

Primer: Medicare Advantage

An Endangered Source of Added Value and Innovation

Douglas Holtz-Eakin & Michael Ramlet | March 15, 2010

Introduction

More than 47 million Americans are enrolled in Medicare. Each year, enrollees are given the option to choose a private Medicare Advantage (MA) plan through which to receive their Medicare benefits. These Medicare approved private health plans are required to cover basic Medicare benefits, but can also offer reduced cost sharing or additional benefits like vision, dental, and enhanced or lower cost prescription drug coverage. This Congressional Primer outlines how the MA program works, the history of private plans in Medicare, and examines how the Patient Protection and Affordable Care Act will impact existing MA beneficiaries.

What Is Medicare Advantage?

Medicare Advantage (MA) is a federally administered program that allows beneficiaries to receive Medicare covered benefits through private companies. MA plans must provide an equivalent package of basic Medicare A and B services, but most plans typically provide lower cost sharing and a range of additional benefits for their members. Nearly all Medicare beneficiaries (89 percent) have some form of supplemental coverage to fill the gaps left by the traditional Medicare program. For over 11.7 million seniors, their choice is to receive these supplemental benefits through enrollment in a Medicare Advantage plan.ⁱ They receive additional benefits compared to traditional Medicare benefits, often at no or a very low monthly premium. This is particularly valuable to low-income seniors who may not be able to afford upwards of \$200 per month for a Medicare supplement policy.

Beneficiaries have restrictions on when they can join an MA plan. They can enroll when they first become eligible for Medicare, during the annual enrollment period, or during a special election period. In 2011, the MA open

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Executive Summary

Medicare began contracting with private health plans on a limited basis in the 1970s. This expanded dramatically after TEFRA was implemented in 1985, with the expectation that these plans would deliver better, more cost effective care. This expectation has been met.

The healthcare reform law (PPACA) reverses this policy by substantially tilting the policy playing field against Medicare Advantage (MA).

- MA plans cover traditional Medicare benefits, and can offer cost reductions or added benefits like vision, dental, and drug coverage.
- The Majority of MA enrollees are lower income seniors who would otherwise need to qualify for Medicaid or go without insurance.
- PPACA cuts \$206.3 billion from the MA program resulting in an average loss of \$3,714 in per enrollee benefits when the effects of the entire bill are considered.
- Economists estimate that the PPACA will lead to 7.4 million fewer MA enrollees by 2017, a net loss of more than 50 percent compared to current MA enrollment.

Looking forward, budgetary pressures are likely to place a premium on efficient care delivery, raising the importance of preserving MA.

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enrollment period is scheduled to run from October 15th through December 7th. At that time, beneficiaries can join, leave or switch plans. Coverage for seniors who choose to enroll in an MA plan begins on January 1st of the following year.

To prepare seniors for the annual enrollment period, the Centers for Medicare and Medicaid Services (CMS) provides a “Medicare and You Handbook” as well as an online portal for seniors to find and compare Medicare private health plans available in each market. Seniors can enroll in an MA plan by filing a paper application, by calling a health plan, or by enrolling online at the health plan’s or CMS’s websites. MA plans are rated on a five “star” scale by CMS based on quality and performance metrics to help beneficiaries in their selection of a plan.

History of Private Insurance in Medicare

When Medicare began in 1965 it was a fee-for-service, indemnity insurance program (and still is largely today). There was no mechanism to reimburse physicians or hospitals operating in the pre-paid, group practices of the time. Congress corrected this in the 1970s by allowing capitated, private contracts for certain types of provider groups. This expanded through a number of Medicare Health Management Organization (HMO) demonstration projects in the late 1970s. These projects were intended to demonstrate that the private sector could offer innovative and flexible approaches to reducing the costs of Medicare benefits while improving quality and health outcomes. These successful demonstration projects led the way to legislation that allowed expansion and broad availability of private Medicare plans to beneficiaries across the country.ⁱⁱ

- *Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)* – Congress introduced the first risk contracting program, which paid private health plans a fixed monthly payment per enrollee to furnish all Part A and B Medicare-covered services. Payments from the federal government to private plans varied widely across the country.
- *Balanced Budget Act of 1997 (BBA)* – Congress renamed the program, Medicare + Choice (M+C), and revised the payment structure in an effort to expand access to managed care and decrease geographic variation in the payment rates. Ultimately, the M+C program failed to achieve its primary goal of increasing access to private plans because of the unintended consequences created by the new reimbursement methodology. The result was a significant reduction in access as plans had to withdraw from the program. Even where plans could remain, beneficiaries experienced significantly reduced benefits and increased premiums.
- *Medicare Modernization Act of 2003 (MMA)* – While Congress made many attempts during the BBA era to undo the damage inadvertently caused by this legislation, it was not until passage of the Medicare Modernization Act that returned stability to the program. MMA once again changed the payment methodology for private plans, and altered the way in which plans filed benefits and determined payment rates. Under MMA’s mandated competitive bidding process, monthly capitation payments to MA plans are determined by a combination of: 1) the relationship between plans’ bids and the appropriate county or regional “benchmarks”, and 2) the enrolled beneficiaries’ demographics and health risk characteristics based on the Hierarchical Condition Categories (HCC) model.

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How Medicare Advantage Works

Private organizations must apply to the federal government to offer Medicare plans. Once approved, organizations submit annual filings for the service areas they intend to serve, including the benefits to be provided to their members. The process begins annually in February (eleven months before a benefit plan's start date). In February, CMS releases an advance notice to private insurers of any changes to the MA payment methodology, payment rates, or program requirements. A final payment rate notice is then issued 45 days later in April. Private plans then submit their "bids" to CMS in June. CMS evaluates those bids, negotiates the proposed benefit package during the summer and typically approves the plans in September.

The advanced timeline for approving private health plan bids in the MA program means that the impact of policy decisions is delayed and therefore, felt by beneficiaries after-the-fact. Any legislated policy changes made after April would not typically be implemented or impact beneficiaries for 20 months, with member notification occurring in approximately 17 months. For example, a legislated change in Medicare Advantage payment rates made on May 1, 2011 would impact bids for the 2013 plan year, with beneficiaries informed of that change around October 1st of 2012.

The plan's bid includes the expected cost of Medicare's core benefits, the administrative expense of running the plan, and a targeted profit margin. Each bid is then compared to the predetermined county "benchmark" rate. If the bid is above the benchmark rate, Medicare pays the benchmark rate and beneficiaries pay the difference in the form of a monthly premium. If the bid is below the benchmark, CMS retains 25 percent, and the plan keeps 75 percent (also known as the "rebate"). Plans must use these funds to provide reduced cost sharing or additional benefits to their members.

Innovative MA plan designs that are priced below Medicare's benchmark rate create added value for beneficiaries. Private plans are able to provide Medicare benefits at a cost below the established benchmark by implementing several proven approaches to managing cost and quality:

- 1) Having members receive care from a contracted network of providers.
- 2) Altering the Medicare benefit design to encourage cost effective utilization behaviors by members (for example, reducing the cost of primary care physician visits to encourage members to get appropriate care for chronic conditions).
- 3) Providing innovative programs like disease and high risk care management for members with advanced illness or multiple, chronic conditions.

Figure 1: Use of MA Rebate Dollars in 2010

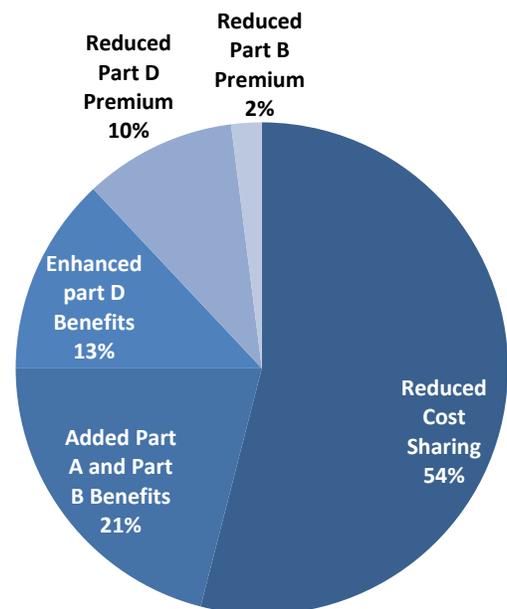


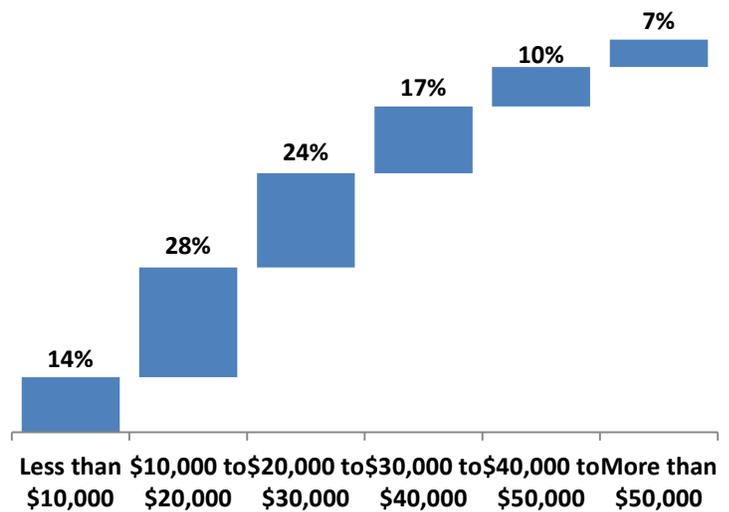
Figure 1 shows how MA rebate dollars improved beneficiary value in 2010. The majority of MA plans, 66 percent, chose to apply rebate dollars toward reduced cost sharing. The remaining 34 percent of rebate dollars were spent on offering additional benefits like vision and dental care. ⁱⁱⁱ

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The use of rebate dollars for reduced cost sharing has made the MA program critical to lower-income seniors. Figure 2 shows the large percentage of low-income MA members. A disproportionate share of low-income beneficiaries selects MA as their source of supplemental Medicare coverage.

Experience following the passage of the Balanced Budget Act suggests that without the MA program, many of these lower-income Medicare beneficiaries will revert to traditional Medicare because they will not be able to afford the high premiums of a Medicare Supplement plan; they also will not be able to afford the higher cost sharing under traditional Medicare, leaving them unable to effectively access the health care system to meet their medical needs.

FIGURE 2: Income Distribution of Medicare Advantage Beneficiaries^{iv}



Growing Enrollment and Improved Care Through Plan Innovation

The Medicare Modernization Act was extremely successful in achieving the policy objectives of attracting private health plans to Medicare and increasing enrollment of Medicare beneficiaries. Table 1 shows how MA enrollment has more than doubled since the MMA passed in 2003. In 2010, all Medicare beneficiaries had access to an MA plan and over 11.6 million chose to enroll. Approximately 85 percent of Medicare beneficiaries had access to at least one zero premium MA health plan that included prescription drug coverage.

MA plans are designed to provide care through a coordinated care model. Through this model, MA plans are able to effectively manage costs and improve the quality of care and healthcare outcomes. Furthermore, beneficiaries in high-quality MA plans experience fewer hospital readmissions and acute care stays.

TABLE 1: Medicare Private Health Plan Enrollment (Thousands of Persons)^v

Calendar Year	Total Private Health Plan	Total Medicare	Percent Private Health Plans
1985	1271	31081	4.1%
1990	2017	34251	5.9%
1995	3467	37594	9.2%
2000	6856	39688	17.3%
2001	6166	40103	15.4%
2002	5538	40103	13.7%
2003	5302	40508	12.9%
2004	5375	41188	12.8%
2005	5794	41902	13.6%
2006	7292	42606	16.8%
2007	8666	43436	19.5%
2008	10008	44368	22.0%
2009	11098	45453	24.0%
2010	11683	47351	24.7%

An initial review of data from peer reviewed medical studies and the National Committee for Quality Assurance (NCQA) suggests that MA plans outperform FFS in numerous HEDIS quality measures (HEDIS measures include metrics associated with safety and potential waste, wellness and prevention, chronic disease management, and patient engagement).^{vi}

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Medicare Advantage Under The Health Reform Law (PPACA)

With the positive results shown by Medicare Advantage plans in serving their members, it is concerning that Congress would make a policy reversal on its support of the program. PPACA undoes decades of deliberate policy decisions to support use of effective private sector incentives and innovation for the benefit of the Medicare program and its beneficiaries. This includes cutting a total of \$206.3 billion from the MA program.^{vii}

PPACA supporters used misleading MA and fee-for-service (FFS) expenditure comparisons to enact substantial changes to the Medicare Advantage payment methodology and to drive large reductions in MA benchmarks. In 2010, the Medicare Payment Advisory Commission (MedPAC) projected that MA payments would be 109 percent of FFS spending, a differential that continues to decrease and would have continued to decrease in the absence of PPACA.^{viii}

Critics of the MA program cite the per beneficiary expenditure difference between MA and traditional FFS Medicare as evidence that the MA program should be eliminated or cut dramatically. Under the new formula, MA benchmarks will be tied directly to the estimated Medicare FFS costs at a county level, as measured by the Medicare program's actuarial staff. All counties and similar jurisdictions in the U.S. will be ranked in order of their estimated, annual, per capita FFS spending. The MA benchmarks for each county will be an "applicable percentage" of that county's estimated FFS costs:

- For counties ranked in the highest quartile (top 25 percent) by FFS spending, the MA benchmark will be 95 percent of the measured FFS spending for that county.
- For counties in the second quartile, the benchmark will be equal to the county's measured FFS spending.
- For counties in the third quartile, the benchmark will be 107.4 percent of the county's measured FFS spending.
- For counties in the lowest quartile, the benchmark will be 115 percent of the county's measured FFS spending.^{ix}

All counties will be treated with equal weight in these rankings, regardless of population, number of Medicare beneficiaries, or relative availability of MA. For example, while 25 percent of counties will move to a payment benchmark of 95 percent of estimated Medicare FFS costs, nearly 45 percent of Medicare Advantage members reside in those counties. CBO estimates that this new benchmark formula will account for \$136 billion of the total \$206 billion in direct cuts from the MA program in the first decade. The PPACA's changes to the MA benchmark formula are scheduled to start in 2012 and are to be phased in by 2017.^x

PPACA also made dramatic changes in payment to MA rebates. As mentioned above, MA plans whose bids are below the benchmarks set by CMS currently retain 75 percent of the difference between the benchmark and the

A Misleading Comparison: Medicare Advantage vs. Medicare FFS

- 1) Most MA plans provide additional benefits compared to Medicare Fee-For-Service (FFS).
- 2) FFS payments are estimated by county and may not reflect local market conditions. In these cases, the FFS program has an inappropriate "efficiency advantage" as it pays below cost rates through regulatory fiat.
- 3) FFS payments do not take into account the cost of capital to needed to finance Medicare's administrative costs. Private insurance companies pay interest on the money borrowed to finance health plan operations, whereas FFS borrows against the national debt without interest leading to artificially lower administrative costs.

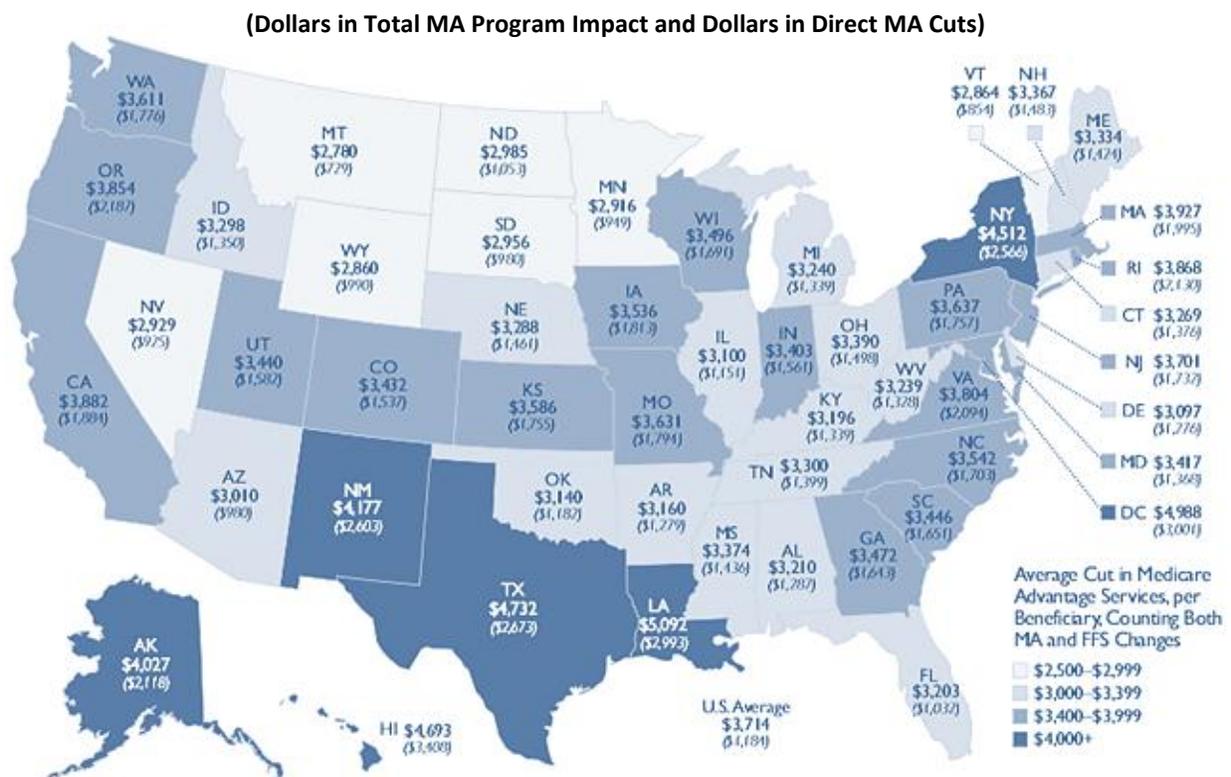
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bid. Beginning in 2012, rebates will be reduced overall and calculated based on quality star ratings. Medicare Advantage plans with quality ratings of 4.5-5 stars will retain only 70 percent of the difference between the benchmarks and bid; plans with 3.5 but less than 4.5 stars will retain 65 percent of the difference, and plans with less than 3.5 stars will be permitted to retain 50 percent of the difference. These rebate changes will be phased in between 2012-2014, resulting in overall reduction of payments to Medicare Advantage plans. Over 45 percent of Medicare Advantage members who are currently enrolled in plans with a rebate level of 75 percent will be enrolled in a plan in 2014 receiving a 50 percent rebate (this percentage assumes all non-rated plans receive the enrollment weighted average of the parent organization's star rating). Reductions in rebates directly and negatively impact beneficiaries given that CMS's bidding rules require rebate dollars only be spent on either supplemental benefits or lower premiums.

Costs Shifted to MA Beneficiaries

A concerning number of MA beneficiaries will be in for a rude awakening when the new MA payment formula and rebate thresholds are fully implemented. A recent estimate by Robert Book and James Capretta found that in 2017 Medicare beneficiaries who would have enrolled in Medicare Advantage under prior law will lose an average of \$1,841 due to MA changes alone and \$3,714 when the effects of the entire bill, including the FFS cuts, are considered.^{xi} Figure 2, shows the total impact of reimbursement cuts to MA services on a state by state basis. Direct cuts to MA services are shown in parentheses.

Figure 2: PPACA's Cuts to MA in 2017

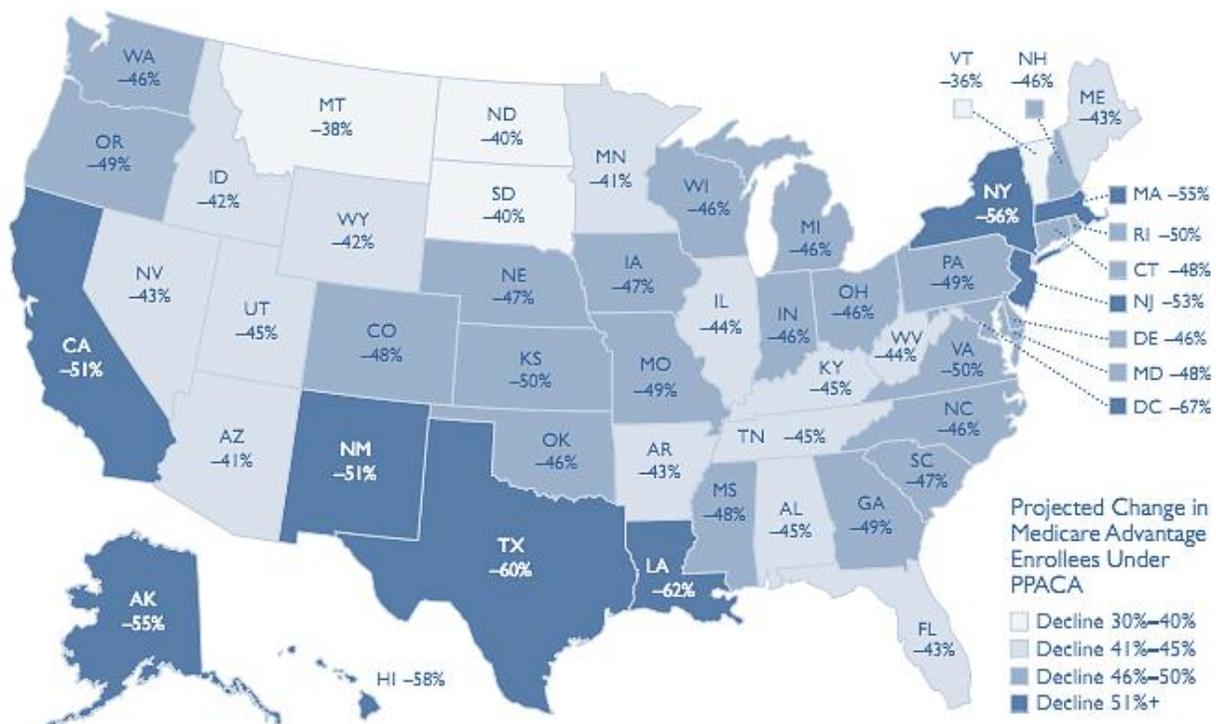


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These changes will not only result in reduced payments to plans (and the resulting reduction in value of benefits to members), it will also result in much less availability of MA to beneficiaries as plans are forced to withdraw from the program like they did after implementation of the Balanced Budget Act.

CMS estimates that as a result of the PPACA changes to the MA program, there will be 7.4 million fewer MA enrollees by 2017.^{xii} In Figure 3, Book and Capretta show how their estimate is likely to affect MA enrollment in 2017 on a state by state basis.

Figure 3: PPACA's Estimated Effect on Medicare Advantage Enrollment in 2017 (Percent)^{xiii}



But we won't have to wait until 2017 to see this impact. The scheduled cuts to MA services will begin to disrupt the MA market in 2012, with negative outcomes for the over 11 million Medicare beneficiaries currently enrolled in a private healthcare plan.

CONCLUSION

Medicare has a long and successful history of developing and expanding private-sector managed care options for beneficiaries. These plans have been very successful in attracting and serving Medicare beneficiaries, and providing expanded benefits, cost-effective care, and superior results. The recent health care reform – the Patient Protection and Affordable Care Act – reverses this policy by substantially tilting the policy playing field against Medicare Advantage. This policy reversal will not only harm current members by reducing benefits and increasing premiums, it will disadvantage all beneficiaries by reducing their access to private plan choices. Looking forward, budgetary pressures are likely to place a premium on efficient delivery of care, raising the importance of preserving Medicare Advantage to ensure that we protect the infrastructure now in place that may be critical to addressing Medicare's long-term cost challenges.

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- ⁱⁱⁱ ["A Data Book: Healthcare Spending and the Medicare Program,"](#) MedPAC, June 2010.
- ^{iv} Medicare Current Beneficiary Survey Access to Care Files, 2008 (CMS)
- ^v ["A Data Book: Healthcare Spending and the Medicare Program,"](#) MedPAC, June 2010.
- ^{vi} The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The data set is maintained by the National Committee for Quality Assurance.
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