

MEDICARE

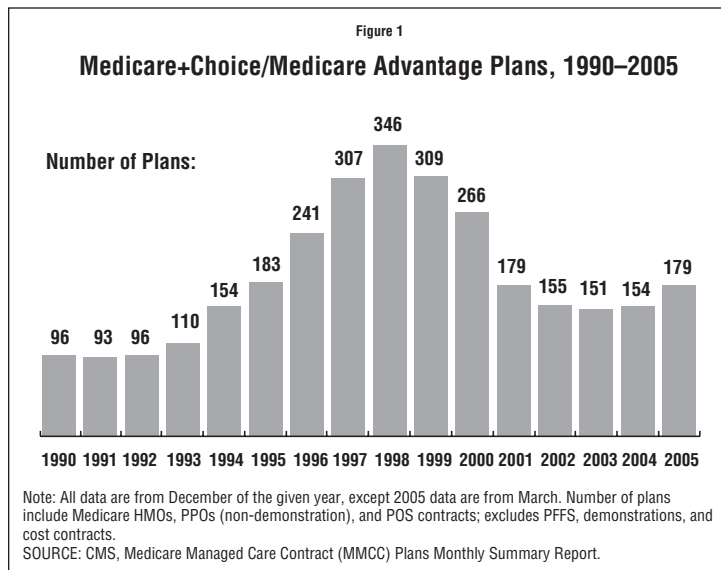
MEDICARE ADVANTAGE

April 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 managed care plans, primarily HMOs.

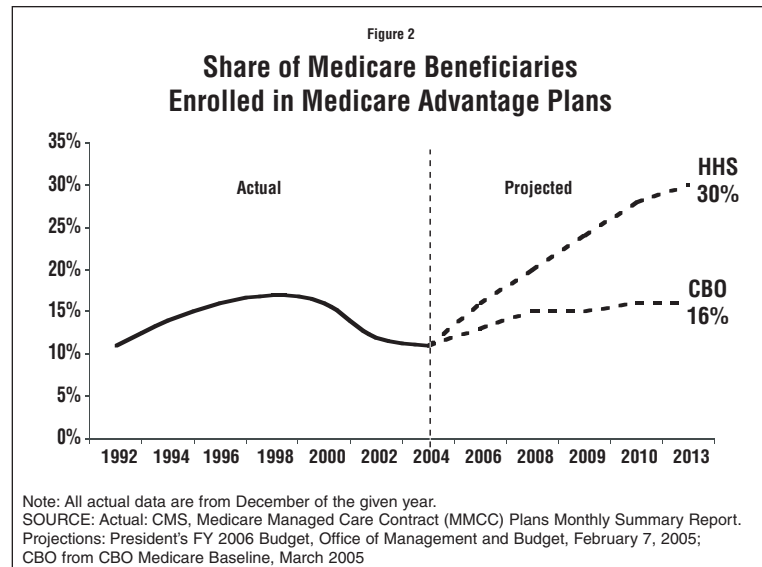
HMOs have been an option under Medicare since the 1970s. The Balanced Budget Act (BBA) of 1997 expanded the role of private plans under "Medicare+Choice" to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings 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 those who are institutionalized or have severe and disabling conditions, and new private drug plans that will go into effect January 2006.



PLAN PARTICIPATION AND ENROLLMENT

Plan participation and enrollment have fluctuated in recent years. After a period of rapid growth from 1992-1998, the number of plans declined by half. In 2005, there are 179 plans (most of which are HMOs) with 4.8 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, HHS estimates 30% of Medicare beneficiaries will enroll in Medicare Advantage plans, while CBO projects an enrollment rate of 16%.

Enrollment varies widely across states. Less than 1% of Medicare beneficiaries are enrolled in HMO plans in 16 states and D.C., 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

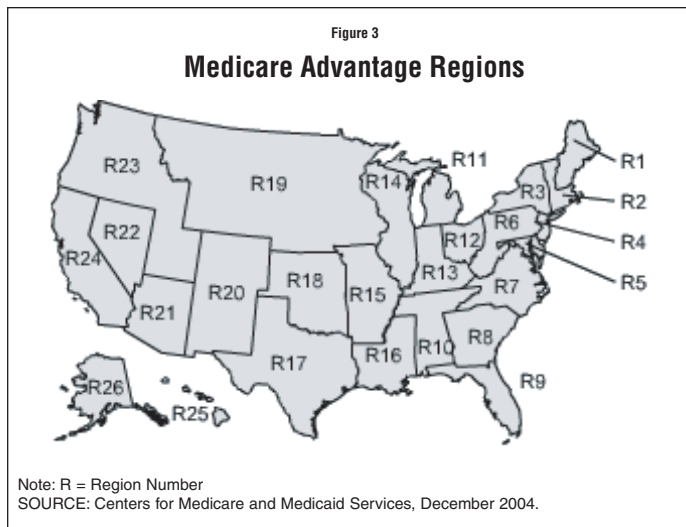
Medicare Advantage plans are generally required to provide all Medicare-covered benefits. Plans with costs below their Medicare payments must distribute savings to beneficiaries as lower plan premiums and copayments, additional benefits, or a reduction in Part B premiums, or contribute to a reserve fund.

In 2004, over a quarter (29%) of Medicare Advantage enrollees were in plans that did not provide drug coverage (up from 16% in 1999). While the majority of enrollees had drug coverage, some faced restrictions on these benefits: 19% of enrollees had an annual cap of \$1,000 or less for brand drugs, and 38% of enrollees were in plans that covered only generic drugs.

When the Medicare drug benefit takes effect, managed care plans (but not PFFS or MSA plans) must offer at least one plan with drug coverage in a service area and will receive additional payment for providing that coverage. Plans may also offer enhanced drug benefits for an additional premium.

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.



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 two-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 two-year period. Lastly, the MMA created a \$10 billion stabilization fund that may be drawn upon to promote PPO participation on a regional basis.

PAYMENTS TO PLANS

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%, or \$546 per MA plan enrollee, 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 payments would be if those same beneficiaries were to remain in FFS Medicare.

Beginning in 2006, 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%). If a plan’s bid is higher than the 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%.

RISK ADJUSTMENT

A number of studies have shown that Medicare beneficiaries enrolled in managed care plans are, on average, in better health and have lower medical costs than those in FFS. To modify payments accordingly, Medicare began implementing a new risk-adjustment system in 2003. By 2006, 75% of plan payments are to be risk-adjusted; by 2007, 100% will be risk-adjusted, while holding plans harmless in the aggregate.

FUTURE ISSUES

Private plans are expected to play a greater role in Medicare in the future, though enrollment projections vary widely. 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.

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