Medicare Advantage

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What is Medicare?

Medicare is a health insurance program administered by the federal government for individuals age 65 or over, individuals with certain disabilities and people with End-Stage Renal Disease.
Medicare categorizes their insurance coverage into four distinct "parts":

- **Part A**: Hospital Insurance; covers inpatient services. Most beneficiaries do not pay a premium for Part A.[i]
- **Part B**: Medical Insurance; covers outpatient services. Most beneficiaries pay a set monthly premium for Part B.
- **Part C**: **Medicare Advantage.**
- **Part D**: Prescription Drugs; covers prescription drugs. Costs vary by plan.

What is Medicare Advantage?

Costs vary by plan. Medicare Advantage (MA) plans are private health plans that contract with Medicare to provide benefits to beneficiaries. These private plans are approved by the Centers for Medicare and Medicaid Services (CMS) and provide all Part A and Part B benefits for those who choose to enroll. In addition, most plans also include Part D, and could include benefits not offered by traditional Medicare, such as vision, hearing or dental.

Private health plans have had a role in the Medicare program long before the advent of what is now known as Medicare Advantage. In fact, they have been part of the program since its inception in 1965. Significant growth of private plans in the Medicare program came in 1997 when the Balanced Budget Act (BBA) created Medicare +Choice as a means to provide beneficiaires with greater choice in how they receive their benefits. The program was based on plans available to those under 65 and the notion that it would create more competition thereby reducing costs and enhancing quality of care, while simultaneously contributing to savings in the Medicare program.[ii] Due to changes made by Congress in the program, Medicare +Choice ultimately did not work as intended, with plans dropping out over time resulting in only a small portion of Medicare beneficiaries having access to plans.[iii]

In 2003, Congress passed the Medicare Modernization Act (MMA), which renamed and reformed the Medicare +Choice program as Medicare Advantage. In addition to changing the program's name, the MMA authorized additional plan types and updated the payment system to further encourage participation.[iv] By bringing new types of plans, such as Private Fee-for-Service plans, into the marketplace and increasing funding levels, the MMA sought to expand beneficiary access to a wider array of plans and further increase enrollment, particularly in rural areas.

Types of Medicare Advantage Plans?

Similar to the private health insurance market, there are several types of MA plans: [v,vi,vii]

Health Maintenance Organizations (HMOs):
HMOs are plans that contract with networks of providers and typically require beneficiaries to receive care from these networks, except in the case of an emergency. If a beneficiary receives care out-of-network, they would incur the cost of coverage. HMOs typically have the lowest out-of-pocket costs for beneficiaries.

- *Point-of-Service (POS)*: POS plans are similar to HMOs but with slightly more flexibility to receive care out-of-network (at a higher cost-share for beneficiaries). POS plans have out-of-pocket costs that fall somewhat between HMOs and PPOs.[v]

Preferred Provider Organizations (PPOs):
PPOs are plans that contract with provider networks but allow beneficiaries to see providers outside of the network, generally at a slight additional cost. PPOs typically have the highest out-of-pocket costs for beneficiaries.[v]

Private Fee-For-Service (PFFS):
PFFS plans generally allow beneficiaries to see any Medicare-approved provider although some do have provider networks. PFFS plans generally have lower premiums.[v]

Special Needs Plans (SNPs):
SNPs are plans designed to target individuals with special needs. There are three types of SNPs:

- D-SNPs: available to those dually eligible for both Medicare and Medicaid.
- C-SNPs: available to those with certain chronic conditions.
- I-SNPs: available to those who require an institutional level of care.

*Out-of-pocket costs for D-SNP plans cannnot exceed what these costs would be under traditional Medicare or Medicaid.[vi]

Who is Eligible?

Any individual who qualifies for Medicare is eligible for Medicare Advantage. The open enrollment period for MA plans occurs once a year, typically at the end of the preceding calendar year for enrollment the following January.[viii] Failing to sign up during the open enrollment period would, in most cases, require that an individual wait until the next year to join a plan. However, there are a number of circumstances that allow for enrollment at other points throughout the year, known as special enrollment periods.[ix] Additionally, the Affordable Care Act (ACA) implemented new enrollment criteria for plans with a 5-star rating; as of 2012, MA plans with this rating may enroll individuals at any time.[vii]

How are Medicare Advantage Plans Paid?

All MA plans (with the exception of PFFS) are paid by CMS to cover Part A and Part B benefits. Plans are paid a capitated rate, or a set fee per beneficiary per month, which is risk-adjusted to account for the health status of beneficiaries.[v]

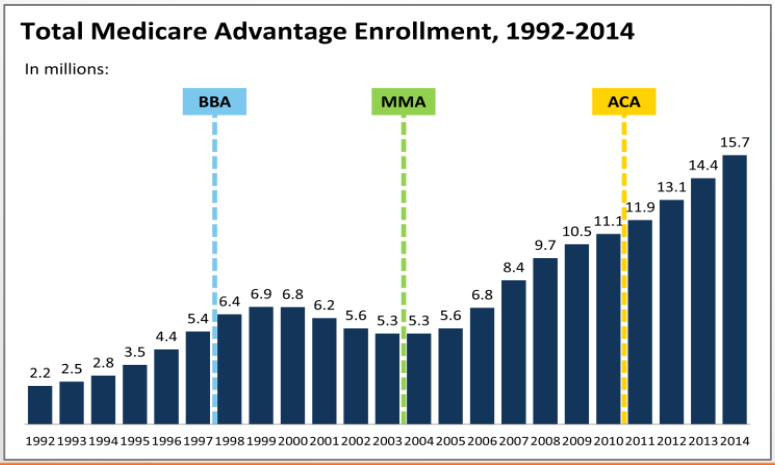
Medicare uses a bidding process to determine rates and sets a benchmark to serve as a bidding target for plans.[x] If a plan bids above the benchmark, their base rate is set at the benchmark and enrollees make up the difference by paying higher premiums. If a plan bids below the benchmark, their base rate is set at the standard bid for their locality; Medicare retains 25 percent of the savings (the difference between the bid and the benchmark) and 75 percent is returned as a rebate, to the plan. All rebates must be refunded to enrollees in the form of supplemental benefits, lower premiums, or decreased cost-sharing.[iv]

The ACA made significant changes to payments made to MA plans by lowering the benchmarks for MA plans, ultimately leveling benchmark payments to the cost of traditional FFS enrollees in the same service area.[xi] Lower benchmarks are an attempt by the ACA to lower overall expenditures in the Medicare program. These payment reforms began in 2012 and are laddered to gradually reduce payments to FFS levels over the course of five years, ending in 2017, amounting to approximately $200 billion in spending reductions. As of 2012, plans that receive a 4-star or better quality rating receive bonus payments from CMS.[xii] Additionally, CMS instituted a demonstration project through which they issue bonus payments to plans that show improvement, even if their star rating is lower than 4-stars.[xiii]

In addition to payment changes resulting from the ACA, MA plans typically face yearly adjustments to their payments depending on factors such as health spending levels, changes in the health status of beneficiaries, or any new legislatively mandated adjustments. (For a comprehensive review of policies impacting MA program payments in 2014, click here.)

Current Enrollment

There are currently 17.3 million individuals enrolled in Medicare Advantage, which equates to approximately 30 percent of all Medicare beneficiaries.[xiv] Enrollment has almost tripled since the passage of MMA, from 5.3 enrollees in 2003 to 17.3 million today.[xv] One reason for this increase was the change in payment policy authorized in MMA, which gave plans flexibility to design and offer more robust benefit packages and attract new enrollees.[xvi]



Source: Medicare Advantage Fact Sheet. Kaiser Family Foundation (2014)

Enrollee Demographics

MA enrollment levels vary by state, as well as other demographics, which can often be attributed to plan availability in urban versus rural counties and states.[vii] In 2013, less than 1 percent of Alaska's Medicare beneficiaries were enrolled in an MA plan, compared with more than 42 percent of Oregon's Medicare beneficiaries.[xvii] Similarly, 2011 data show that national enrollment rates for MA were higher in urban counties (26 percent) than in rural counties (15 percent).[iv]

In line with increasingenrollment, Medicare Advantage continues to be a growing source of health coverage for both low-income and minority populations. According to CMS Medicare Current Beneficiary Survey (MCBS) data from 2012, 44 percent of Hispanic Medicare beneficiaries and 30 percent of African-American beneficiaries were enrolled in Medicare Advantage plans.[xviii] In addition, 37 percent of Medicare beneficiaries enrolled in Medicare Advantage had incomes of less than $20,000.[xix] Medicare Advantage is the greatest source of coverage for the Medicare population with incomes between $10,000 and $20,000, surpassing both Medicaid and traditional Medicare.[xx] A 2010 study revealed that 35 percent of low-income beneficiaries surveyed chose Medicare Advantage plans because they were lower in cost.[xxi]

The Future of Medicare Advantage

Medicare Advantage is an important, comprehensive and affordable health coverage option for over 17 million beneficaries. In fact, recent polls find Medicare beneficiaries report high rates of overall satisfaction with their Medicare Advantage coverage.[xxii] Despite high approval among beneficiaries, the program has faced a series of federal payment rate cuts, including the ACA, which have affected the program's stability, beneficiaries' benefits and plans' resources to provide critical health care services. [xxiii] CMS recently proposed a -.95 percent reduction in Medicare Advantage payment rates for 2016. In response, beneficiaries, providers, and a bipartisan, bicameral majority in Congress urged CMS to stabilize and prevent further cuts to the program. As a result, CMS increased 2016 rates by 1.25 percent.[xxiv]

In January 2015, Sylvia Mathews Burwell, Secretary of the U.S. Department of Health and Human Services, announced that the agency aims to shift the Medicare program from volume to value-based payments, a payment model Medicare Advantage has implemented for years.[xxv] The administration's focus on accountable, efficient and high-quality care, coupled with increasing Medicare Advantage enrollment, suggests Medicare Advantage will remain an important aspect of the transition to "fee-for-value". Concerns about achieving fiscal sustainability while adequately meeting the health needs of beneficiaries, will continue to be chief concerns for the Medicare program and are likely to be at the forefront of policy discussions into the future.

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