

Medicare Advantage: Private Health Plans in Medicare

Medicare provides federal health insurance for 43 million people who are aged or disabled or who have end-stage renal disease. Most receive services through the traditional fee-for-service (FFS) part of the program, which pays providers a set fee for each covered service (or bundle of services). Participants can choose their providers and are not required to obtain prior authorization for any covered service.

Medicare beneficiaries have the option of enrolling in Medicare Advantage—the program through which private plans participate in Medicare—rather than receiving their care through the FFS program.¹ They may choose to do so because such plans provide additional benefits beyond those available within traditional Medicare, including coverage for services not covered by FFS Medicare (for instance, dental services) and cash rebates of premiums or reduced cost-sharing. As of June 2007, about 18 percent of beneficiaries are enrolled in Medicare Advantage plans.² This brief describes how those private plans function, how they are paid, how their costs compare with the costs of traditional Medicare, and how those costs vary by geographic area.

In summary:


- Enrollment in Medicare Advantage is growing rapidly, particularly in a relatively unmanaged type of plan called private fee for service (PFFS).
- Medicare's payments for beneficiaries enrolled in Medicare Advantage plans are higher, on average, than what the program would spend if those beneficiaries were in the FFS sector—so shifts in enrollment out of the FFS program and into private plans increase net Medicare spending.

1. Medicare Advantage is also called Part C. Previously, the program had been called Medicare+Choice.

2. Another 1 percent of beneficiaries are enrolled in other types of group plans, including cost-reimbursed plans, health care prepayment plans, a program of all-inclusive care for the elderly, and demonstration plans.

- The difference in costs relative to those for the traditional FFS program is particularly large for PFFS plans.
- The additional cost to the government for Medicare Advantage plans subsidizes the beneficiaries who enroll in such plans, which fuels the plans' growth in enrollment and raises costs for Medicare beneficiaries who do not participate in Medicare Advantage.
- Reducing the payment differential between Medicare Advantage and the FFS program could result in substantial savings to the Medicare program. But it would also diminish the supplemental benefits and cash rebates that Medicare Advantage plans can offer to enrollees and lessen enrollment in those plans. Lowering payments to those plans would slightly reduce the standard premiums for Part B of Medicare (Supplementary Medical Insurance) and delay the exhaustion of the trust fund that supports Part A (Hospital Insurance).

This brief was written by J. Timothy Gronniger and Robert A. Sunshine. Related publications include these testimonies: *The Medicare Advantage Program*, before the House Budget Committee (June 28, 2007), *The Medicare Advantage Program: Enrollment Trends and Budgetary Effects*, before the Senate Committee on Finance (April 11, 2007), and *The Medicare Advantage Program: Trends and Options*, before the Subcommittee on Health of the House Committee on Ways and Means (March 21, 2007). All are available on the Congressional Budget Office's Web site (www.cbo.gov).



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Director

Box 1.**How Medicare Advantage Plans Are Paid**

The current payment system for private health plans was established by the Medicare Modernization Act, which was enacted in 2003.¹ Private plans that want to participate in the Medicare Advantage program must submit bids indicating the per capita payment for which they are willing to provide Medicare's Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) benefits—and to take on the financial risk of doing so.²

The government compares those bids with county-level benchmarks that are determined in advance through statutory rules. The benchmarks are the maximum payment the government will make for enrollees in private plans; in most cases the plans' bids (and the resulting payments) are lower than the benchmarks. (The benchmark for a plan that serves more than one county is an enrollment-weighted average of the county-level benchmarks in its service area.)

If a plan's bid is less than the benchmark, Medicare pays the plan its bid plus 75 percent of the amount by which the benchmark exceeds the bid. Such a plan must return that 75 percent to beneficiaries as additional benefits or as a rebate of their Part B or Part D premiums.³ For example, if a county's benchmark is

\$800 per person per month and a plan bids \$700, Medicare will pay the plan \$775, and \$75 of that amount must be returned in some form to the beneficiaries. Such additional benefits and lower premiums are a primary factor distinguishing one Medicare Advantage plan from another and Medicare Advantage plans from Medicare's fee-for-service (FFS) program.

Benchmarks are required to be at least as high as per capita expenditures in the FFS program in every county and are higher than FFS expenditures in many counties. For 2007, the Congressional Budget Office calculates that benchmarks are 17 percent higher, on average, than projected per capita FFS expenditures nationwide. Benchmarks are updated each year by either the growth in national per capita Medicare spending or 2 percent, whichever is greater. For 2008, the benchmarks will increase by 3.5 percent.

Medicare also adjusts payments to Medicare Advantage plans to reflect their enrollees' health status. That "risk adjustment" is meant to encourage plans to compete on the basis of efficient delivery of services rather than selective enrollment of healthier beneficiaries. To that end, the Centers for Medicare & Medicaid Services (CMS) collects information on the medical diagnoses of every beneficiary in the FFS and Medicare Advantage programs and uses it to calculate the relationship between individuals' health and subsequent spending on their behalf for Medicare services and to thereby adjust payments to plans (upward for those with sicker beneficiaries and downward for those with healthier beneficiaries).

In managing the risk adjustment system, CMS has to confront difficult issues of data collection and validity, statistical complexity, and potentially different coding practices among plans and the FFS sector. Each judgment the agency makes for each of those aspects of risk adjustment can increase or decrease payments to Medicare Advantage plans.

1. The description of the payment mechanism in this box pertains to plans that participate in Medicare on a county-by-county basis (or "local" plans). The mechanism for regional preferred provider organizations is analogous to that described here for local plans but uses a modified approach to compute benchmarks. See Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program* (June 2005), pp. 59–81.
2. Part A covers inpatient services provided by hospitals as well as skilled nursing and hospice care. Part B covers services provided by physicians and other practitioners, hospitals' outpatient departments, and suppliers of medical equipment.
3. If a plan's bid is above the benchmark, Medicare pays the bid amount, and the plan is required to charge enrollees the difference between the bid and what Medicare pays.

Types of Medicare Advantage Plans

About 80 percent of beneficiaries currently enrolled in the Medicare Advantage program are in health maintenance organizations (HMOs) or preferred provider organizations (PPOs). Both HMOs and PPOs have comprehensive networks of providers, but PPOs allow beneficiaries to obtain care outside the network if they pay higher amounts.³ A key feature of many HMO and PPO plans is care management services, which are intended to promote better coordination and more-effective use of health care, although little evidence exists on whether HMO and PPO plans succeed in delivering higher-quality care than traditional Medicare.

The other main type of Medicare Advantage plan is private fee for service. Such plans allow their enrollees to obtain care from any provider who will furnish it and are not required to maintain networks of providers. In contrast to the FFS system, which requires participating providers to accept Medicare's rates for all covered services and all beneficiaries, providers in a PFFS plan can decide each time they see a patient whether to accept the plan's terms of participation and payment rates, which are usually those of Medicare's FFS program. Beneficiaries' premiums, copayments, and deductibles are generally lower than those in the FFS program, and private fee-for-service plans typically provide significantly less care management and utilization control than do HMOs and PPOs (see Box 1).

In 2007, 82 percent of Medicare beneficiaries live in a county served by an HMO or a local PPO, up from 67 percent in 2005.⁴ All beneficiaries have access to a PFFS plan in 2007, up from 80 percent in 2006 and only 45 percent in 2005. Most Medicare beneficiaries have access to more than one private plan.

3. PPOs in the Medicare Advantage program are either local or regional; regional PPOs, an option that became available in 2006, are required to serve broad regions of the country rather than defining their service areas on a county-by-county basis. About 2 percent of Medicare Advantage beneficiaries are enrolled in regional PPOs.

4. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2007), Chapter 4, "Update on Medicare Private Plans," pp. 237–266.

Enrollment in Medicare Advantage Plans Is Increasing Rapidly

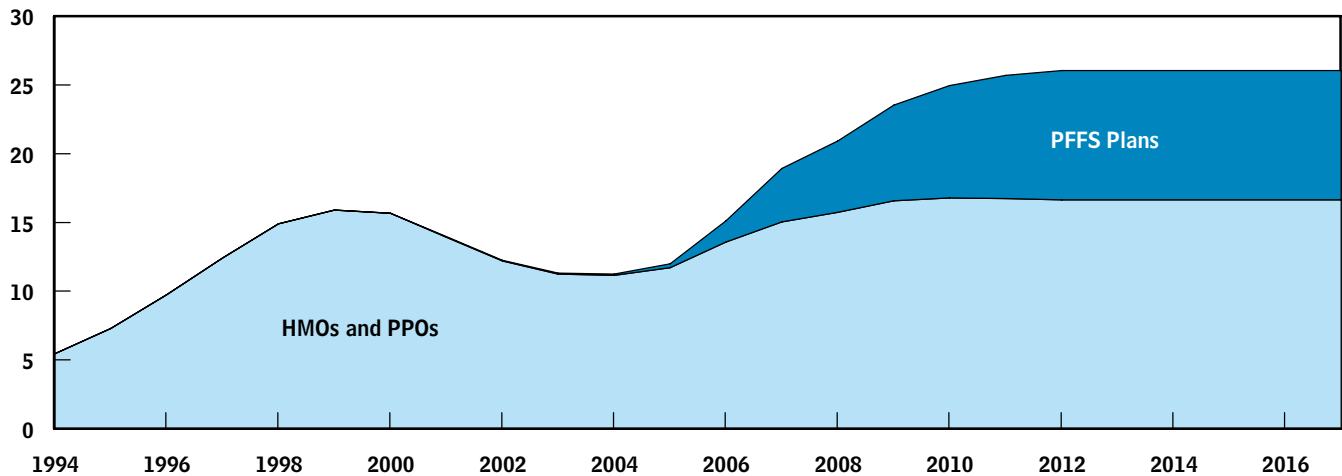
Enrollment in Medicare Advantage plans has grown rapidly in recent years. In 2003 and 2004, Medicare Advantage plans accounted for 11 percent of enrollment in Medicare, the lowest level since 1996. Over the past two years, however, enrollment in those health plans has increased to about 18 percent of all enrollment, or 8 million beneficiaries. That increase reflects, among other factors, changes enacted in the Medicare Modernization Act that increased payment rates and added the prescription drug benefit to complement the medical benefits provided under Parts A and B of Medicare.⁵ The Congressional Budget Office (CBO) projects that, under current law, enrollment in Medicare Advantage will grow at an annual average rate of about 7 percent over the next 10 years, compared with a growth rate of about 2.5 percent for Medicare overall—reaching 21 percent of total enrollment in 2008 and 26 percent by 2017 (see Figure 1).

The projected increase in enrollment in Medicare Advantage is driven largely by CBO's expectation of continuing growth in enrollment in private fee-for-service plans, which rose from 200,000 members at the end of 2005 to more than 1.6 million members in June 2007—about 700,000 of whom were added during 2007. By 2017, CBO anticipates, enrollment in PFFS plans will reach 5 million members, accounting for one-third of all Medicare Advantage enrollment at that time, up from about one-fifth now.

Spending on Medicare Advantage Is Rising

CBO projects that, under current law, payments to Medicare Advantage plans for benefits under Parts A and B

5. Part A, Hospital Insurance, covers inpatient services provided by hospitals as well as skilled nursing and hospice care. Part B, Supplementary Medical Insurance, covers services provided by physicians and other practitioners, hospitals' outpatient departments, and suppliers of medical equipment. Home health care may be covered by either Part A or Part B. Health maintenance organizations and preferred provider organizations must offer a prescription drug benefit under Part D; they may choose to also offer an option that does not include that benefit. Plans must submit separate bids for the prescription drug benefit and identify the premiums they intend to charge for any supplemental benefits they offer.

Figure 1.**Enrollment in Medicare Advantage as a Percentage of Enrollment in Medicare**

Source: Congressional Budget Office.

Notes: HMO = health maintenance organization; PPO = preferred provider organization; PFFS = private fee for service.

For the purpose of this figure, enrollment in Medicare is considered to be that in Part A (Hospital Insurance).

will rise from \$60 billion in 2006 to \$196 billion in 2017—reflecting an annual average growth rate of 11 percent (see Figure 2).⁶ Much of that increase (about 7 percent per year) will result from growing enrollment; the rest (about 4 percent per year), from increasing payments per enrollee. By comparison, CBO estimates that total enrollment in Medicare will grow much more slowly and that total spending will increase by an average of 6.5 percent per year. Spending for Medicare Advantage is projected to total approximately \$1.5 trillion from 2007 through 2017, more than a quarter of all spending for benefits under Parts A and B.

CBO expects that private fee-for-service plans will account for a rapidly growing share of Medicare Advantage spending under current law, with payments to them increasing from approximately \$5 billion in 2006 to \$13 billion in 2007 and \$59 billion in 2017. That increase represents an annual average nominal growth

rate of 25 percent over the 11-year period, reflecting a 20 percent average rate of growth in enrollment. In 2006, PFFS plans accounted for approximately 8 percent of Medicare Advantage spending; in 2017, CBO anticipates, those plans will account for about 30 percent. Although they are expected to grow more slowly than PFFS plans, HMOs and PPOs are likely to continue to account for the largest portion of spending throughout the coming decade.

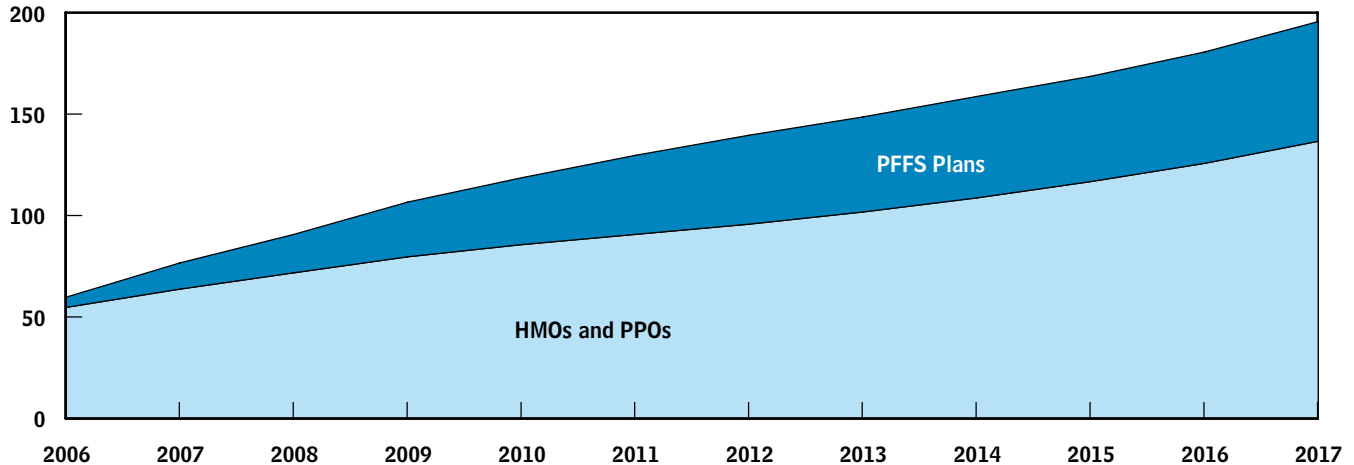
Medicare Advantage Plans Cost the Government More Than Traditional Medicare

The government's spending for beneficiaries in Medicare Advantage plans will, in almost all cases, exceed what it would spend if those beneficiaries were in the traditional fee-for-service sector. That outcome occurs because benchmarks are almost always higher than FFS costs, and the government retains only 25 percent of the difference between a plan's bid and the benchmark.

6. Excluded here are payments for Part D benefits, which are managed separately.

Figure 2.**Projected Spending on Medicare Advantage, by Type of Plan**

(Billions of dollars)



Source: Congressional Budget Office.

Note: HMO = health maintenance organization; PPO = preferred provider organization; PFFS = private fee for service.

In 2007, CBO estimates, the average payment to such plans is 12 percent above traditional FFS costs.⁷ The differential is larger for private fee-for-service plans: According to estimates by the Medicare Payment Advisory Commission (MedPAC), the payments to those plans in 2006 averaged 19 percent above FFS costs.⁸ Of that difference, 10 percentage points' worth went to beneficiaries in the form of extra benefits or rebates. In contrast, payments to HMOs averaged 10 percent above FFS costs, MedPAC estimates. On average, HMOs offered extra benefits and rebates equal to 13 percent of FFS costs; those additional benefits and rebates reflected the difference between the benchmark (which averaged 10 percent above FFS costs)

7. In areas with high FFS costs per capita, benchmarks and plans' bids tend to be closer to FFS spending; in areas with low FFS costs, benchmarks and bids diverge more from FFS spending. In particular, in areas with the highest FFS spending, health plans' bids for 2007 are about 9 percent *below* FFS spending; benchmark rates in those areas average about 4 percent *above* FFS costs. By contrast, in the lowest-cost FFS areas, health plans' bids are about 16 percent *above* FFS spending, and benchmark rates average about 26 percent *above* FFS costs. For further discussion, see Congressional Budget Office, *Designing a Premium Support System for Medicare* (December 2006).

8. Statement of Glen M. Hackbarth, Chairman, Medicare Payment Advisory Commission, *The Medicare Advantage Program and MedPAC Recommendations*, before the Senate Committee on Finance (April 11, 2007), p. 5.

and the plans' bids (which averaged 3 percent below FFS costs).

The extra benefits and rebates offered by Medicare Advantage plans attract enrollees, and the rising proportion of beneficiaries enrolling in the plans will add to the growth in Medicare spending. In addition, because premiums for Part B of Medicare are set to cover 25 percent of the costs of that program, the higher costs of Medicare Advantage plans add about \$2 to the monthly premium for Part B.⁹ Those higher costs also accelerate the exhaustion of the trust fund that supports Part A.

Private plans can provide the services of Parts A and B at a lower cost than the FFS program can only if they offset their higher administrative costs by achieving savings through lower utilization of services or smaller payments to providers. In general, HMOs keep their medical costs down by reducing the level and intensity of utilization, particularly by limiting their enrollees' use of services such as visits to specialists, inpatient hospital care, costly tests and procedures, and services in intensive care units.¹⁰ In contrast to HMOs and PPOs, private

9. *Ibid.*

10. See Robert H. Miller and Harold S. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997-2001," *Health Affairs*, vol. 21, no. 4 (July/August 2002), pp. 63-86.

fee-for-service plans generally do not incur the costs of establishing and maintaining networks of providers, and the rates paid to providers by PFFS plans generally are the same as Medicare's FFS costs. PFFS plans also incur administrative costs for acquiring and maintaining enrollment, but they do not realize comparable savings from managing utilization. In a given area, differences between the costs incurred by various Medicare Advantage plans may not substantially affect the government's costs, however, because in most cases, three-quarters of any savings accrues to beneficiaries.

Enrollment in Medicare Advantage Varies Geographically

Most enrollment in HMOs and PPOs tends to be in relatively densely populated areas (where establishing provider networks is easier) with relatively high benchmarks and generally high per capita FFS spending.¹¹ Because those types of private plans try to restrain medical costs by managing the utilization of services, they have a greater potential to achieve savings relative to the FFS program in areas where FFS practice involves relatively high utilization of costly services. (To the extent that such cost savings are realized, they should be reflected in future bids and thus lead to expanded benefits for Medicare Advantage enrollees, with a quarter of the savings returned to the Medicare program.) HMOs and PPOs have much less opportunity to achieve such savings in areas where the utilization of expensive services in the FFS sector is already relatively low.

In contrast to HMOs and PPOs, private fee-for-service plans have enrollment that is far more dispersed, including significant enrollment in rural areas. The rapid growth of those plans increased the market share of private plans in rural areas from about 4 percent in 2005 to about 7 percent in 2006, and CBO expects that share to continue to grow under current law as PFFS plans play an increasingly large role in Medicare Advantage. They are able to grow in rural areas, first, because they face little

11. It is easier for a plan to establish a network in a relatively densely populated area that has a relatively large number of providers than in a more sparsely populated area because the plan's leverage in negotiations with providers (to get them to accept lower payment rates and to cooperate with the plan's efforts to manage utilization) relies on promising them some volume of business by diverting to them patients from providers who do not participate in the network.

competition from other types of private plans there; unlike HMOs and PPOs, they do not require networks of providers, which are difficult to establish in those areas. Second, Medicare rules enable private fee-for-service plans to pay providers at the same rates as FFS Medicare does, which are generally lower than the rates that HMOs and PPOs negotiate with providers that join their networks. Finally, benchmarks in rural areas are sufficiently high that PFFS plans are able to offer extra benefits or rebates to attract members even without the cost-reducing tools available to other types of plans.

The Impact of Reducing Payments to Medicare Advantage Plans

All counties have benchmarks set at or above local per capita FFS spending. On average, benchmarks are 17 percent higher, CBO calculates. By CBO's estimates, more than one-half of Medicare Advantage spending is in counties where the benchmark is at least 10 percent above FFS costs, and more than one-fifth is in counties where the benchmark is 20 percent higher or more (see Table 1). Reducing benchmarks to FFS levels would therefore constitute a significant reduction in spending in most counties. Relative to spending under current law, CBO estimates, that policy would save \$54 billion over the 2009–2012 period and \$149 billion over the 2009–2017 period.¹² Limiting benchmarks to 100 percent of FFS costs for private fee-for-service plans and maintaining current-law benchmarks for other plans would reduce federal spending by about \$14 billion over the 2009–2012 period and \$43 billion over the 2009–2017 period. Each policy would, however, have a considerable impact on both plans and their participants.

12. The county-level benchmarks for 2008 have been announced, and the bidding process is under way. CBO's estimates assume that the policy would take effect in 2009 to avoid interrupting the bidding process for 2008. There are numerous other policy options for reducing payments to Medicare Advantage plans; for some of those and their estimated budgetary impact, see Statement of Peter R. Orszag, Director, Congressional Budget Office, *The Medicare Advantage Program*, before the House Committee on the Budget (June 28, 2007), Tables 4 and 5, pp. 16–20.

Table 1.**Distribution of Medicare Advantage Spending, by the Percentage by Which County Benchmarks Exceed Local FFS per Capita Costs**

(Percent)

Percentage by Which Benchmark Exceeds FFS Costs	Portion of Medicare Advantage Spending	
	Within Category	Within or Above Category
0	10	100
Greater Than 0 to 9.9	38	90
10 to 19.9	31	52
20 to 29.9	12	21
30 to 39.9	5	9
40 to 49.9	1	4
50 and Higher	3	3

Source: Congressional Budget Office.

Note: Categories are based on the Medicare Advantage program's local county benchmarks and local fee-for-service (FFS) rates. The total spending is calculated as if all bids were equal to the benchmark and all beneficiaries had average expected costs. The analysis includes all counties with reported FFS spending for 2007 (as well as Puerto Rico).

Much of the benefit of the higher benchmarks accrues to participants in the plans in the form of supplemental benefits or lower premiums, and reducing benchmarks would leave less money for those purposes. (In the example cited in the box, with a benchmark of \$800 and a plan's bid of \$700, if per capita FFS spending in the county averaged \$660, setting payments to the plan at the FFS average would reduce the government's costs from \$775 to \$660 per person; at least \$75 of that reduction would be reflected as reduced benefits or increased costs to the plan's participants.) Such a change, in turn, would make the program less attractive to beneficiaries and lead some to return to the traditional fee-for-service program. Others who would have joined Medicare Advantage plans would remain in the FFS program.

The change also would make the Medicare Advantage program less attractive for health plans and cause some to leave the program, as they did after the Congress constrained increases in payment rates in the Balanced Budget Act of 1997. By CBO's estimates, setting benchmarks to FFS levels would reduce enrollment in Medicare

Advantage by about 6.2 million beneficiaries in 2012 relative to the agency's baseline projection, a decline of about 50 percent from the projected level of 12.5 million in 2012 and about 1.7 million relative to today's enrollment. Limiting the policy change to private fee-for-service plans would result in a smaller reduction in enrollment, approximately 3.3 million beneficiaries in 2012.

Some types of plans and some areas would be affected more than others. Under both options, PFFS plans, which generally receive the highest per capita payments relative to FFS costs, would be affected more than HMOs and PPOs. Rural areas would be affected more than urban ones. And some states would be affected more than others; on average, the benchmarks exceed FFS costs by as little as 6 percent in Connecticut but by as much as 41 percent in Hawaii.¹³ Lowering the benchmarks would also delay the exhaustion of the Hospital Insurance trust fund, and slightly reduce the standard Part B premiums.

13. See Congressional Budget Office, *Medicare Advantage Statistics by State* (April 17, 2007).