	0	39
Delaware	213	7	8	0	0	0	15
Florida	4,796	29	9	6	0	0	43
Georgia	1,830	11	18	8	0	0	37
Hawaii	280	17	27	2	0	0	45
Idaho	347	19	13	0	0	0	32
Illinois	2,327	11	12	0	0	0	24
Indiana	1,312	10	17	3	0	0	30
Iowa	650	8	12	0	0	2	21
Kansas	558	7	9	0	1	0	18
Kentucky	970	9	18	4	0	1	32
Louisiana	906	30	4	2	0	0	36
Maine	353	18	13	1	1	0	33
Maryland	1,085	7	4	0	0	0	11
Massachusetts	1,382	15	5	1	0	0	22
Michigan	2,150	14	23	1	0	0	38
Minnesota	1,072	14	24	0	0	6	43
Mississippi	632	11	4	4	0	0	19
Missouri	1,296	21	10	3	0	0	35
Montana	241	7	10	0	1	0	18
Nebraska	359	10	4	0	1	1	16
Nevada	555	30	5	0	0	0	35
New Hampshire	313	8	7	2	0	0	17
New Jersey	1,694	13	15	0	0	0	28
New Mexico	440	20	15	0	0	0	34
New York	3,761	26	10	3	0	0	39
North Carolina	2,070	14	18	3	0	0	35
North Dakota	137	0	3	0	0	14	17
Ohio	2,418	22	15	1	0	0	38
Oklahoma	779	12	8	1	0	0	20
Oregon	910	28	14	0	0	0	43
Pennsylvania	2,821	25	15	0	0	0	41
Puerto Rico	812	70	3	0	0	0	72
Rhode Island	229	33	3	1	0	0	37
South Carolina	1,111	8	8	11	0	0	27
South Dakota	185	1	7	0	0	13	20
Tennessee	1,418	25	13	1	0	0	38
Texas	4,333	20	12	4	0	0	37
Utah	413	28	8	0	0	0	36
Vermont	154	3	3	4	1	0	11
Virgin Islands	22	0	1	0	0	0	1
Virginia	1,599	10	6	2	1	2	20
Washington	1,426	27	4	0	0	0	32
Washington, DC	99	7	10	0	0	6	18
West Virginia	458	3	24	1	1	4	33
Wisconsin	1,215	22	14	1	1	4	41
Wyoming	114	0	2	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 2019.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2019

	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	107%	107%	109%	105%	107%
Bids/FFS	89	88	96	91	104
Payments/FFS	100	100	104	97	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 2018.

- 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.

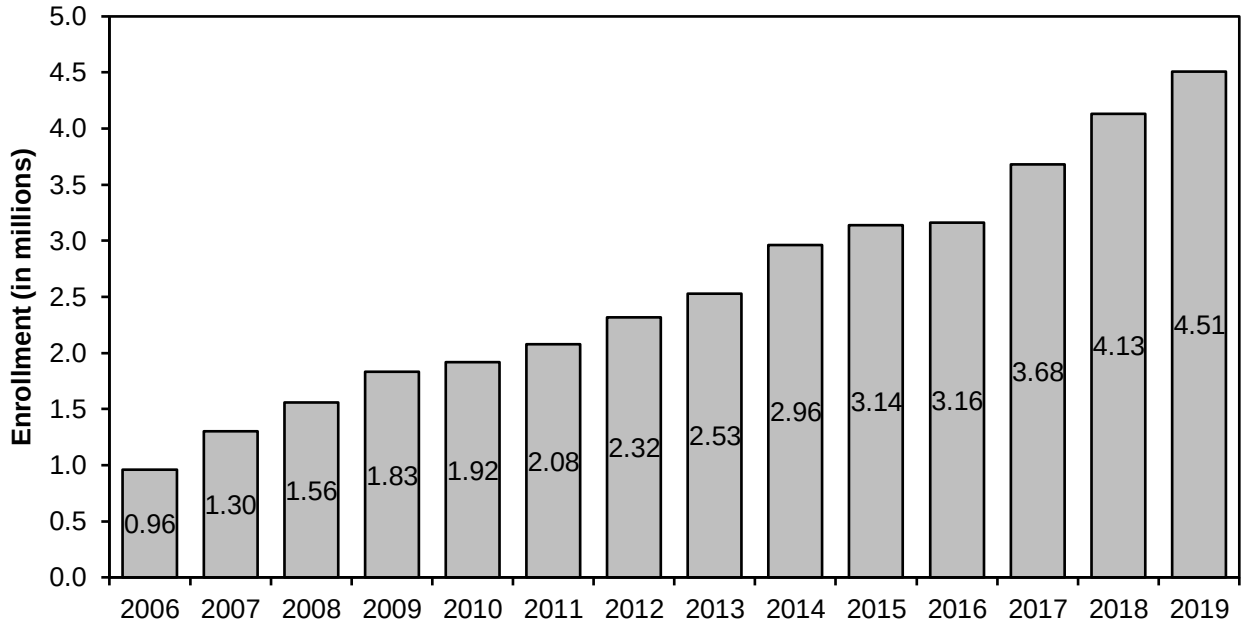
- We estimate that MA benchmarks average 107 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type because different types of plans tend to draw enrollment from different types of geographical areas.

- Plans' enrollment-weighted bids (excluding employer plans, which no longer submit bids) average 89 percent of FFS spending in 2019. We estimate that HMOs bid an average of 88 percent of FFS spending, while bids from other plan types average at least 91 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 2019 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 100 and 97 percent of FFS, respectively, while payments to local PPOs and PFFS plans average 104 percent and 106 percent of FFS, respectively.

Chart 9-7. Enrollment in employer group MA plans, 2006–2019



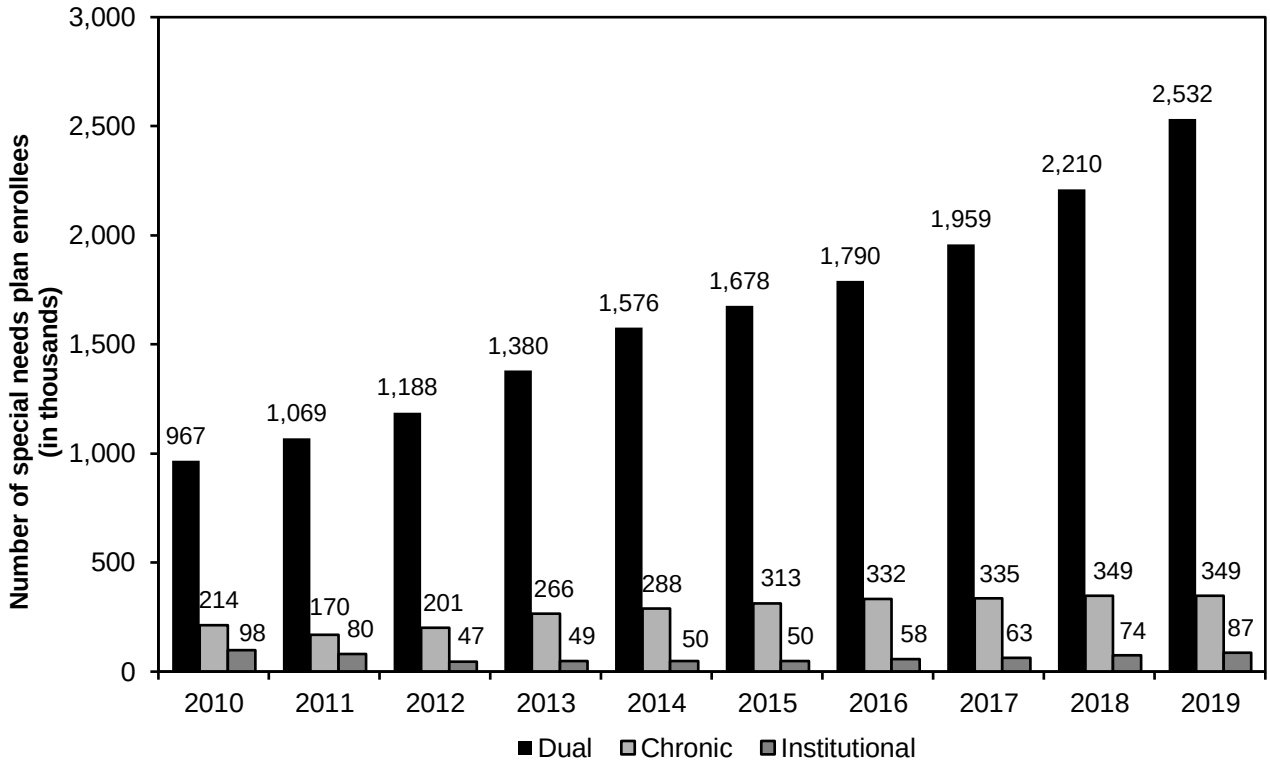
Note: MA (Medicare Advantage). Enrollment numbers are as of May for 2006, November for 2007, and February for 2008 through 2019.

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 2019, about 4.5 million enrollees were in employer group plans, or about 21 percent of all MA enrollees. Employer plan enrollment grew by 9 percent from 2018 and has almost doubled since 2012.

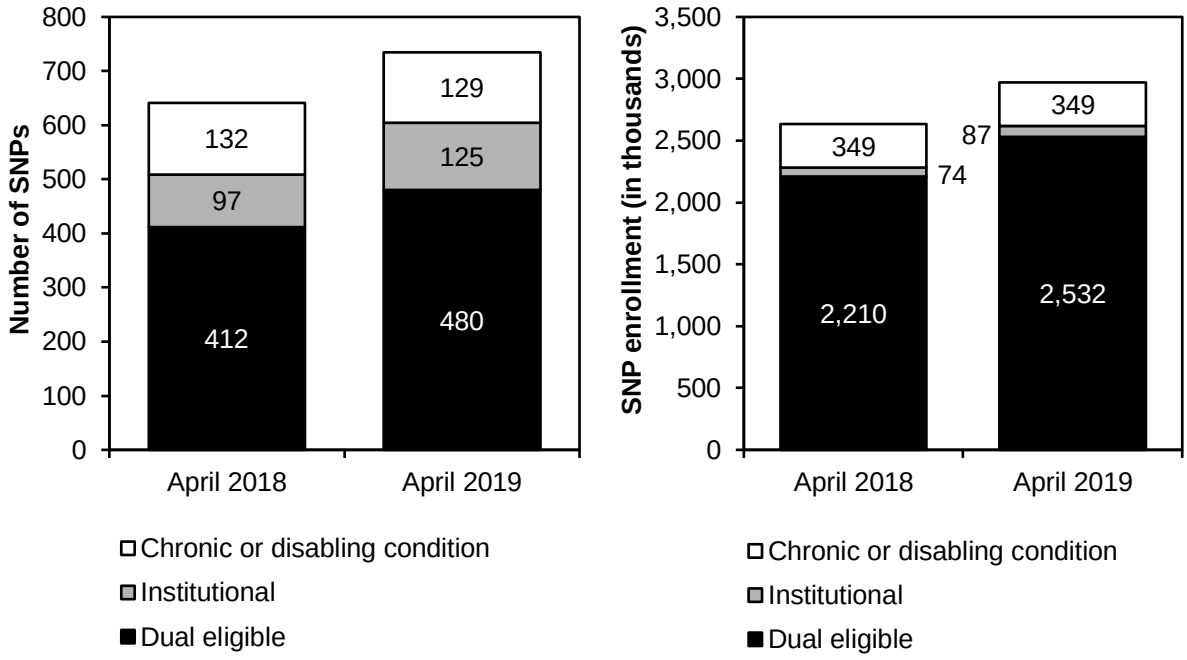
Chart 9-8. Number of special needs plan enrollees, 2010–2019



Source: CMS special needs plans comprehensive reports, April 2010–2019.

- The Congress created special needs plans (SNPs) as a new 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 2.5 million in 2019, doubling since 2012.
- Enrollment in chronic condition SNPs has fluctuated as plan requirements have changed, but has risen annually since 2011, until flattening in 2019.
- 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 2018 to 2019



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2018 and 2019.

- The number of SNPs increased by 15 percent from April 2018 to April 2019. Dual-eligible SNPs increased by 17 percent and institutional SNPs increased by 29 percent, while the number of chronic condition SNPs decreased slightly.

- In 2019, most SNPs (65 percent) are for dual-eligible beneficiaries, while 17 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need), and 18 percent are for beneficiaries with chronic conditions.

- From April 2018 to April 2019, the number of SNP enrollees increased by 13 percent. Enrollment in SNPs for dual eligibles grew by 15 percent and enrollment in SNPs for institutionalized beneficiaries grew by 18 percent, while enrollment in SNPs for chronic conditions remained stable. Enrollment in all SNPs has grown from 0.9 million in May 2007 (not shown) to 3.0 million in April 2019.

- The availability of SNPs varies by type of special needs population served (data not shown). In 2019, 89 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 86 percent in 2018), 63 percent live where SNPs serve institutionalized beneficiaries (up from 56 percent in 2018), and 47 percent live where SNPs serve beneficiaries with chronic conditions (the same as in 2018).

Chart 9-10. Twenty most common condition categories among MA beneficiaries, as defined in the CMS–HCC model, 2017

Conditions (defined by HCC)	Percent of beneficiaries with listed condition	Percent of beneficiaries with listed condition and no others
Diabetes with chronic complications	20.0%	3.6%
Vascular disease	18.9	2.2
COPD	14.2	1.7
CHF	11.8	0.5
Major depressive, bipolar, and paranoid disorders	11.5	1.8
Specified heart arrhythmias	11.4	1.3
Morbid obesity	8.6	1.0
Diabetes without complications	8.5	3.1
Rheumatoid arthritis and inflammatory connective tissue disease	6.5	1.1
Breast, prostate, colorectal, and other cancers and tumors	5.1	1.3
Coagulation defects and other specified hematological disorders	4.9	0.4
Angina pectoris	4.0	0.3
Drug/alcohol dependence	3.7	0.3
Other significant endocrine and metabolic disorders	3.6	0.3
Acute renal failure	3.4	0.1
Cardio-respiratory failure and shock	2.5	0.0
Seizure disorders and convulsions	2.5	0.3
Ischemic or unspecified stroke	2.2	0.1
Septicemia, sepsis, systemic inflammatory response syndrome/shock	1.8	0.0
Hemiplegia/Hemiparesis	1.6	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.
- Diabetes with chronic complications is the most common HCC, and over 28 percent of MA enrollees are in two diabetes HCCs combined.

Chart 9-11. Medicare private plan enrollment patterns, by age and Medicare–Medicaid dual-eligible status, December 2017

	As percent of Medicare population	Percent of category in FFS	Percent of category in private plans
All beneficiaries	**100%**	**67%**	**33%**
Aged (65 or older)	85	66	34
Under 65	15	71	29
Non–dual eligible	**82**	**67**	**33**
Aged (65 or older)	74	67	33
Under 65	8	71	29
Dual eligible	**18**	**64**	**36**
Aged (65 or older)	11	59	41
Under 65	7	71	29
Dual-eligible beneficiaries by category (all ages)			
Full dual eligibility	**13**	**68**	**32**
Beneficiaries with partial dual eligibility			
QMB only	3	58	42
SLMB only	2	51	49
QI	1	49	51

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 2017, Puerto Rico had 570,000 Medicare Advantage enrollees. Dual-eligible special needs plans in Puerto Rico had 279,000 enrollees in December 2017. Figures may not sum due to rounding.

Source: MedPAC analysis of 2017 denominator and common Medicare environment files and CMS monthly Medicare Advantage reports.

- Medicare plan enrollment among the dually eligible continues to increase. In 2017, 36 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 (29 percent vs. 34 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 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 (49 percent and 51 percent, respectively) than any other category shown in this chart, and the rates are higher than the average rate (33 percent) across all Medicare beneficiaries. This is the first year in which the majority of any category of beneficiaries are in MA (51 percent of the about 500,000 QI beneficiaries were enrolled in plans in December of 2017).