

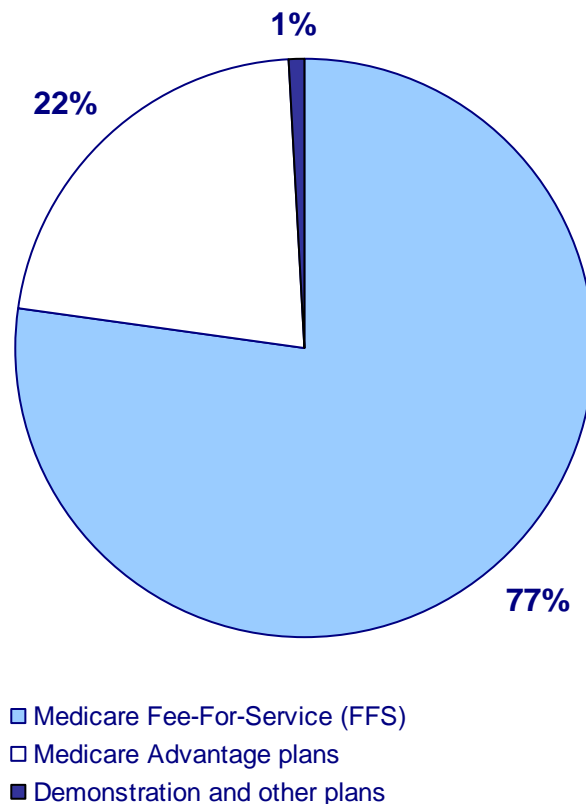
Medicare Advantage: Program Overview and Recent Experience

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In 2008, About 22 Percent of Medicare Beneficiaries Were Enrolled in Medicare Advantage Plans

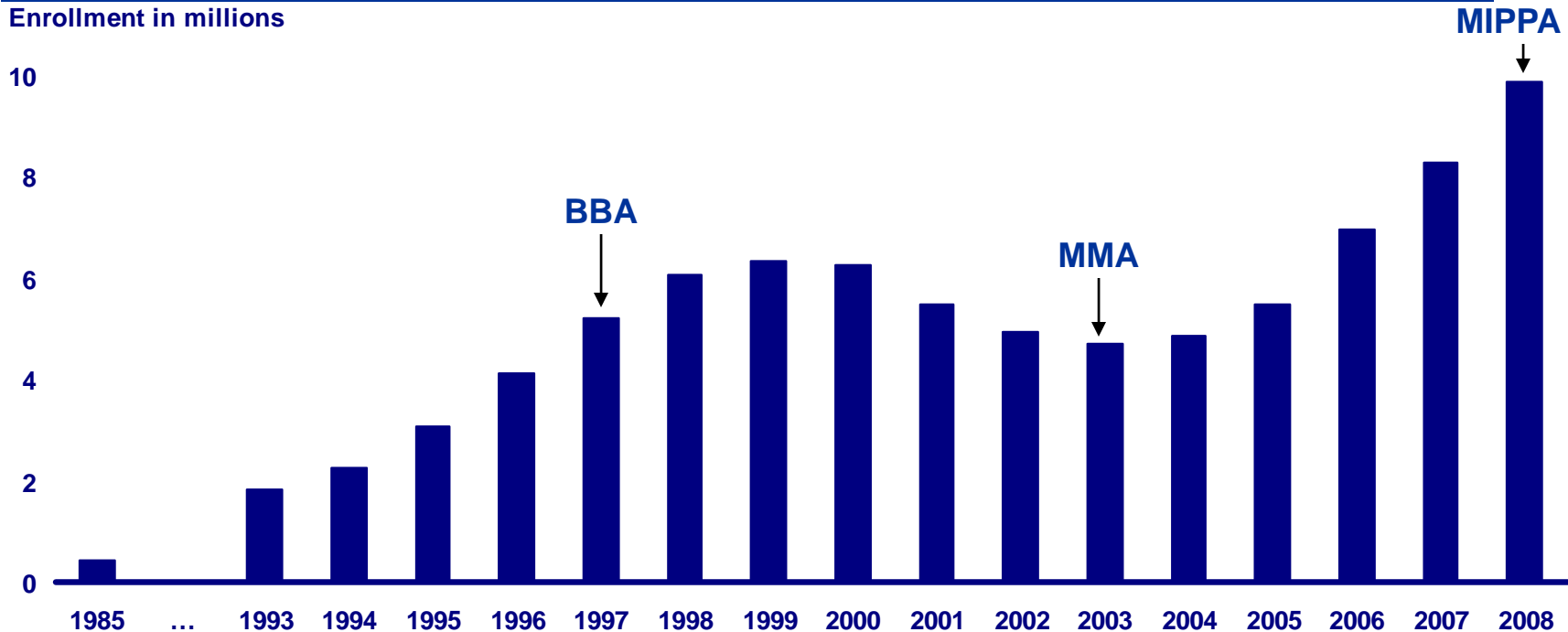


Source: Mathematica Policy Research, Inc., and The Henry J. Kaiser Family Foundation

Note: Estimate of Medicare FFS enrollment is based on the differences between the total number of individuals eligible for Medicare and the number of beneficiaries enrolled in an MA demonstration or other plan.

Enrollment in Medicare Advantage, 1985-2008

Enrollment in millions



Source: Centers for Medicare & Medicaid Services.

Notes: The Medicare Advantage Program was called the Medicare Risk Program prior to 1997 and the Medicare+Choice program from 1997 through 2003. BBA = Balanced Budget Act of 1997 (P.L. 105-33); MMA = Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173); MIPPA = Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275).

Features Common to Medicare Advantage Plans

- Cover almost all Medicare Part A and Part B items and services, except hospice care.
- May offer Medicare Part D prescription drug coverage (most plan types).
- May cover items and services not available under original Medicare fee-for-service.
- Are paid a predetermined monthly amount, known as a capitation payment, by Medicare, for each beneficiary enrolled.
- May charge beneficiaries a monthly premium (in addition to the Medicare Part B premium) and cost-sharing amounts.

Medicare Advantage Plan Types Available in 2008

Local Plans – County-based geographic service areas

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-For-Service (PFFS)
- Medical Savings Account (MSA)

Regional Plans – State-based geographic service areas.

- Preferred Provider Organization (PPO)

Selected Characteristics of Local Medicare Advantage HMOs, PPOs, and PFFS Plans

Characteristics	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)	Private Fee-for-Service (PFFS)
Use a network of providers	Yes	Yes	No
Get care from any physician or hospital	No	Yes, but pay more if use providers outside of network	Yes
Need a referral from a primary care physician to see a specialist	Yes, for most services	No	No
Prescription drugs covered (Part D)	Must offer option	Must offer option	May offer option

Source: CMS

Note: HMOs are required to cover non-network services in certain circumstances, such as emergencies. PFFS plans are not currently required to contract with providers. Under MIPPA, beginning in 2011, some PFFS plans will be required to have provider networks.

Regional Preferred Provider Organizations (PPO)

- Serve one or more of 26 state-based regions defined by CMS.
- Premiums, benefits, and beneficiary cost-sharing uniform across the region and available to all beneficiaries.
- Single deductible for hospital and physician services.
- Catastrophic limit on beneficiary cost sharing.

Medicare Medical Savings Account (MSA) MA Plans

- Combine a high-deductible insurance policy and a savings account for health care expenses.
- Medicare pays premium and deposits money into MSA.
- Beneficiaries use money in MSA to pay for health care before deductible is reached – unspent funds carry over to the following year.
- Once deductible is met, plan pays 100% of covered services.
- Maximum annual deductible set by law (\$10,500 in 2009).
- Do not cover Part D drugs.

Special Needs Plans (SNP)

- SNPs are designed like HMOs or PPOs and target for enrollment certain categories of Medicare beneficiaries:
 - Dual eligibles
 - Institutionalized beneficiaries
 - Beneficiaries with severe chronic or disabling conditions
- SNPs must offer Part D coverage
- 1.3 million beneficiaries in SNPs in November 2008

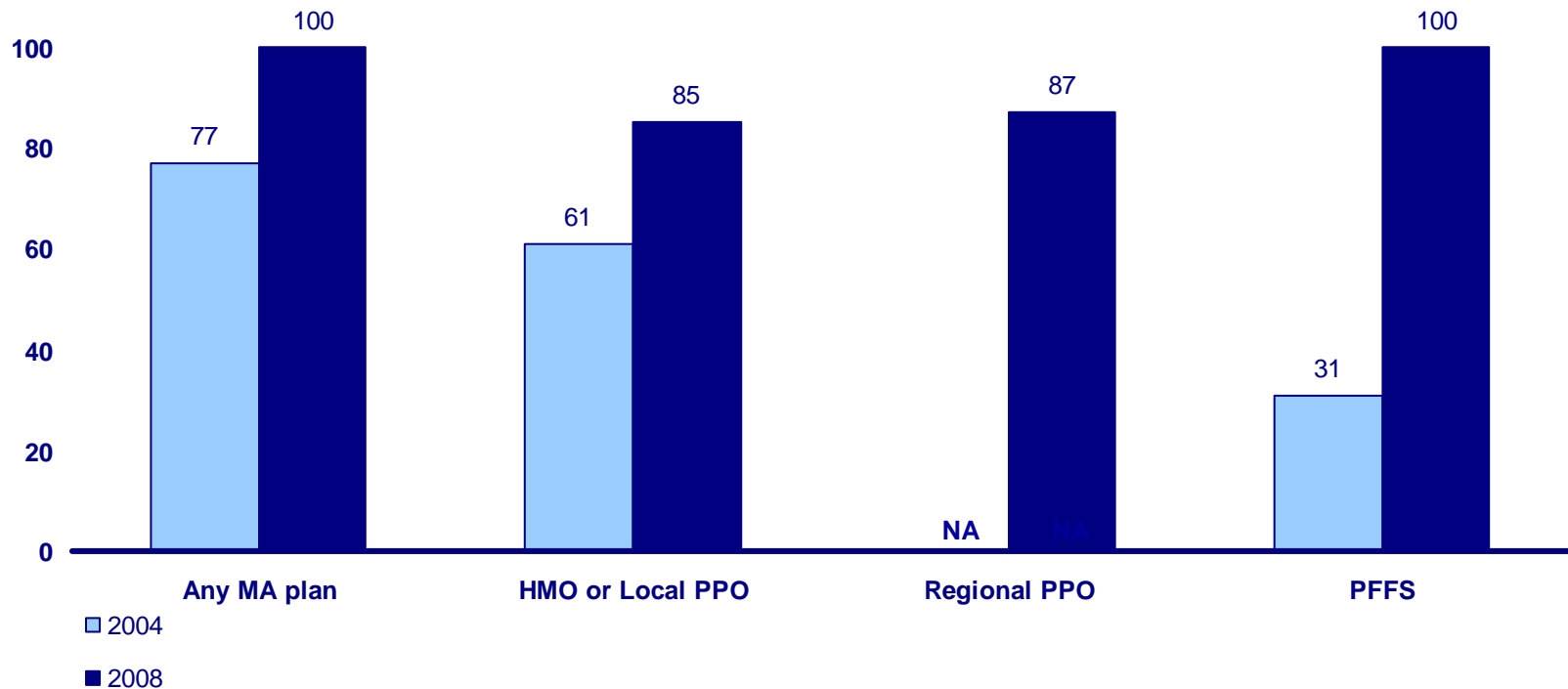
Beneficiary Enrollment

- Beneficiaries can join, switch or drop MA and prescription drug plans during the annual election period from November 15 through December 31 of each year.
- Beneficiaries can join, switch or drop MA plans once during the open enrollment period, from January 1 through March 31 of each year.
- In addition, beneficiaries can join, switch or drop MA plans under certain other circumstances.

Note: Beneficiaries can not add or drop prescription drug coverage during the open enrollment period but may switch plans if they already have coverage.

Beneficiary Access to Medicare Advantage Plans by Plan Type, 2004 and 2008

Percentage of beneficiaries with access to a plan



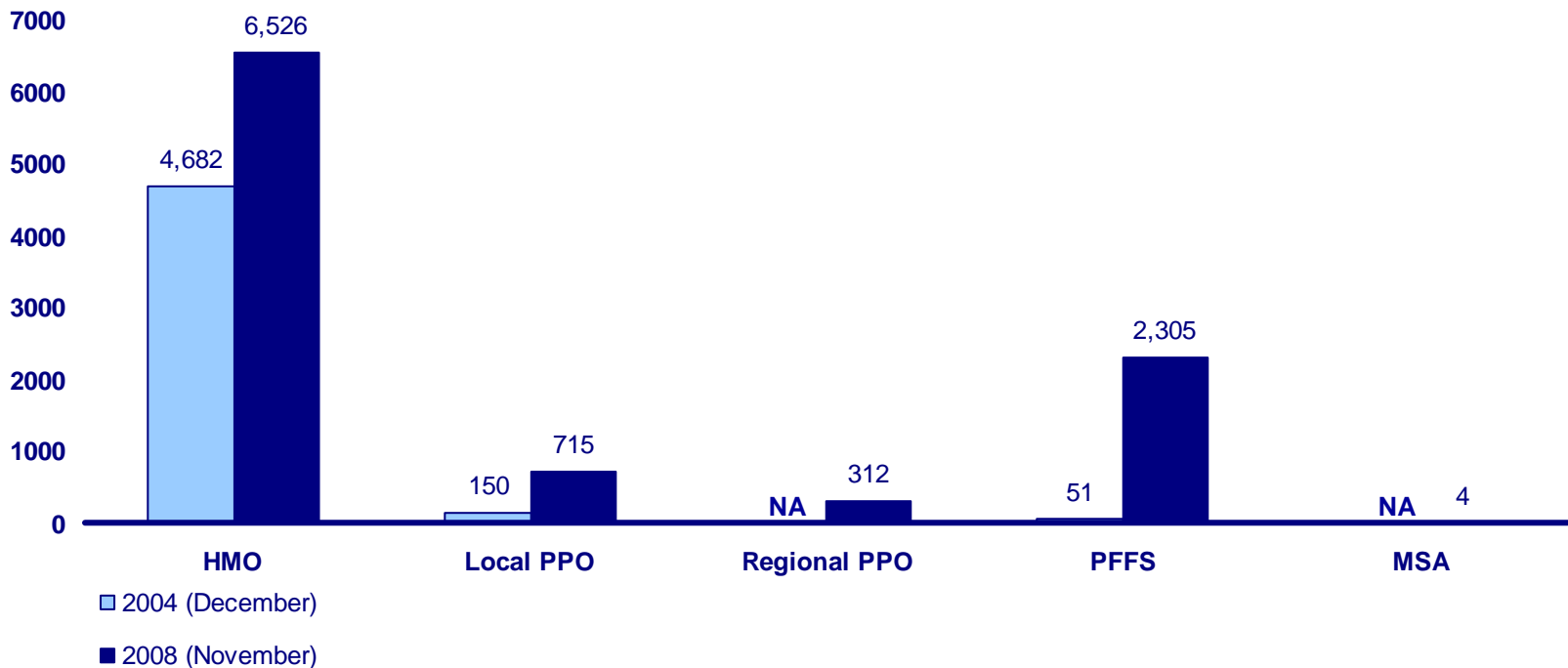
Source: Medicare Payment Advisory Commission (MedPAC).

Note: Excludes SNPs and employer-only plans.

NA = not available in given year.

Enrollment in Medicare Advantage by Plan Type, 2004 and 2008

Enrollment in thousands



Source: GAO analysis of CMS data and analysis of CMS data by Mathematica Policy Research, Inc. for The Henry J. Kaiser Family Foundation.
 Note: Enrollment rounded to the nearest thousand. Local PPO includes provider-sponsored organizations, which had 28,434 enrollees in 2004 and 19,428 enrollees in 2008.

NA = not available in given year.

How Medicare Pays an MA Plan

- Payment is per beneficiary, per month
- Plan's "bid" and Medicare's "benchmark" determine:
 - Medicare's base payments to the plan
 - Beneficiaries' plan premium
 - Extent of extra benefits
- Payments adjusted for beneficiary health status

Benchmarks

- Maximum base payment rate for each county
- Updated annually
- For 2009, range from \$741 to \$1,366
- Equal or exceed fee-for-service (FFS) spending
- Reflect legacy of previous payment systems

How Medicare Sets MA Plan Base Payment

- Each plan submits a bid reflecting its expected monthly cost of providing Part A and Part B benefits
- If plan bid is below the benchmark:
 - Base payment equals bid plus 75% of difference between bid and benchmark
 - Beneficiary receives extra benefits in the form of additional covered items and services, reduced premiums and/or reduced cost sharing
- If plan bid equals or exceeds the benchmark:
 - Base payment is set at benchmark
 - Beneficiary pays excess as plan premium

Hypothetical Examples of Bid-to-Benchmark Comparisons

FFS Spending	\$720	
Benchmark	\$800	
	Plan A	Plan B
Plan bid	\$700	\$840
“Savings” (amount below benchmark)	100	0
Plan rebate = 75% of “savings”	75	0
Medicare base payment	775	800
Beneficiary plan premium	0	40
Extra benefits to beneficiary	75	0

Source: GAO

Note: All numbers are standardized to represent a beneficiary of average health status. Dollar amounts are calculated per member per month.

MA Benchmarks and Payments Relative to FFS by Plan Type, 2008

Plan Type	Benchmark relative to FFS expenditures	Bids relative to FFS expenditures	Payments for MA beneficiaries relative to FFS expenditures
All MA Plans	118%	101%	113%
HMO	117	99	112
Local PPO	122	108	119
Regional PPO	115	103	112
PFFS	120	108	117

Source: MedPAC Analysis of CMS data.

Note: Data for all MA Plans include Puerto Rico.

Allocation of Average Per Member Per Month (PMPM) Projected Rebate by MA Plans, 2007

Average PMPM rebate	\$87.44
Amount of rebate allocated to	
Additional benefits	9.95
Part D premium reduction	14.70
Part B premium reduction	2.29
Cost-sharing reduction	60.51

Source: GAO analysis of CMS data.

Note: This analysis included the 1,874 plans that received a rebate and included HMOs, PFFS plans, PPOs, and PSOs.

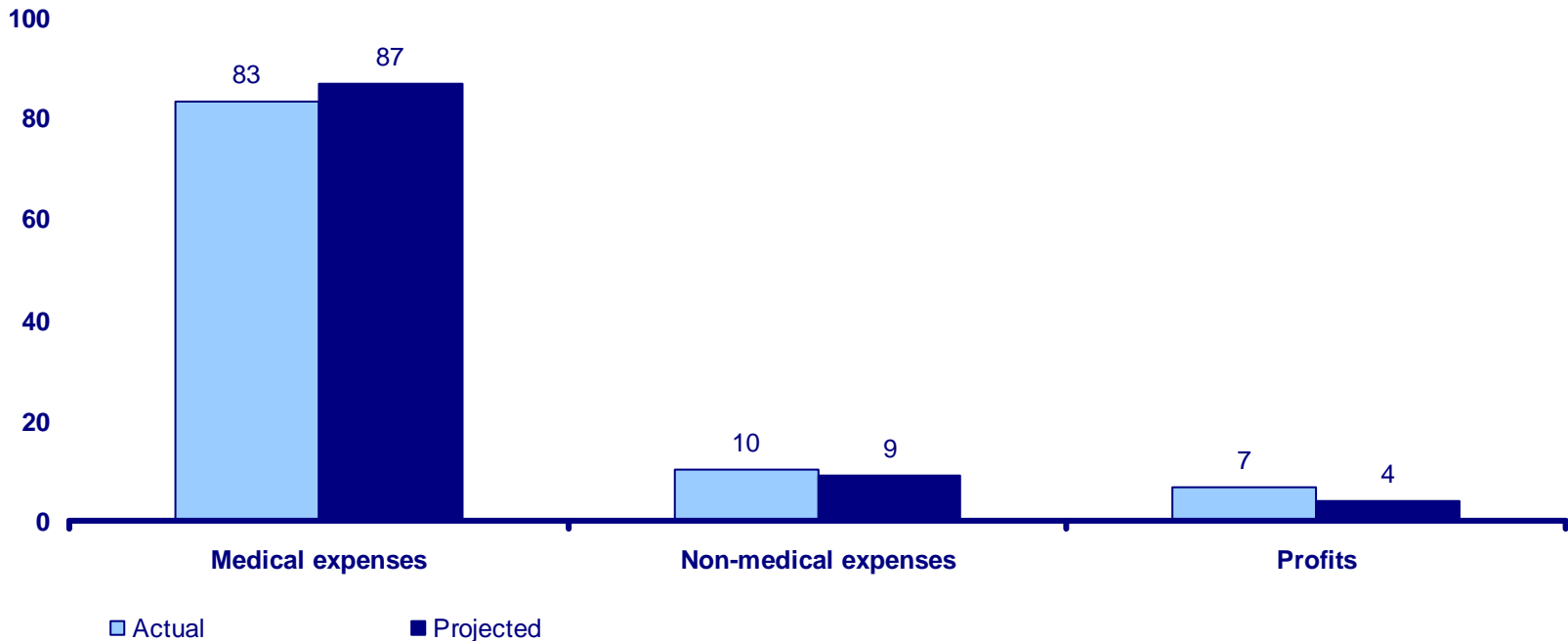
MA Plan Projected Cost Sharing Relative to Medicare FFS, 2007

- On average, beneficiaries in MA plans had projected cost sharing that was 42 percent of projected cost sharing in Medicare FFS (\$49 PMPM vs. \$116 PMPM).
- In some MA plans, cost sharing is higher than Medicare FFS cost sharing for some categories of service, such as inpatient, home health, and skilled nursing facility services.
- About half of beneficiaries were enrolled in MA plans that had beneficiary out-of-pocket maximums.

Source: GAO analysis of CMS data.

Actual and Projected Expenses and Profits as Percentages of Revenue, 2006

Percentage of revenue



Source: CMS

Note: Profits are an MA organizations' remaining revenue after medical and non-medical expenses are paid and may include certain revenue offsets, such as income taxes, not categorized as non-medical expenses.