October 2017 | Fact Sheet

Medicare Advantage

Since the 1970s, Medicare beneficiaries have had the option to receive their Medicare benefits through private health plans, mainly Health Maintenance Organizations (HMOs), as an alternative to the federally administered traditional Medicare program. The Balanced Budget Act (BBA) of 1997 named Medicare's managed care program "Medicare+Choice" and the Medicare Modernization Act (MMA) of 2003 renamed it "Medicare Advantage." Medicare payments to plans for Medicare Part A and Part B services are projected to total $207 billion in 2017, accounting for 30% of total Medicare spending (CBO June 2017 Medicare Baseline).

Medicare Advantage Enrollment

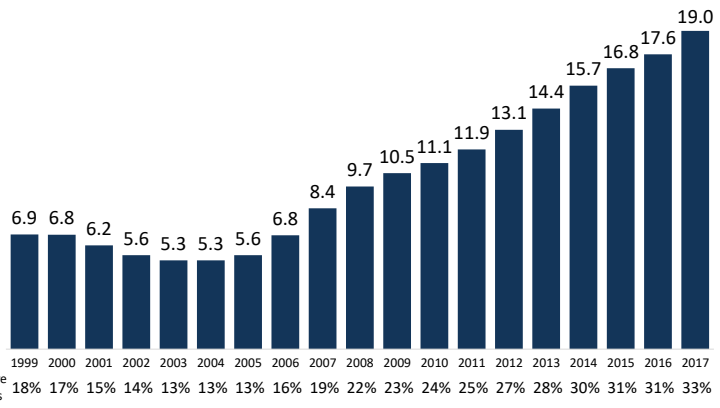
In 2017, the majority of the 57 million people on Medicare are covered by traditional Medicare, with one-third (33%) enrolled in a Medicare Advantage plan (**Figure 1**). Since 2004, the number of beneficiaries enrolled in private plans has more than tripled from 5.3 million (13%) to 19.0 million in 2017 (33%).

Medicare Advantage enrollment varies widely across the states, and by county (**Figure 2**). In six states, at least 40% of Medicare beneficiaries are enrolled in a private plan (CA, FL, HI, MN, OR, and PA) as well as Puerto Rico where 74% of beneficiaries are in a private plan. In 3 states (AK, VT, and WY), fewer than 10% of all beneficiaries are in a Medicare Advantage plan.

Enrollment also varies widely across counties. In 2017, about 11% of all Medicare beneficiaries live in a county where more than half of all beneficiaries are enrolled in a Medicare Advantage plan (excluding Puerto Rico), as compared to 9% in 2015. Enrollment continues to be highly concentrated among a handful of firms, both nationally and in local markets; UnitedHealthcare and Humana together account for 41% of enrollment in 2017.

Figure 1

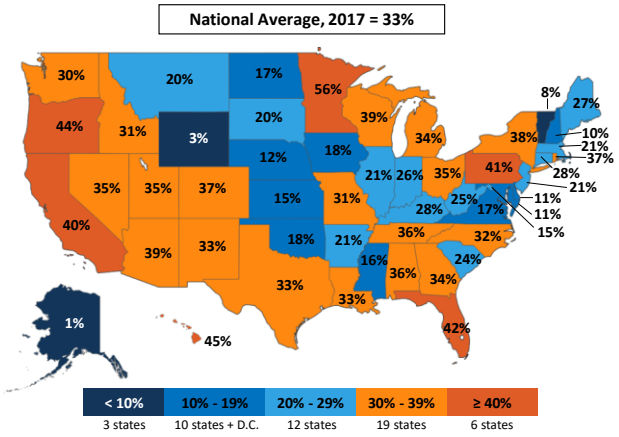
Total Medicare Private Health Plan Enrollment, 1999-2017



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS Medicare Advantage enrollment files, 2008-2017, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

Figure 2

Share of Medicare Beneficiaries Enrolled in Medicare Private Plans, by State, 2017



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS State/County Market Penetration Files, 2017.

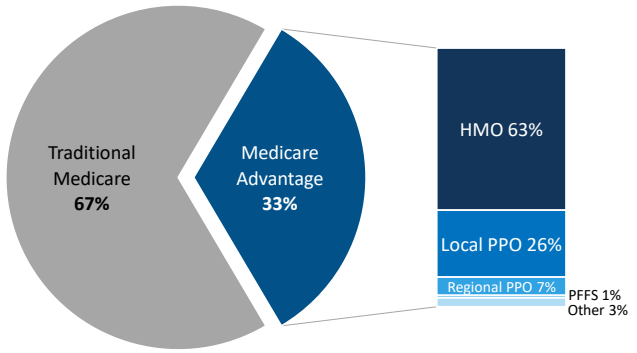
Medicare Advantage Plan Types

Medicare contracts with insurers to offer the following types of health plans:

HMOs and Local PPOs contract with provider networks to deliver Medicare benefits. HMOs account for the majority (63%) of total Medicare Advantage enrollment in 2017; local PPOs, account for 26% of all Medicare Advantage enrollees (**Figure 3**).

Figure 3

Distribution of Enrollment in Medicare Advantage Plans, by Plan Type, 2017



Total Medicare Advantage Enrollment, 2017 = 19.0 Million

NOTE: PFFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Other includes MSAs, cost plans, and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and in territories other than Puerto Rico.
SOURCE: Authors' analysis of the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage enrollment files, 2017.

Regional PPOs were established to provide rural beneficiaries greater access to Medicare Advantage plans, and cover entire statewide or multi-state regions. Regional PPOs account for 7% of all Medicare Advantage enrollees in 2017.

Other Plan Types. In addition to Medicare Advantage HMOs and PPOs, Medicare contracts with insurers to offer other types of plans, although enrollment in these other plan types is relatively low. Private Fee-for-Service (PFFS) plans account for 0.2 million enrollees in 2017, or 1% of all enrollees. Another 0.7 million beneficiaries are enrolled in cost plans, PACE plans, medical savings accounts, demonstrations, and pilots that together account for 3% of private plan enrollment. In a few states (MN, ND, and SD), the majority of private plan enrollment is in cost plans, which are paid based on the "reasonable cost" of providing services, and do not assume financial risk if federal payments do not cover their costs.

Special Needs Plans (SNPs), typically HMOs, are restricted to beneficiaries who: (1) are dually eligible for Medicare and Medicaid; (2) live in long-term care institutions or would otherwise require an institutional level of care; or (3) have certain chronic conditions. In 2017, 2.3 million beneficiaries are enrolled in SNPs; enrollment in SNPs for dual eligibles accounts for 83% of total enrollment in SNPs.

Group Plans. Nearly one in five (19%) Medicare Advantage enrollees (3.7 million) are in a group plan in 2017 – more than double the number of Medicare beneficiaries in group plans in 2008. Group plans are largely sponsored by unions and employers for retirees. Under these arrangements, employers or unions contract with an insurer to provide Medicare benefits and additional retiree health benefits to their Medicare-eligible retirees. Medicare pays the insurer a fixed amount per enrollee to provide benefits covered by Medicare, and the employer or union pays for any additional benefits. In contrast to the Medicare Advantage individual market where HMOs dominate, more than two-thirds (69%) of group plan enrollees are in local PPOs. According to the 2017 Kaiser Employer Health Benefits Survey, one-quarter of all large firms that offer retiree benefits contribute to those benefits through a contract with a Medicare Advantage plan.

Payments To Medicare Private Plans

Medicare pays Medicare Advantage plans a capitated (per enrollee) amount to provide all Part A and B benefits. In addition, Medicare makes a separate payment to plans for providing prescription drug benefits under Medicare Part D. Prior to the BBA of 1997, Medicare paid plans 95% of average traditional Medicare costs in each county because HMOs were thought to be able to provide care more efficiently than could be provided in traditional Medicare.

Beginning in the late 1990s, Congress revised the payment formula to attract more plans throughout the country, particularly in rural and certain urban areas. The BBA of 1997 established a payment floor, applicable almost exclusively to rural counties. The Benefits Improvement and Protection Act (BIPA) of 2000 created payment floors for urban areas and increased the floor for rural areas. The MMA of 2003 increased payments across all areas.

Since 2006, Medicare has paid plans under a bidding process. Plans submit "bids" based on estimated costs per enrollee for services covered under Medicare Parts A and B; all bids that meet the necessary requirements are accepted. The bids are compared to benchmark amounts that are set by a formula established in statute and vary by county (or region in the case of regional PPOs). If a plan's bid is higher than the benchmark, enrollees pay the difference between the benchmark and the bid in the form of a monthly premium, in addition to the Medicare Part B premium. If the bid is lower than the benchmark, the plan and Medicare split the difference between the bid and the benchmark; the plan's share is known as a "rebate," which must be used to provide supplemental benefits to enrollees. Payments to plans are then adjusted based on enrollees' risk profiles.

As a result of changes made over the years to encourage private plan participation and enrollment, the Medicare Payment Advisory Commission (MedPAC) determined that Medicare was paying private plans 14% more per enrollee than the cost of care in traditional Medicare. In response, the ACA of 2010 revised the methodology for paying plans by gradually reducing benchmarks. As of 2017, with the new benchmarks fully phased-in, the benchmarks range from 95% of traditional Medicare costs in the top quartile of counties with relatively high per capita Medicare costs, to 115% of traditional Medicare costs in the bottom quartile of counties with relatively low Medicare costs.

The ACA also established a new system to compensate plans with high quality ratings. Since 2012, Medicare Advantage plans with 4 or more stars and plans without ratings have been receiving bonus payments based on quality ratings. In 2017, 66 percent of Medicare Advantage enrollees are in plans with 4 or more stars. The ACA also reduced rebates for all plans, but allowed plans with higher quality ratings to keep a larger share of the rebate than plans with lower quality ratings.

Medicare Advantage Provider Networks

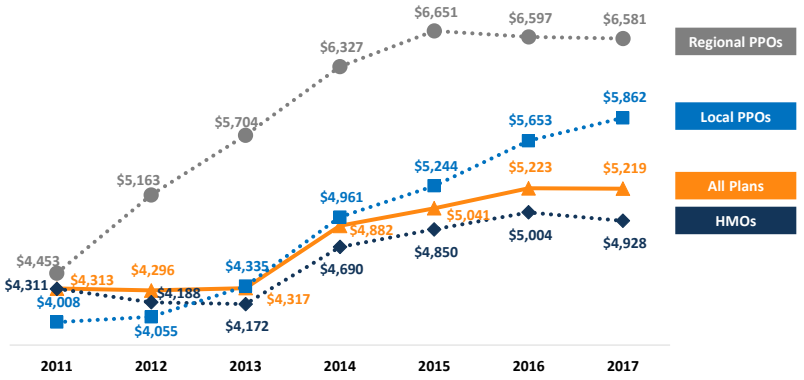
Medicare Advantage plans are required to include a specified number of physicians for each of 26 medical specialties, plus chiropractic care, along with hospitals, and other providers within a particular driving time and distance of enrollees in order to ensure that Medicare Advantage enrollees have access to the physicians that they may need. Medicare Advantage plan networks have been found to include 51% of all hospitals in their county and 46% of the physicians in their county, on average. In 2015, more than one-third of Medicare Advantage enrollees (35%) were in plans with narrow physician networks.

Supplemental And Prescription Drug Benefits

Medicare Advantage plans are paid to provide all Medicare benefits. In addition, since 2011, all plans have been required to limit beneficiaries' out-of-pocket spending for services covered under Medicare Parts A and B to no more than $6,700. In 2017, the average out-of-pocket limit for Medicare Advantage enrollees is $5,219, and about half (52%) of enrollees are in plans with out-of-pocket limits exceeding $5,000 (**Figure 4**).

Figure 4

Average Out-of-Pocket Limits for Enrollees in Medicare Advantage Prescription Drug Plans, 2011-2017



NOTE: Excludes special needs plans (SNPs) and employer group health plans. Percentages may not sum to 100% due to rounding. In 2016, plans with 2% of enrollees were missing information about out-of-pocket limits. Includes only Medicare Advantage plans that offer Part D benefits.
SOURCE: Authors' analysis of CMS Medicare Advantage enrollment and landscape files, 2011-2017.

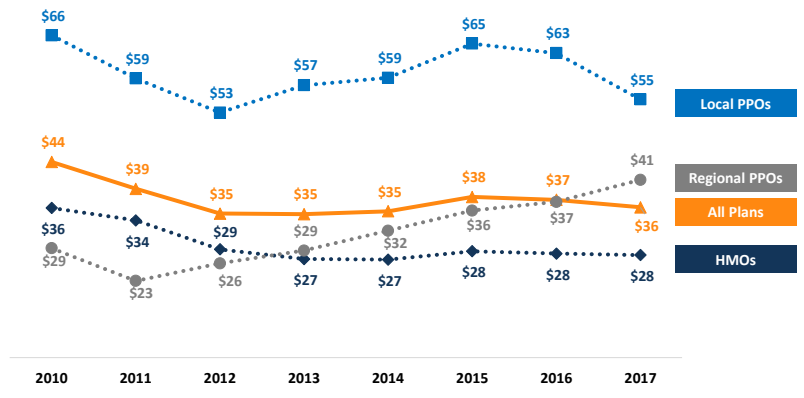
In addition, plans that receive rebates are required to use these payments to provide additional benefits, such as eyeglasses, or reduce premiums or cost sharing for covered benefits. Medicare Advantage plans are generally required to offer at least one plan that covers the Part D drug benefit, and 88% of Medicare Advantage plans offer prescription drug coverage in 2017. In 2017, half (52%) of enrollees in Medicare Advantage plans with prescription drug coverage (MA-PDs) are in plans that do not have a Part D deductible. The standard Medicare Part D benefit in 2018 will have a $405 deductible (up from $400 in 2017) and 25% coinsurance up to an initial coverage limit of $3,750 (up from $3,700 in 2017) in total drug costs, followed by a coverage gap (the so-called "donut hole"), until their total out-of-pocket Part D spending reaches $5,000 (up from $4,950 in 2017) when the catastrophic limit kicks in and beneficiaries pay 5% of the cost of drugs. The ACA gradually closes the coverage gap, and in 2018, enrollees in plans with no additional gap coverage will pay 35% (down from 45% in 2017) of the total costs of brand-name drugs and 44% (down from 58% in 2017) of the total cost of generics in the gap until they reach the catastrophic limit.

Medicare Advantage Premiums

The average premium for enrollees of Medicare Advantage Prescription Drug plans will be $36 per month in 2017, similar to premiums in the past five years. Premiums are lower for HMOs than for regional and local PPOs and significantly vary across counties. However, we do not know to what extent enrollees' out-of-pocket expenses have changed since 2010 because we do not know whether cost-sharing for individual services has changed (**Figure 5**).

Figure 5

Weighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, Total and by Plan Type, 2010-2017



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations. Includes only Medicare Advantage plans that offer Part D benefits. The total includes cost plans and PFFS plans (not shown separately), as well as plans with zero premiums. The premiums for a subset of sanctioned plans were not available in 2011; these plans were excluded from this analysis. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS's Landscape Files for 2010–2017 and March Enrollment files for 2010-2017.

Future Issues

Historically, Congress has enacted a number of changes that affect the role of private plans under Medicare, including adding new types of plans to the program, increasing or decreasing Medicare payments to plans, and tightening the rules governing the marketing of the plans.

In 2017, Medicare Advantage markets and plans look much as they did in 2016, in terms of the number of plans available to beneficiaries. Over the longer term, companies offering Medicare Advantage plans may respond to payment changes in several different ways, depending on the circumstances of the company, the location of their plans, their historical commitment to the Medicare market, their ability to leverage efficiencies in the delivery of care to enrollees, and possibly their quality ratings and bonus payments. Decisions made by these firms could have important implications for beneficiaries with respect to their choice of plans, out-of-pocket costs, and access to providers.

Achieving a reasonable balance among multiple goals for the Medicare program—including keeping Medicare fiscally strong, setting adequate payments to private plans, and meeting beneficiaries' health care needs—will continue to be a critical issue for policymakers in the future.