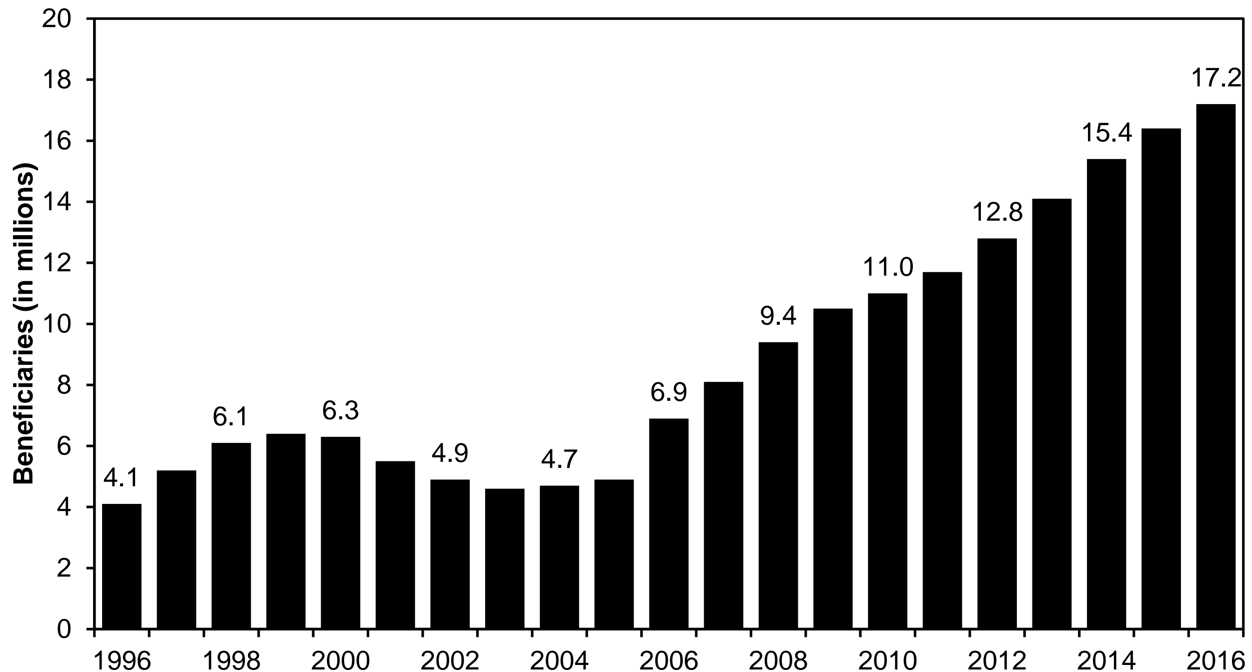
SECTION 9

Medicare Advantage

Chart 9-1. Enrollment in MA plans, 1996–2016



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 is at an all-time high, at 17.2 million enrollees (31 percent of all Medicare beneficiaries). 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 the MA plans about $170 billion in 2015 to cover Part A and Part B services for MA enrollees.

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

	CCPs					
	HMO or local PPO	Regional PPO	Any CCP	PFFS	Any MA plan	Average plan offerings per county
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

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).

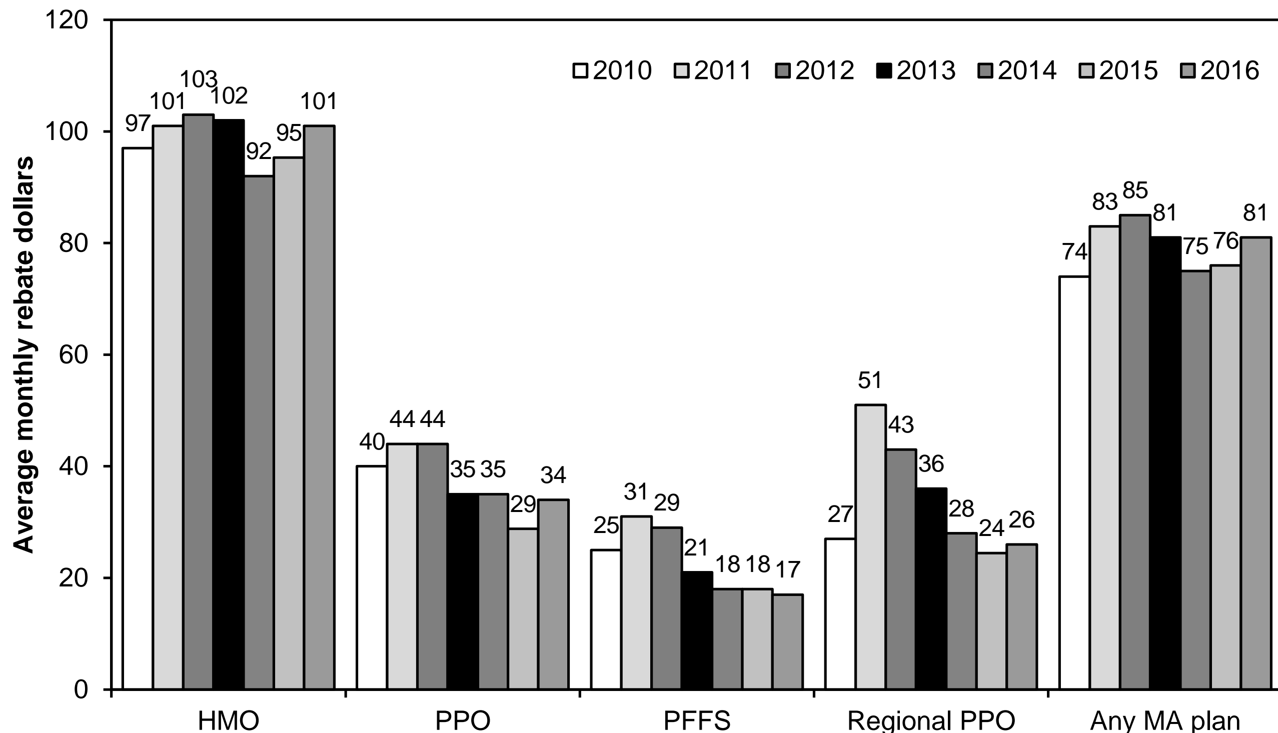
Source: MedPAC analysis of plan bid data from CMS.

- 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 2016, and regional PPOs are available to 73 percent of beneficiaries; the availability of both plan types has increased from 2013. For the past 10 years, almost all Medicare beneficiaries have had MA plans available: 99 percent in 2016, up from 84 percent in 2005 (2005 data not shown).

- The number of plans from which beneficiaries may choose in 2016 is the same as last year. In 2016, beneficiaries can choose from an average of 9 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 2016 was due to the reduction in the number of PFFS and regional PPO plans.

Chart 9-3. Average monthly rebate dollars, by plan type, 2010–2016



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 generosity 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.

- HMOs have had, by far, the highest rebates because they tend to bid lower than other types of plans. Average rebates for HMOs have remained relatively stable over this period.

- For the three non-HMO categories, the rebates rose from 2010 to 2011 and declined through 2015.

- For all categories of non-PFFS plans, the rebates rose from 2015 to 2016.

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

	Total enrollees (in thousands)					
Plan type	February 2012	February 2013	February 2014	February 2015	February 2016	Percent change 2015–2016
Local CCPs	11,382	12,580	13,809	14,824	15,588	5%
Regional PPOs	930	1,060	1,221	1,237	1,315	6
PFFS	518	417	309	260	238	–8

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 5 percent over the past year. Enrollment in regional PPOs grew by 6 percent, while enrollment in PFFS plans continued to decline. Combined enrollment in the three types of plans grew by 5 percent from February 2015 to February 2016.

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2016

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	55,576	20%	8%	2%	0%	1%	32%
Alabama	966	16	9	2	0	0	27
Alaska	83	0	0	0	0	0	0
Arizona	1,145	35	2	1	0	0	39
Arkansas	600	9	3	5	3	0	21
California	5,709	38	1	0	0	0	39
Colorado	798	30	3	0	0	3	37
Connecticut	635	23	3	1	0	0	26
Delaware	183	5	4	0	0	0	9
Florida	4,060	29	3	9	0	0	41
Georgia	1,541	11	15	7	1	0	33
Hawaii	248	19	26	1	0	0	46
Idaho	286	18	14	0	0	0	33
Illinois	2,085	9	10	0	0	0	20
Indiana	1,161	6	14	4	0	0	24
Iowa	578	5	11	0	0	2	18
Kansas	492	6	7	0	1	0	15
Kentucky	869	6	15	6	0	0	27
Louisiana	802	27	2	3	0	0	31
Maine	309	15	8	0	1	0	24
Maryland	942	3	2	0	0	4	10
Massachusetts	1,229	15	4	1	0	0	20
Michigan	1,915	13	18	1	0	0	33
Minnesota	922	13	4	0	0	39	56
Mississippi	564	8	3	4	0	0	16
Missouri	1,145	19	6	3	1	0	30
Montana	204	1	18	0	1	0	20
Nebraska	317	7	3	0	2	1	13
Nevada	458	31	4	0	0	0	35
New Hampshire	267	4	2	0	1	0	8
New Jersey	1,506	12	4	0	0	0	16
New Mexico	377	20	11	0	0	0	32
New York	3,369	27	6	3	1	0	37
North Carolina	1,788	14	15	2	0	0	31
North Dakota	119	0	2	0	0	17	19
Ohio	2,171	18	13	3	0	1	35
Oklahoma	684	11	5	1	1	0	18
Oregon	763	28	16	0	0	0	45
Pennsylvania	2,549	25	14	0	0	0	40
Puerto Rico	777	70	3	0	0	0	73
Rhode Island	205	33	1	1	0	0	36
South Carolina	953	7	5	11	1	0	24
South Dakota	157	0	5	0	0	16	21
Tennessee	1,245	25	10	1	0	0	36
Texas	3,683	19	8	4	1	1	32
Utah	350	28	6	0	0	0	35
Vermont	133	1	2	4	1	0	8
Virgin Islands	20	0	0	0	0	0	1
Virginia	1,366	6	4	2	2	2	17
Washington	1,205	26	4	0	0	0	30
Washington, D.C.	89	2	5	0	0	7	14
West Virginia	418	2	21	1	1	2	28
Wisconsin	1,061	19	12	2	1	5	39
Wyoming	97	0	1	0	2	1	3

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 2016.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2016

	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	107%	106%	109%	103%	111%
Bids/FFS	94	90	105	98	108
Payments/FFS	102	101	108	101	110

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 2015.

- 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. Legislation established the formula, being phased in by 2017, for calculating benchmarks in each county, 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.

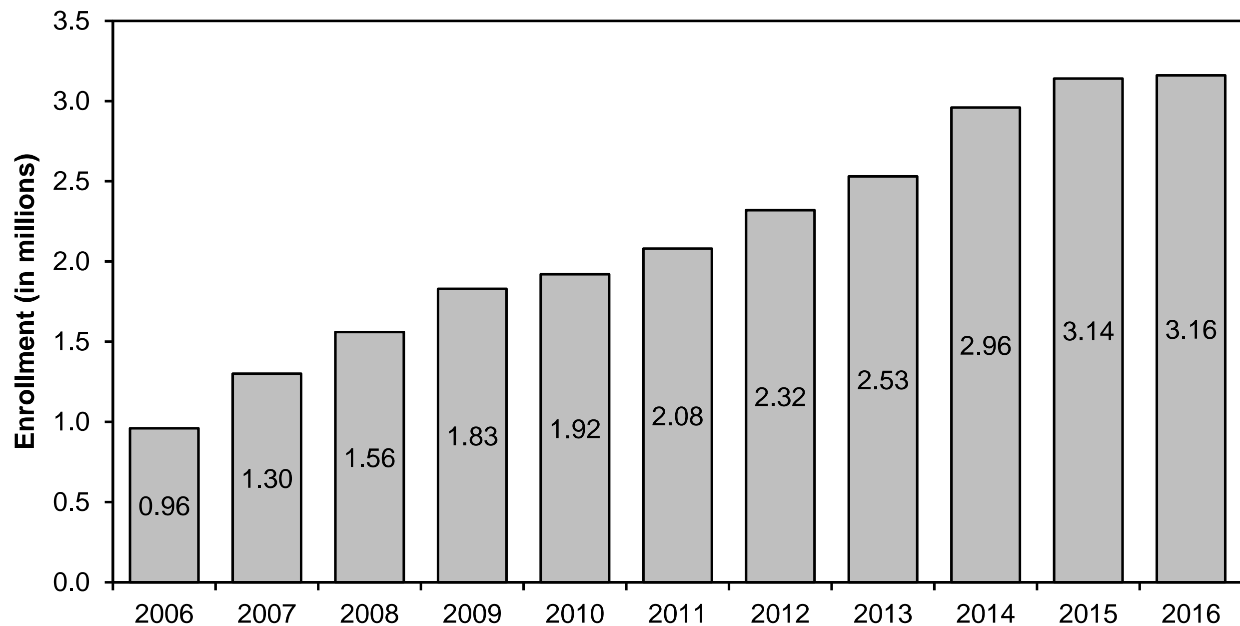
- We estimate that MA benchmarks average 107 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type because different types of plans tend to draw enrollment from different types of geographical areas.

- Plans' enrollment-weighted bids average 94 percent of FFS spending in 2016. We estimate that HMOs bid an average of 90 percent of FFS spending, while bids from other plan types average at least 98 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS in the areas where they bid, while most other plan types tend to charge more.

- We project that 2016 MA payments will be 102 percent of FFS spending. It is likely this number will decline further over the next year as benchmarks are reduced relative to FFS levels to complete the transition to the requirements under the Patient Protection and Affordable Care Act of 2010.

- The ratio of payments relative to FFS spending varies by the type of MA plan. HMO and regional PPO payments are estimated to be 101 percent of FFS, while payments to PFFS and local PPOs average 110 percent and 108 percent of FFS, respectively.

Chart 9-7. Enrollment in employer group MA plans, 2006–2016



Note: MA (Medicare Advantage). Enrollment numbers are as of May for 2006, November for 2007, and February for 2008 through 2016.

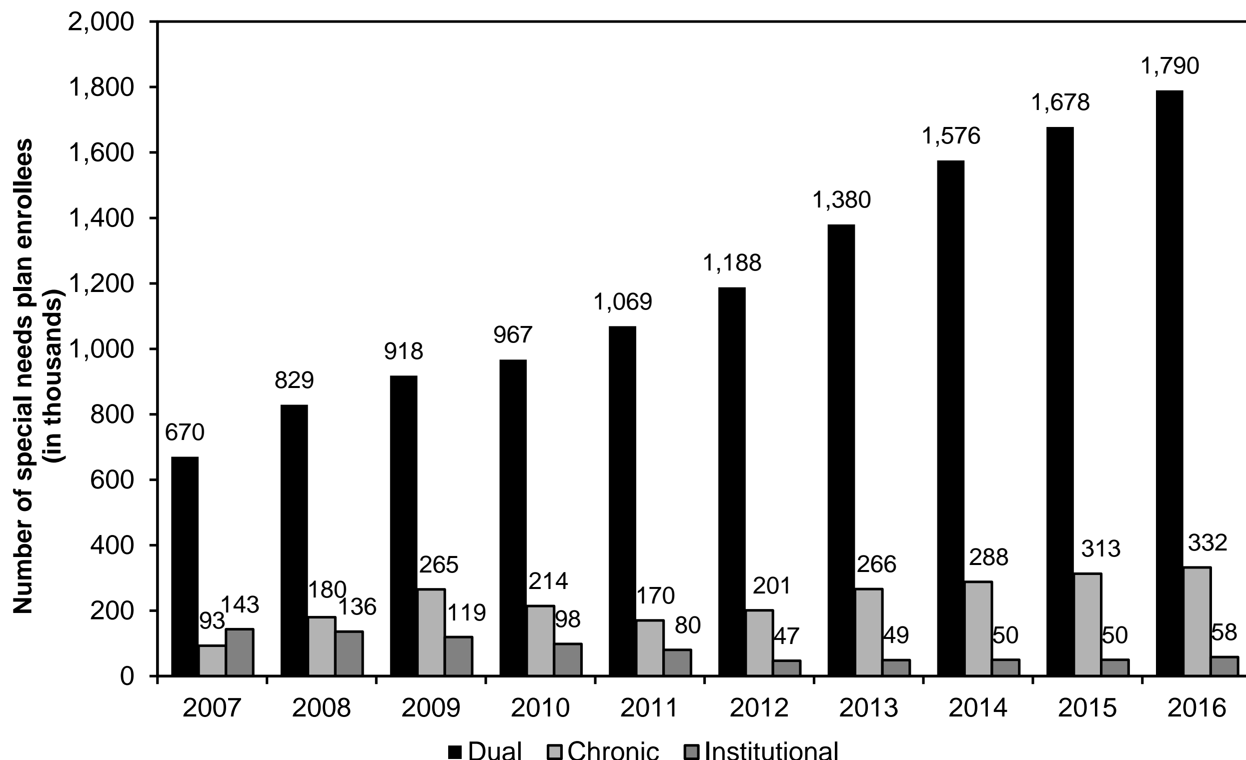
Source: CMS enrollment data.

- 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 2016, about 3 million enrollees were in employer group plans, or about 18 percent of all MA enrollees.

- Our analysis of MA bid data shows that employer group plans on average have bids that are higher relative to FFS spending than individual plans, meaning that group plans appear to be less efficient than individual market MA plans. Employer group plans bid an average of 103 percent of FFS, compared with 92 percent of FFS for individual plans (data not shown).

Chart 9-8. Number of special needs plan enrollees, 2007–2016



Source: CMS special needs plans comprehensive reports, May 2007, April 2008–2016.

- 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.

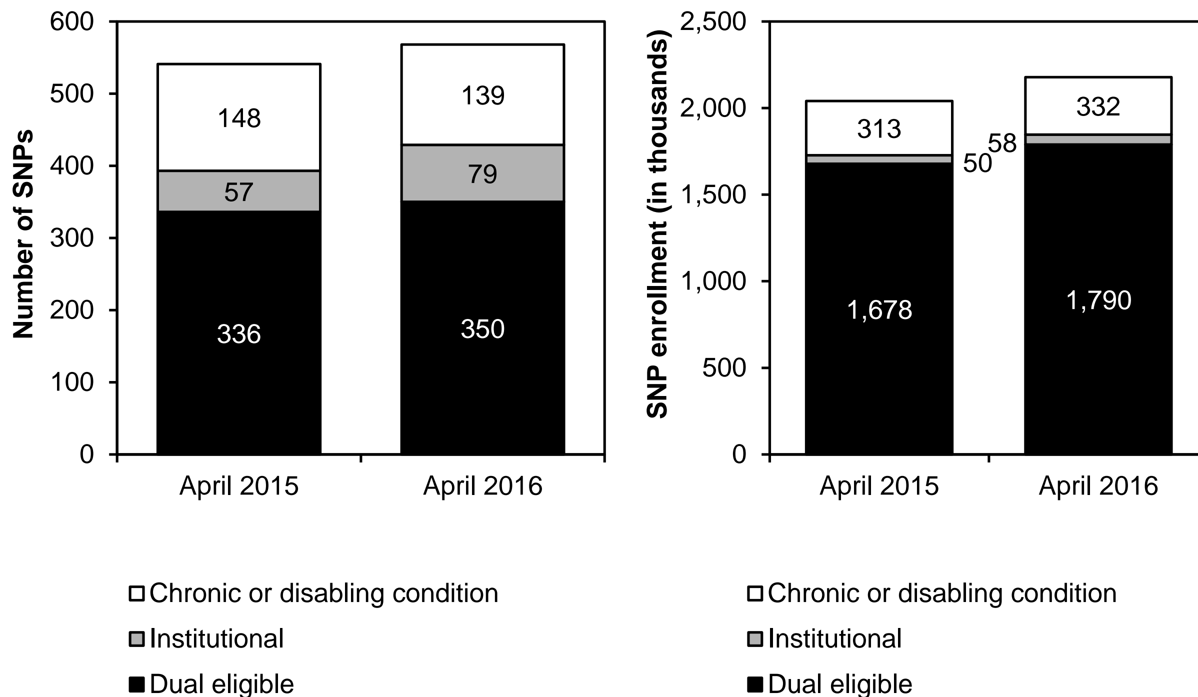
- CMS approves three types of SNPs: dual-eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or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

- Enrollment in dual-eligible SNPs has grown continuously and is about 1.8 million in 2016.

- 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.

Chart 9-9. Number of SNPs and SNP enrollment rose from 2015 to 2016



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2015 and 2016.

- The number of SNPs increased by 5 percent from April 2015 to April 2016, and the number of SNP enrollees increased by 7 percent. All three types of SNPs showed increases in the number of plans and enrollment in those plans, except that the number of chronic disease SNPs decreased by about 6 percent.

- In 2016, most SNPs (62 percent) are for dual-eligible beneficiaries, while 24 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 2.2 million in April 2016.

- The availability of SNPs varies by type of special needs population served (data not shown). In 2016 83 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 82 percent in 2015), 50 percent live where SNPs serve institutionalized beneficiaries (up from 47 percent in 2015), and 54 percent live where SNPs serve beneficiaries with chronic conditions (down from 55 percent).

Chart 9-10. Twenty most common condition categories among MA beneficiaries, as defined in the CMS–HCC model, 2014

Conditions (defined by HCC)	Percent of beneficiaries with listed condition	Percent of beneficiaries with listed condition and no others
Vascular disease	16.4%	2.0%
Diabetes with chronic complications	14.4	2.6
COPD	14.1	2.1
Diabetes without complications	13.2	4.8
Specified heart arrhythmias	11.2	1.4
CHF	11.1	0.6
Major depressive, bipolar, and paranoid disorders	8.7	1.6
Morbid obesity	5.8	0.7
Rheumatoid arthritis and inflammatory connective tissue disease	5.5	1.0
Breast, prostate, colorectal, and other cancers and tumors	5.2	1.5
Angina pectoris	3.5	0.3
Coagulation defects and other specified hematological disorders	3.5	0.3
Acute renal failure	2.8	0.1
Other significant endocrine and metabolic disorders	2.6	0.3
Ischemic or unspecified stroke	2.6	0.2
Seizure disorders and convulsions	2.5	0.3
Drug/alcohol dependence	2.2	0.2
Cardio-respiratory failure and shock	2.1	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). There are some differences between the conditions in this table and the analogous table in our 2015 data book. Most of these differences reflect a 2014 change in the condition categories that CMS used in the CMS–HCC model.

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.
- CMS previously used a version of the CMS–HCC model that had 70 HCCs, but this analysis uses a newer model that has 79 HCCs. Vascular disease is the most common HCC, but two diabetes HCCs combined are more common than vascular disease. Over 27 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 2014

	As percent of Medicare population	Percent of category in FFS	Percent of category in plans
All beneficiaries	**100%**	**70%**	**30%**
Aged (65 or older)	84	69	31
Under 65	16	76	24
Non–dual eligible	**82**	**70**	**30**
Aged (65 or older)	73	69	31
Under 65	9	76	24
Dual eligible	**18**	**70**	**30**
Aged (65 or older)	10	64	36
Under 65	8	75	25
Dual-eligible beneficiaries by category (all ages)			
Full dual eligibility	**13**	**74**	**26**
Beneficiaries with partial dual eligibility			
QMB only	2	66	34
SLMB only	2	58	42
QI	1	54	46

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 2014, Puerto Rico had 532,000 Medicare Advantage enrollees, which is nearly three-quarters of the Medicare-eligible population. Dual-eligible special needs plans in Puerto Rico had 272,000 enrollees in December 2014.

Source: MedPAC analysis of 2014 denominator and common Medicare environment files.

- 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 30 percent at the end of 2014.

- A substantial share of dual-eligible beneficiaries (43 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 plans (24 percent vs. 31 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 (42 percent and 46 percent, respectively) than any other category shown in this chart, and the rates are higher than the average rate (30 percent) across all Medicare beneficiaries.

Chart 9-12. Distribution of MA plans and enrollment by CMS overall star ratings, March 2016

	Year 2016 star ratings: Number of stars						
Plans and enrollment	**5**	**4.5**	**4**	**3.5**	**3**	**2.5**	**Any star rating**
All plan types							
Number of plans	12	65	102	110	66	11	366
As share of rated plan enrollees	10%	28%	34%	19%	8%	1%	100%
HMOs							
Number of plans	12	45	72	79	49	11	268
As share of HMO enrollees	14%	23%	35%	19%	7%	1%	100%
Local PPOs							
Number of plans	0	20	27	24	11	N/A	82
As share of local PPO enrollees	N/A	53%	40%	5%	2%	N/A	100%
Regional PPOs							
Number of plans	0	0	1	4	5	N/A	10
As share of regional PPO enrollees	N/A	N/A	2%	63%	35%	N/A	100%
PFFS							
Number of plans	0	0	2	3	1	0	6
As share of PFFS enrollees	N/A	N/A	69%	24%	7%	N/A	100%

Note: MA (Medicare Advantage), 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 4.05 on an enrollment-weighted basis. There are 132 plans, with nearly 560,000 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. (In addition, certain plans, such as the Medicare–Medicaid plans participating in the financial alignment demonstration, 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 2016 (continued)

- Under the statutory provisions that introduced quality bonus payments beginning in 2012, plans with ratings of 4 stars or above 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.

- HMOs are the only plan type for which there are 5-star plans. Ten MA HMO plans and two cost-reimbursed HMO plans have 5-star ratings. The highest star rating attained by any local PPO is 4.5, whereas the highest rating for a regional PPO or a PFFS plan is 4. The majority of enrollees in regional PPO plans are in plans with a rating below 4 stars.

- Plans with ratings below 3 stars have an indicator of their status in the Medicare Plan Finder. CMS has the authority to terminate plans that have had three consecutive years of poor performance (a star rating below 3 stars) in either their MA or Part D performance.

- 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 and patient experience measures, with less weight assigned to process and administrative measures. In 2016, excluding two composite improvement measures, 60 percent of the weight of measures reflects Part C and Part D clinical quality measures (outcomes as well as clinical process measures); 22 percent of the weight represents patient experience measures; and the remaining 18 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 2016. These two measures were introduced in the 2013 star rating year, and as new measures were assigned a weight of 1 (the lowest weight of the possible weights of 1, 1.5, or 3). In 2014, the measures had a weight of 3 (the same weight as an outcome measure). For 2015 and 2016, the measures have a weight of 5, while all other measures remain at 1, 1.5, or 3. 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."