THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

MEDICARE ADVANTAGE

September 2005

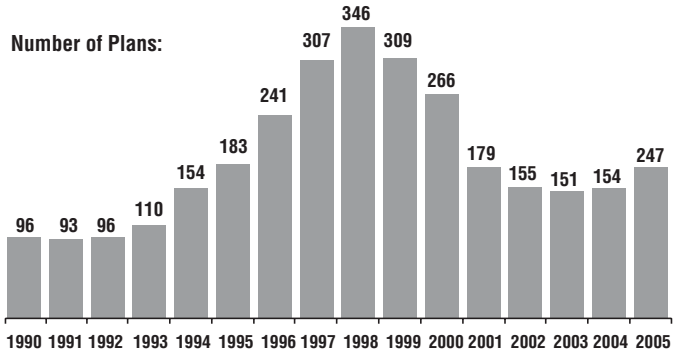
Overview

Medicare provides health benefits to nearly 42 million elderly and disabled Americans. Most (88%) have their health bills paid by the traditional fee-for-service (FFS) program, while 12% are covered by private health plans, primarily HMOs.

HMOs have been an option under Medicare since the 1970s. The Balanced Budget Act (BBA) of 1997 expanded the role of private plans under "Medicare+Choice" to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high-deductible insurance plans. Private plan options have been offered primarily at the county level. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) renamed the program "Medicare Advantage" (MA), created new regional PPOs, "special needs plans" for dual eligibles, the institutionalized, or those with severe and disabling conditions, and new private drug plans that will go into effect January 2006.

Figure 1

Medicare+Choice/Medicare Advantage Plans, 1990–2005



Note: All data are from December of the given year, except 2005 data are from July. Number of plans include Medicare HMOs, PPOs (non-demonstration), and POS contracts; excludes PFFS, demonstrations, and cost contracts.
SOURCE: CMS, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report.

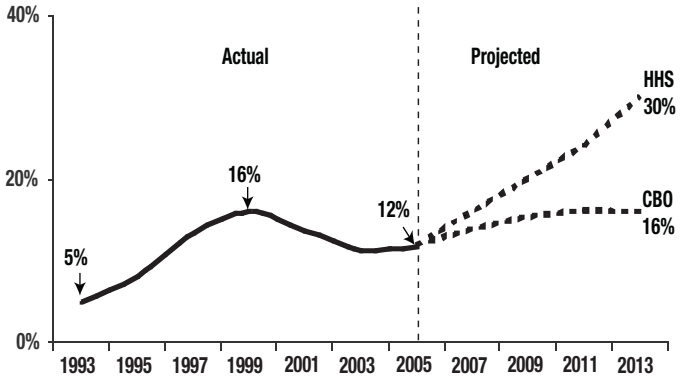
Plan Participation and Enrollment

Plan participation and enrollment have fluctuated over the past decade. After a period of rapid growth from 1992–1998, the number of plans declined by half. In July 2005, there were 247 plans (mostly HMOs) with 4.9 million enrollees (12% of the Medicare population), down from a high of 6.3 million (16%) in 2000.

In 2004, over three-fourths of beneficiaries had access to a private Medicare plan including PFFS plans; 62% had access to a Medicare HMO, PPO, or POS plan, down from 71% in 1999. By 2013, the Administration estimates 30% of Medicare beneficiaries will enroll in Medicare Advantage plans, while CBO projects an enrollment rate of 16%.

Figure 2

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans



Note: All actual data are from December of the given year, except 2005 data are from July.
SOURCE: Actual: CMS, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report. Projections: President's FY 2006 Budget, Office of Management and Budget, February 7, 2005; CBO from CBO Medicare Baseline, March 2005.

Enrollment varies widely across states. Less than 1% of Medicare beneficiaries are enrolled in HMO plans in 16 states and DC, while at least 20% are enrolled in AZ, CA, CO, OR, PA, and RI. Nationwide, more than one in four Medicare Advantage enrollees are in California. Beneficiaries have historically had an option to enroll in a plan (as long as the plan is accepting new enrollees) and disenroll at any time during the year. Beginning in 2006, beneficiaries will be able to disenroll or change plans only once during a six-month period, shortened to a three-month period in later years.

Premiums and Benefits

Medicare Advantage plans are generally required to provide all Medicare-covered benefits. Plans with costs below their Medicare payments must distribute savings to beneficiaries as lower plan premiums and copayments, additional benefits, or a reduction in Part B premiums; or plans can contribute to a reserve fund.

In 2005, over a quarter (26%) of Medicare Advantage enrollees are in plans that do not provide drug coverage (up from 16% in 1999). While the majority of enrollees have drug coverage, some face restrictions on these benefits: 54% with drug benefits have an annual cap of $1,000 or less for brand-name drugs, and 39% are in plans that cover only generic drugs.

In 2006, MA plans (excluding PFFS and cost plans) must offer at least one plan with basic drug coverage or a plan with enhanced alternative drug coverage (for no additional premium). These plans will receive additional payments for providing drug coverage. Medicare MSAs are prohibited from offering drug coverage.

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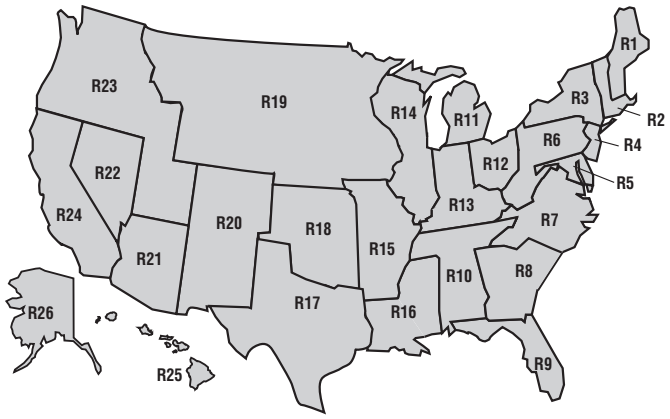
Regional PPOs

Beginning in 2006, regional PPO plans will be added to existing county-based private plans participating in Medicare Advantage. There will be 26 Medicare Advantage regions comprised of single states or groups of states. The regions are designed to maximize beneficiary choice, particularly in rural areas where beneficiaries have not historically had many plan options. Regional PPOs are required to offer a single Part A/B deductible and a catastrophic cap on out-of-pocket spending.

Figure 3
Medicare Advantage Regions



Note: R = Region Number.

SOURCE: Centers for Medicare and Medicaid Services, December 2004.

PPOs entering the market are required to serve at least one Medicare Advantage region in its entirety and must offer the same benefits across a region. To facilitate the start-up of regional PPOs, there will be a 2-year moratorium on new "local" PPO plans and expansion of existing local PPO service areas. Also, Medicare will share risk for medical expenses with all regional plans during that 2-year period and may draw upon a $10 billion stabilization fund to promote PPO participation on a regional basis.

Payments to Plans Prior to 2006

Medicare pays plans a capitated rate to provide Part A and B benefits for each enrollee, totaling a projected $48.1 billion in 2005. For many years, Medicare payments to HMOs were generally set at 95% of FFS costs in each county. In order to reduce deficits in the late 1990s, overall growth in Medicare was constrained leading to limited increases in payments to plans. In the years that followed, plan participation and enrollment declined.

To stabilize the program, the MMA increased aggregate payments to plans by $1.3 billion for 2004 and 2005. In 2005, Medicare pays plans the *highest* of:

- A minimum or "floor" for rural ($592/month) or urban ($654/ month) counties;
- A minimum update over 2004 rates by the national growth rate percentage (6.6% in 2005);
- A blended payment rate which combines a local rate and the national average rate;
- 100% of average 2004 FFS costs in the county; or
- 100% of average 2005 FFS costs for "rebased" counties, that is, counties in which CMS recalculated the average per capita FFS costs for 2005.

A number of studies have shown HMOs have been paid more than the average FFS costs in their area (MedPAC, 2004; Gold, 2004; GAO, 2000). A recent study by Biles et al. found average payments to MA plans in 2005 exceed average local FFS costs by 7.8%, for a national total of more than $2.7 billion. CBO projects Medicare payments for beneficiaries who enroll in regional PPOs in 2006 will be larger than they would be if the same individuals remained in FFS Medicare.

Payments to Plans, 2006 and Beyond

Beginning in 2006, county-based plans will be paid under a new bidding process based on a county benchmark set at the 2005 payment level increased by the Medicare national growth rate percentage in FFS expenditures (4.8%). Payments to regional PPOs will also be based on a bidding process, although the benchmark will be determined separately. If a plan's bid is higher than the applicable benchmark, the enrollee will pay the difference. If lower, 75% of the difference will go to the enrollee as extra benefits or as a rebate and the government will retain 25%.

By 2006, 75% of plan payments are to be adjusted so that Medicare pays plans appropriately based on their enrollees' risk profiles. By 2007, 100% will be risk-adjusted. Current policy holds plans harmless in the aggregate for the effect of implementing a risk adjustment system based on hospital inpatient and ambulatory data rather than demographic information.

Future Issues

Private plans are expected to play a greater role in Medicare in the future. Higher payments to plans and the addition of prescription drug benefits may increase enrollment, but such changes will increase costs to Medicare, according to CBO. Striking the right balance between controlling spending growth, setting payments to plans fairly, and meeting beneficiaries' health care service needs will be an ongoing challenge.

Additional data about Medicare private plan participation, enrollment and benefits are available on the Medicare Health Plan Tracker at: www.kff.org/medicare/healthplantracker/. Copies of this publication (#2052-08) are available on the Kaiser Family Foundation's website at www.kff.org.