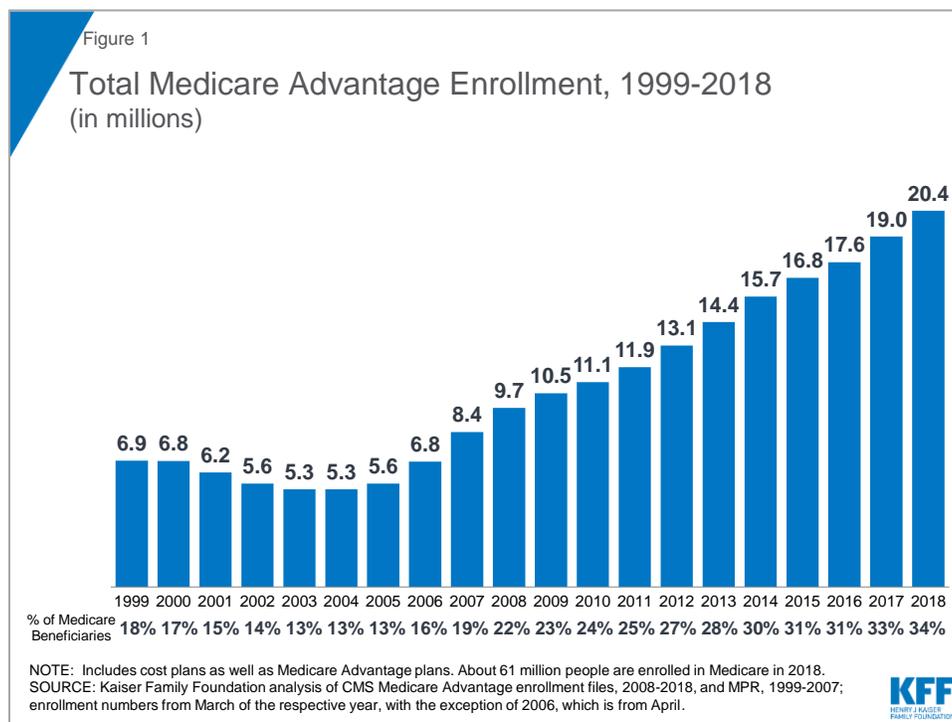


A Dozen Facts About Medicare Advantage

Gretchen Jacobson, Anthony Damico, and Tricia Neuman

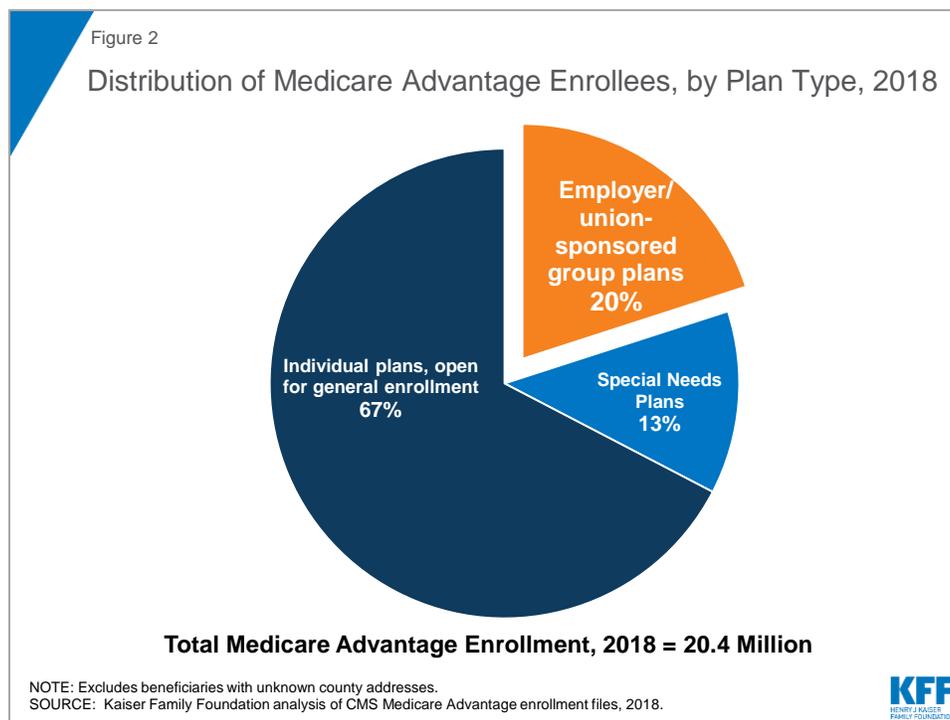
Medicare Advantage plans have played an increasingly larger role in the Medicare program over the past decade. More than 20 million Medicare beneficiaries (34%) are enrolled in Medicare Advantage plans in 2018. This collection provides updated information about Medicare Advantage enrollment trends, premiums, and out-of-pocket limits. It also includes new analyses of Medicare Advantage plans' extra benefits, use of prior authorization, and bonus payments paid by Medicare.

1. Enrollment in Medicare Advantage has nearly doubled over the past decade



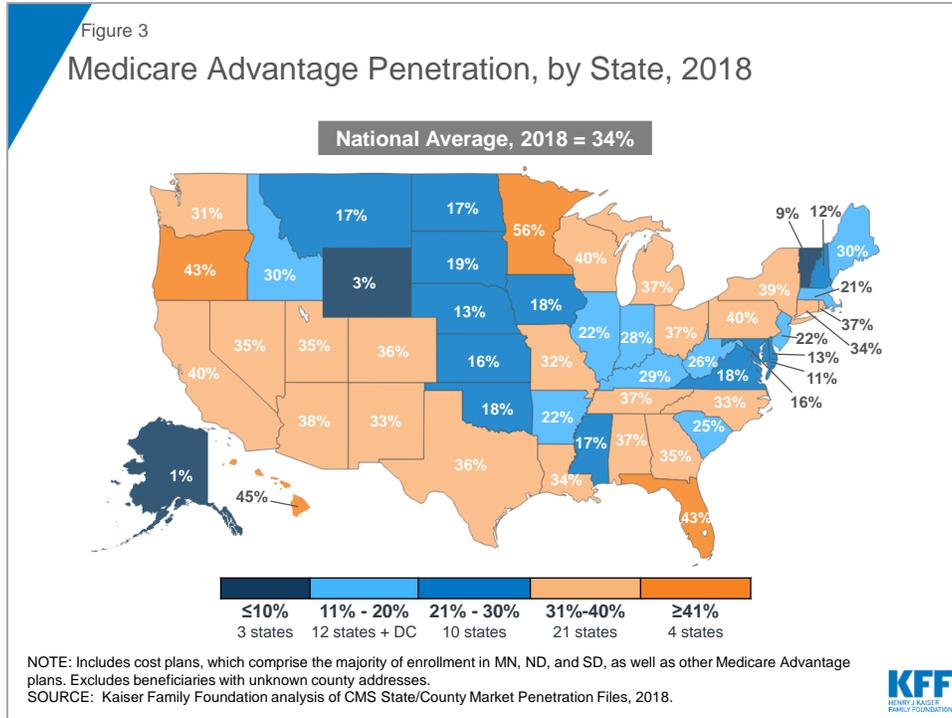
In 2018, one in three (34%) Medicare beneficiaries – 20.4 million people – is enrolled in a Medicare Advantage plan. Between 2017 and 2018, total Medicare Advantage enrollment grew by about 1.5 million beneficiaries, or 8 percent – a nearly identical rate of growth compared to the prior year. The Congressional Budget Office (CBO) projects that Medicare Advantage enrollment will continue to grow over the next decade, with plans including about 42 percent of beneficiaries by 2028.

2. One in five Medicare Advantage enrollees are in employer or union-sponsored group plans in 2018



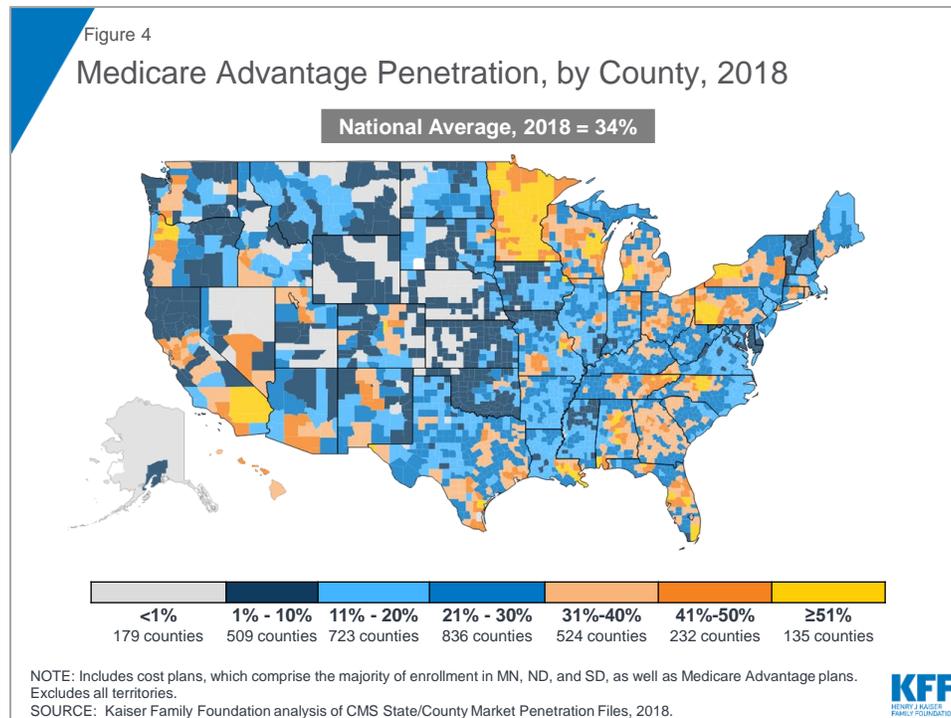
One in five Medicare Advantage enrollees (4.1 million) are in group plans offered by employers and unions for their retirees in 2018. Under these arrangements, employers or unions contract with an insurer and Medicare pays the insurer a fixed amount per enrollee to provide benefits covered by Medicare. The employer or union (and sometimes the retiree) may also pay a premium for additional benefits or lower cost-sharing. The growth in enrollment in Medicare Advantage group plans reflects a larger trend by large employers (including state governments) and unions to adopt strategies to limit their liability for retirees' health costs. Group enrollees comprise a disproportionately large share of Medicare Advantage enrollees in nine states: Alaska (100%), West Virginia (53%), Michigan (51%), Illinois (42%), Kentucky (39%), Delaware (37%), Maryland (35%), New Jersey (34%), and Wyoming (30%).

3. The share of Medicare beneficiaries in Medicare Advantage plans ranges across states from 1% to over 40%



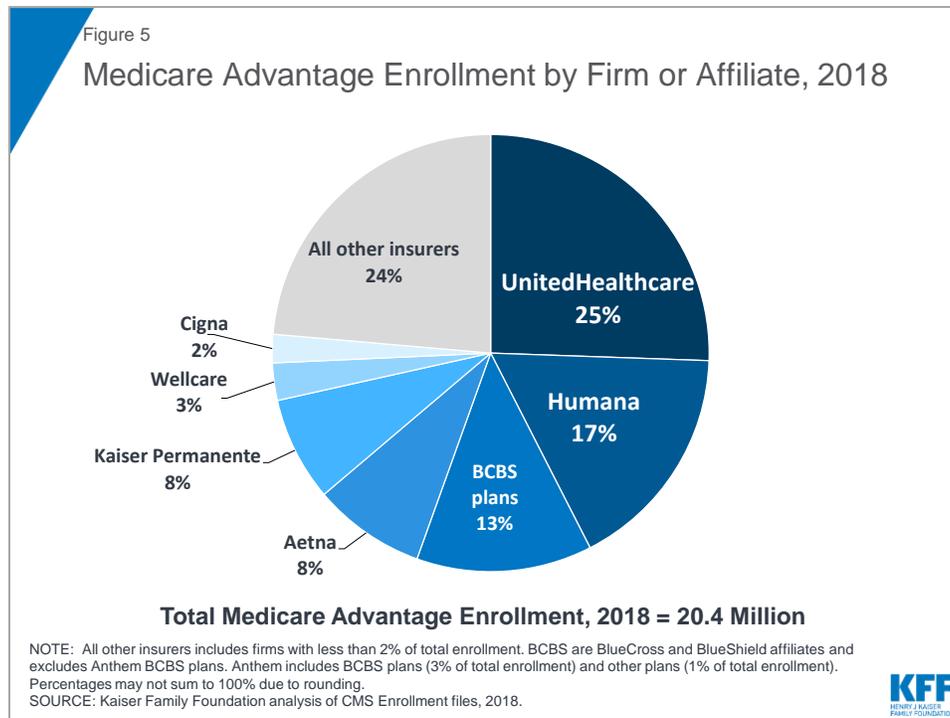
The share of Medicare beneficiaries in Medicare private health plans, including Medicare Advantage plans and Medicare cost plans, varies across the country. In 25 states, at least 31 percent of Medicare beneficiaries are enrolled in Medicare private health plans, with more than 41 percent of enrollees in four states (FL, HI, MN, and OR). The majority of the Medicare private health plan enrollment in Minnesota is in cost plans, rather than Medicare Advantage plans; cost plans are paid differently and subject to different rules than Medicare Advantage plans. Medicare Advantage enrollment is less than 11 percent of Medicare beneficiaries in three mostly rural states (AK, VT, and WY).

4. The share of Medicare beneficiaries in Medicare Advantage plans varies across counties from less than 1% to more than 60%



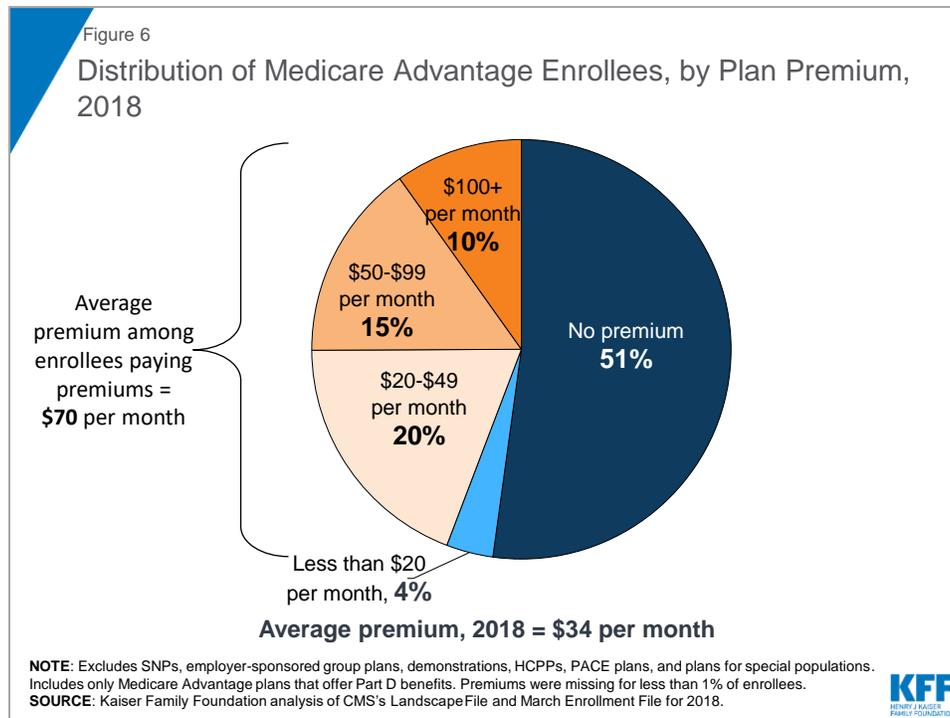
Within states, Medicare Advantage penetration varies across counties. For example, in Florida, 66 percent of all beneficiaries living in Miami-Dade County are enrolled in Medicare Advantage plans whereas only 10 percent of beneficiaries living in Monroe County (Key West) do so. In 135 counties, more than half of all Medicare beneficiaries are enrolled in Medicare Advantage plans or cost plans. Many of these counties are centered around large, urban areas. For example, while Miami-Dade County is the urban area with the highest Medicare Advantage penetration rate, 65 percent of beneficiaries in Monroe County, NY (Rochester) and 62 percent of beneficiaries in Allegheny County, PA (Pittsburgh) are enrolled in Medicare Advantage plans. In contrast, in 688 counties (22%), no more than 10 percent of beneficiaries are enrolled in Medicare private plans; many of these low penetration counties are in rural parts of the country but some urban areas, such as the District of Columbia, also have relatively low Medicare Advantage enrollment.

5. Most Medicare Advantage enrollees are in plans operated by UnitedHealthcare, Humana, or BCBS affiliates in 2018



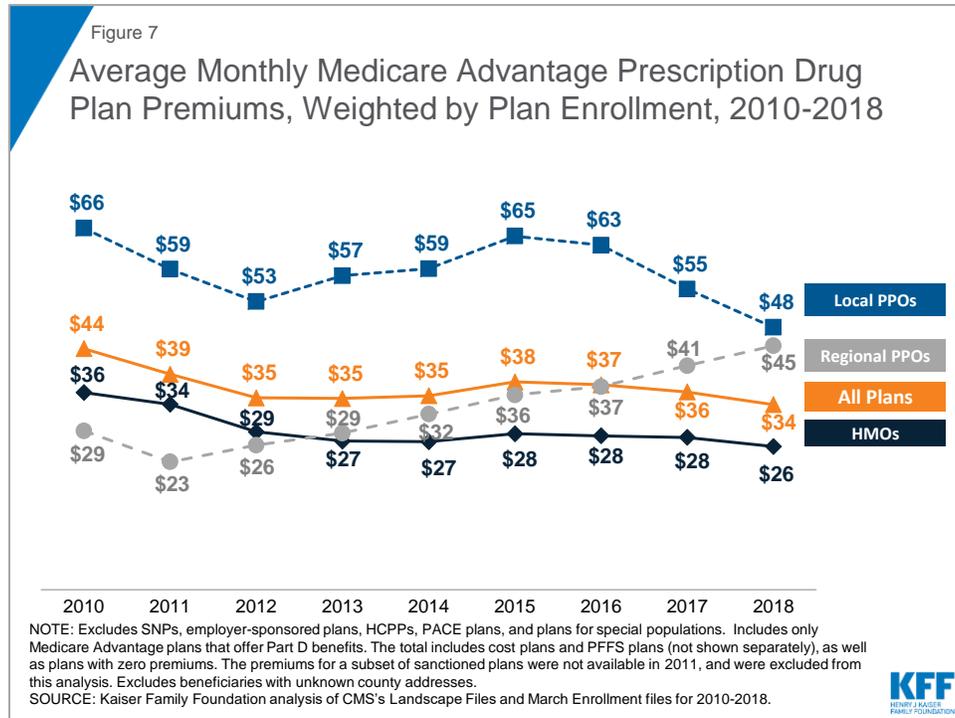
Medicare Advantage enrollment tends to be highly concentrated among a small number of firms. UnitedHealthcare and Humana together account for 43 percent of all Medicare Advantage enrollees, and the BCBS affiliates (including Anthem BCBS plans) account for another 15 percent of in 2018. Another four firms (Aetna, Kaiser Permanente, Wellcare, and Cigna) account for another 21 percent of enrollment in 2018. For the second year in a row, enrollment in UnitedHealthcare's plans grew more than any other firm, increasing by almost 600,000 beneficiaries between March 2017 and March 2018; Aetna had the second largest growth in Medicare Advantage enrollment, increasing by about 280,000 beneficiaries between March 2017 and March 2018.

6. Half of Medicare Advantage Prescription Drug Plan enrollees pay no premium (other than the Part B premium)



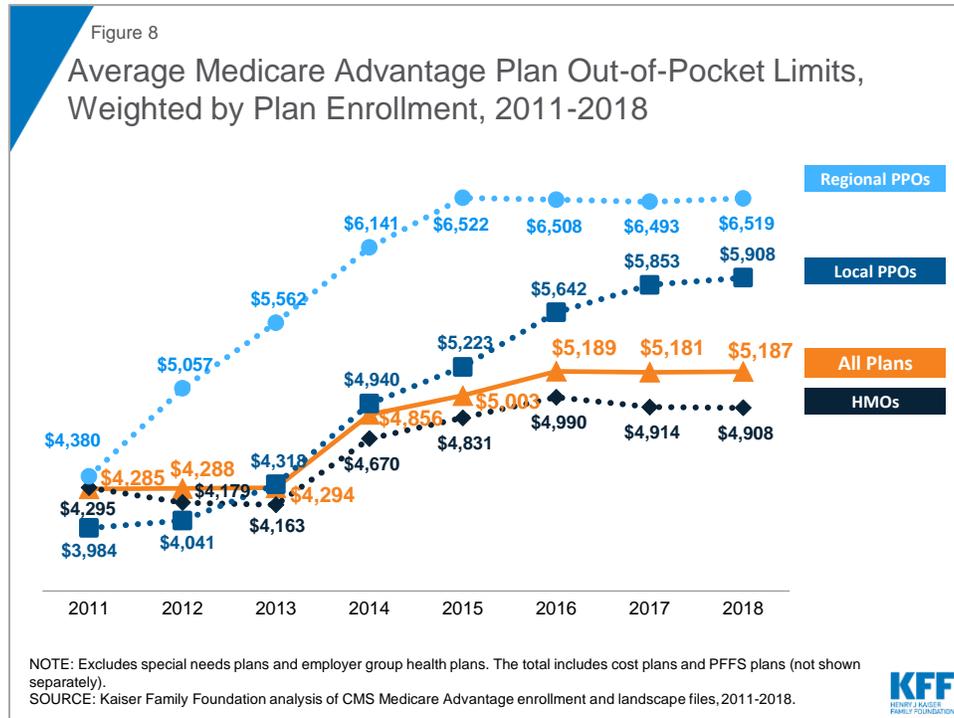
Most Medicare Advantage enrollees (88%) are in plans that include prescription drug coverage (MA-PDs), and about half of these beneficiaries pay no premium for their plan, other than the Medicare Part B premium. However, one-quarter of beneficiaries in MA-PDs pay at least \$50 per month, including 10 percent who pay \$100 or more per month, in addition to the Part B premium. Among MA-PD enrollees who pay a premium for their plan, the average premium is \$70 per month. On average, beneficiaries in MA-PDs pay \$34 per month in 2018.

7. Premiums paid by Medicare Advantage Prescription Drug Plan enrollees have been relatively constant since 2012



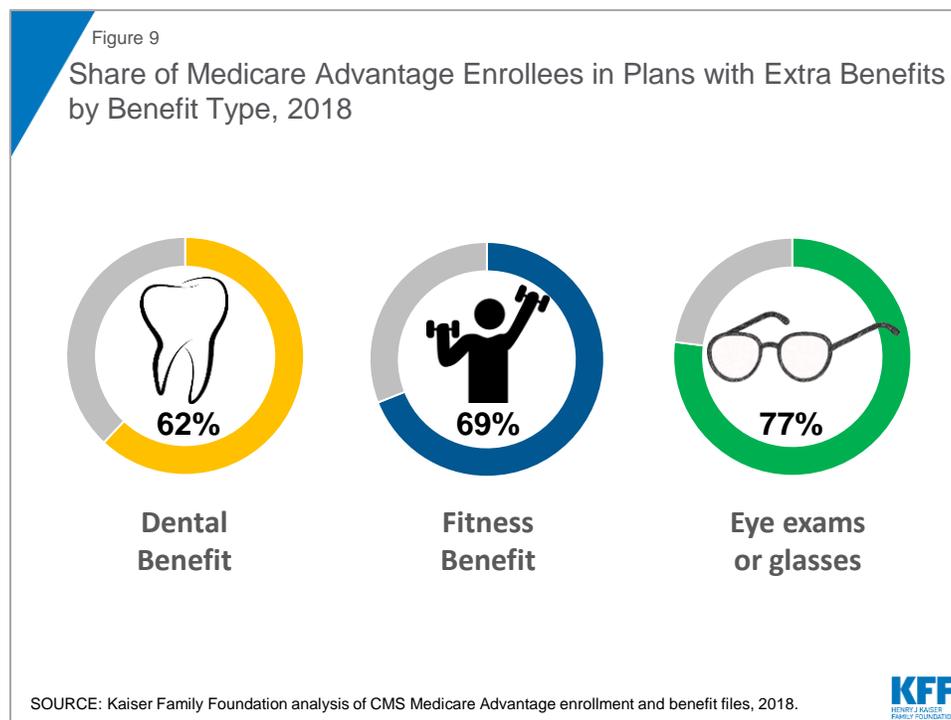
Overall, average premiums at the national level have been relatively steady for MA-PD enrollees since 2012, although premiums for regional PPOs have steadily increased while premiums for other types of plans have declined. Average MA-PD premiums range from \$26 per month for HMO enrollees to \$48 per month for local PPO enrollees and \$45 per month for regional PPO enrollees.

8. Medicare Advantage enrollees' out-of-pocket costs for Part A and B services are capped at \$5,187, on average, in 2018



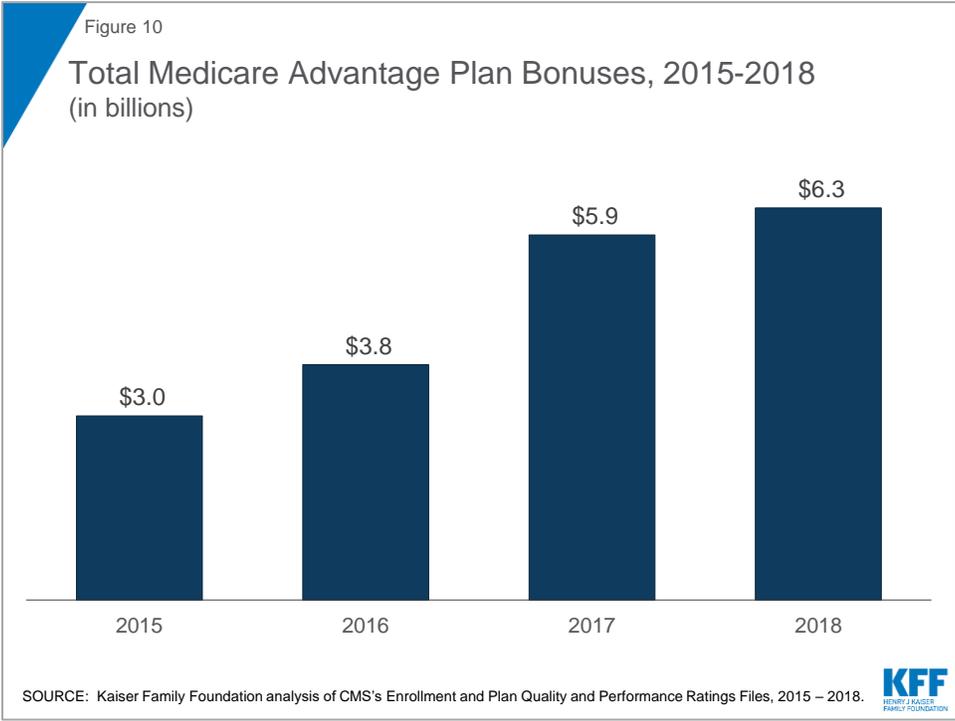
In 2018, the average out-of-pocket limit for in-network services covered under Medicare Part A and B services for Medicare Advantage enrollees is \$5,187, similar to 2017 and 2016 levels, but substantially higher than \$4,288 in 2011. As in prior years, HMO enrollees generally have lower out-of-pocket limits (\$4,908 on average) than enrollees in local PPOs (\$5,908 on average) or regional PPOs (\$6,519 on average). Since 2011, Medicare Advantage plans have been required to limit enrollees' out-of-pocket expenditures for services covered under Parts A and B – in contrast with traditional Medicare – and are required to have limits for in-network services that are no more than \$6,700 annually. Limits were required for regional PPOs since they were first authorized in 2006.

9. Most Medicare Advantage enrollees have access to some benefits not covered by traditional Medicare in 2018



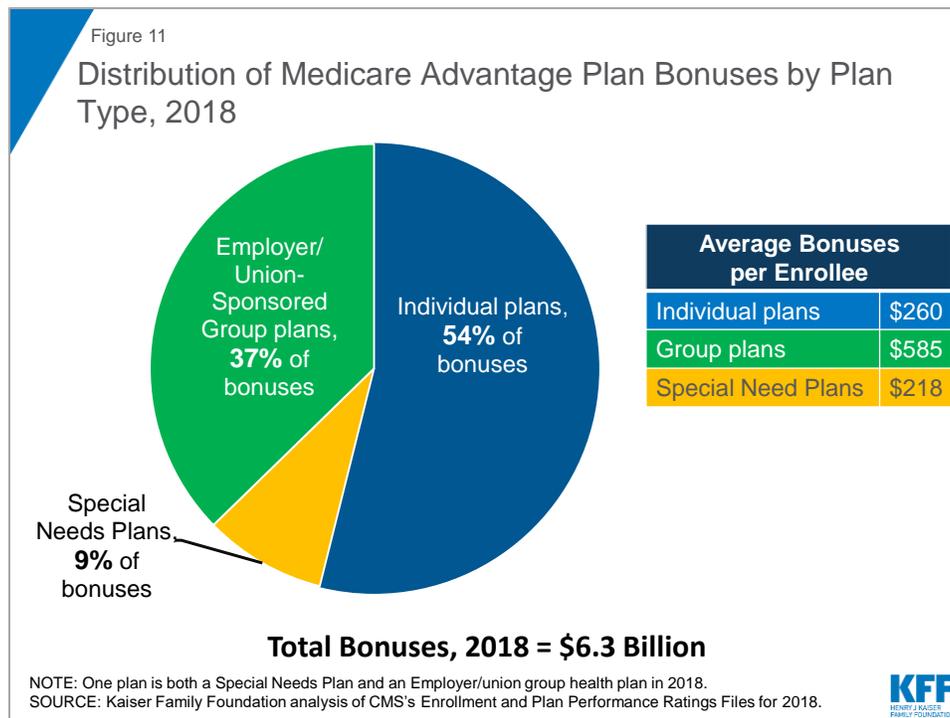
Medicare Advantage plans may provide extra benefits that are not offered in traditional Medicare. Medicare Advantage plans can use rebate dollars (including bonus payments) to help cover the cost of extra benefits. Plans can also charge additional premiums for such benefits. Most enrollees are in plans that provide some dental care (62%), a fitness benefit (69%), and/or eye exams or glasses (77%). Since 2010, the share of enrollees in plans that provide fitness benefits or some dental care has increased (from 52% and 48% of enrollees, respectively) while the share with a vision benefit has been relatively steady (77% in 2010).

10. Total bonuses paid by Medicare to Medicare Advantage plans more than doubled over 4 years



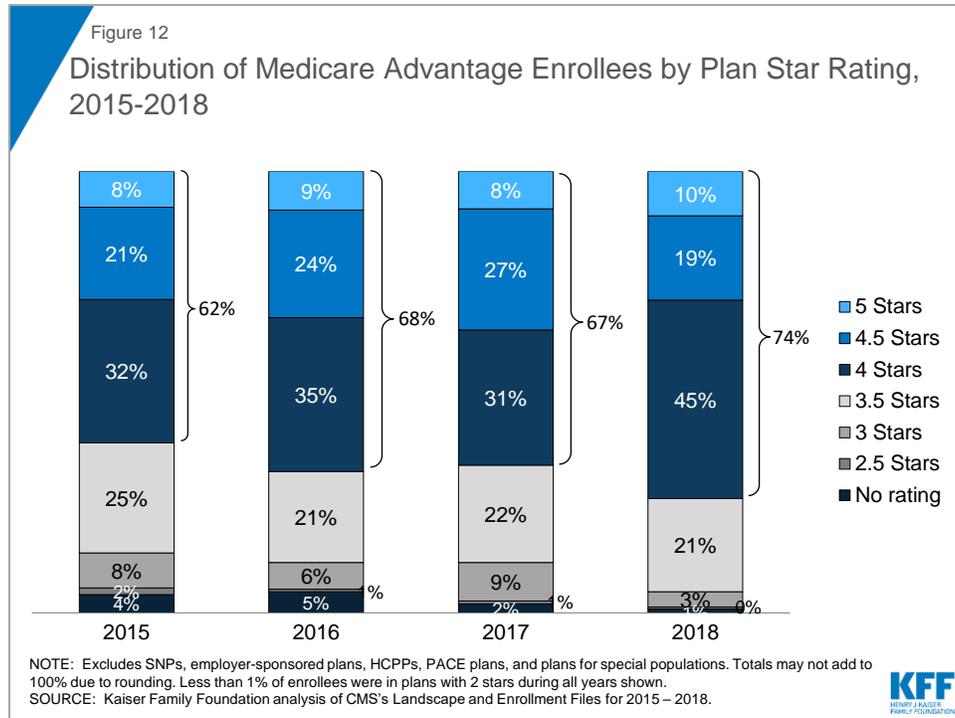
Since 2012, Medicare Advantage plans have been receiving bonus payments, as a result of changes made by the Affordable Care Act of 2010 and a CMS demonstration that terminated after 2014. Medicare Advantage plans with quality ratings of 4 or more stars, and plans without ratings are eligible for bonus payments. Between 2015 and 2018, the total annual bonuses to Medicare Advantage plans have more than doubled, from \$3.0 billion to \$6.3 billion. The rise in bonus payments is due to both an increase in the number of plans receiving bonuses, and an increase in the number of enrollees in these plans.

11. Extra benefits are funded by bonuses and other rebate dollars paid by Medicare



Extra benefits offered by Medicare Advantage plans are funded wholly or in part by bonuses and other rebate dollars. In 2018, Medicare Advantage plans will receive an estimated \$6.3 billion in bonuses, averaging \$321 per enrollee. Medicare requires plans to use bonus payments to reduce cost-sharing or premiums, or provide extra benefits, while retaining some portion of the bonus payments for administrative expenses. Bonus payments are much higher, on average, for people enrolled in Medicare Advantage plans sponsored by employers or unions (\$585 per enrollee) than for people in Medicare Advantage plans open to all beneficiaries (\$260 per enrollee). Employer-sponsored group plans account for 20 percent of Medicare Advantage enrollment but 37 percent of bonus payments. Special Needs Plans, which are mostly comprised of people dually eligible for Medicare and Medicaid, account for 13 percent of enrollment but only 9 percent of bonus payments in 2018.

12. Most (74%) enrollees are in Medicare Advantage plans that receive bonuses in 2018 (4 or more stars or not rated)



In 2018, 74 percent of Medicare Advantage enrollees are in plans with quality ratings of 4 or more stars and eligible for bonus payments, an increase from 67 percent in 2017. An additional 1 percent of enrollees are in plans that were not rated because they were part of contracts that had too few enrollees or were too new to receive ratings.

For many years, CMS has posted quality ratings of Medicare Advantage plans to provide beneficiaries with additional information about plans offered in their area. All plans are rated on a 1 to 5-star scale, with 1 star representing poor performance, 3 stars representing average performance, and 5 stars representing excellent performance. CMS assigns quality ratings at the contract level, rather than for each individual plan, meaning that each plan covered under the same contract receives the same quality rating (and most contracts cover multiple plans).

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Methods

This analysis uses data from the Centers for Medicare and Medicaid services (CMS) Medicare Advantage Enrollment, Benefit and Landscape files for the respective year, with enrollment data from March of each year. Cost plans are grouped with Medicare Advantage plans, and this chart collection uses the term Medicare Advantage to refer to both types of plans, even though cost plans are paid differently and subject to different rules.

Bonuses were calculated using the contract star quality ratings and the Medicare Advantage benchmarks in the counties covered by the respective contract. Bonus calculations assumed that plans bid below the benchmark based on analyses of Medicare Advantage bid data by the Medicare Payment Advisory Commission; bonuses would be slightly lower for the small minority plans that bid above the benchmark. All bonuses were calculated based on March enrollment of the respective year.