



## Medicare Advantage Update: Benefits, Enrollment, and Payments After the ACA

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**OVERVIEW** — *In 2012, the Medicare program paid private health plans \$136 billion to cover about 13 million beneficiaries who received Part A and B benefits through the Medicare Advantage (MA) program rather than traditional fee-for-service (FFS) Medicare. Private plans have been a part of the program since the 1970s. Debate about the policy goals—Should they cost less per beneficiary than FFS Medicare? Should they be available to all beneficiaries? Should they be able to offer additional benefits?—has long accompanied Medicare’s private plan option. This debate is reflected in the history of Medicare payment policy, and policy decisions over the years have affected plans’ willingness to participate and beneficiaries’ enrollment at different periods of the program. Recently, evidence that the Medicare program was paying more per beneficiary in MA relative to what would have been spent under FFS Medicare prompted policymakers to reduce MA payments in the Patient Protection and Affordable Care Act of 2010 (ACA). So far, plans continue to participate in MA and enrollment continues to grow, but payment reductions in 2012 through 2014 have been partially offset by payments made to plans through the quality bonus payment demonstration. This brief contains recent data on plan enrollment, availability, and benefits and discusses MA plan payment policy, including changes to MA payment made in the ACA and their actual and projected effects.*

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Medicare beneficiaries can receive their Medicare Part A and B benefits through private health plans that participate in the Medicare Advantage (MA) program rather than traditional fee-for-service (FFS) Medicare.<sup>1</sup> MA plans can be health maintenance organizations (HMOs), preferred provider organizations (PPOs), or private fee-for-service (PFFS) plans. Except for PFFS plans, MA plans are required to provide an option that includes Medicare Part D, which covers prescription drugs. The program divides plans into two categories—local plans and regional plans—for the purpose of setting payment rates and program requirements. Local plans define their own service areas; may serve one or more counties; and can be HMOs, local PPOs, or PFFS plans.<sup>2</sup> Regional plans must serve the entirety of at least one of 26 geographic regions of the United States (which are the size of an entire state, at minimum) and must be PPOs. Regional PPOs are available to all beneficiaries that reside in the region served, and plans must ensure that all enrollees in the region have appropriate access to care.<sup>3</sup>

**CURRENT ENROLLMENT AND PLAN AVAILABILITY**

In 2013, 14.4 million Medicare beneficiaries (28 percent of all beneficiaries) are enrolled in a Medicare Advantage plan. This is a historically high number and share of beneficiaries enrolled in Medicare private plans.<sup>4</sup> Enrollment in 2013 reflects an increase of 1 million beneficiaries over 2012's enrollment. Most of the enrollment continues to be in HMOs, which accounted for 65 percent of all MA enrollment in 2013 (Figure 1).<sup>5</sup>

In 2013, nearly all Medicare beneficiaries lived in an area with an MA plan; only 0.4 percent did not.<sup>6</sup> Ninety-five percent of all beneficiaries have an HMO or local PPO offering a plan in their county (Figure 2). Due to plan withdrawals, availability of regional PPOs is down, with 71 percent of beneficiaries having access in 2013, compared with 76

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percent in 2012. Access to PFFS plans continues to decline: 59 percent of beneficiaries had access in 2013. Beneficiaries could choose from an average of 12 plans in 2013, which is the same average number of plan choices as the two previous years.<sup>7</sup> The number of available plans varies by geography, with beneficiaries in Miami and other areas of Florida, New York City, and some areas of Pennsylvania having access to as many as 40 MA plans in 2013.<sup>8</sup>

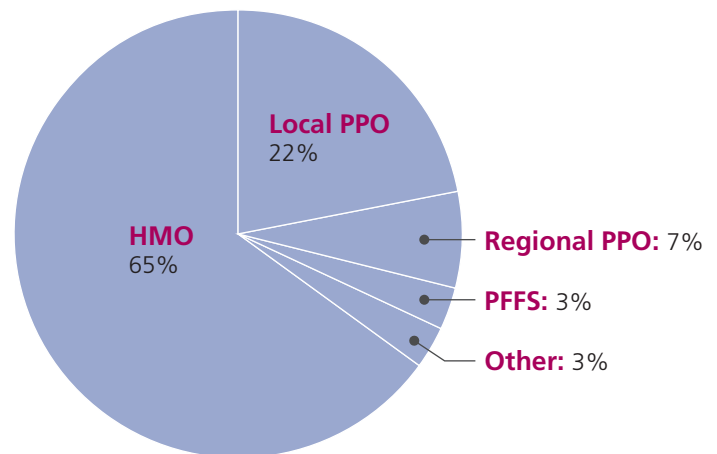
## BENEFITS

Beneficiaries may choose to enroll in an MA plan instead of traditional FFS Medicare for a number of reasons, such as a preference for managed care, the convenience of having a single plan cover all Medicare benefits, or a cap on out-of-pocket spending. Under the current payment system, some MA plans may offer reduced cost sharing or benefits beyond the traditional Part A and B benefit package, which can also be attractive to beneficiaries.<sup>9</sup>

Beginning in 2011, MA plans were required to have a per-beneficiary out-of-pocket spending cap of \$6,700 per year, with a recommended limit of \$3,400 or less, set by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the MA program. In 2013, 46 percent of HMO enrollees had out-of-pocket limits at or below the recommended \$3,400 limit.<sup>10</sup> In 2013, the average out-of-pocket spending limit for MA enrollees is \$4,317 and the median is \$3,900.<sup>11</sup> Out-of-pocket spending limits vary across plans and plan types, and HMOs have, on average, the lowest out-of-pocket limits. Plans have increased out-of-pocket limits since they were first required in 2011, with the largest increases in regional and local PPOs.<sup>12</sup>

In 2013, 98 percent of beneficiaries have access to a Medicare Advantage plan with zero premiums, other than the Part B premium, and prescription drug coverage.<sup>13</sup> Fifty-five percent of MA plan enrollees were enrolled in such zero-premium plans in 2013.<sup>14</sup> The share of beneficiaries in zero-premium plans varies by plan type. Two-thirds of HMO enrollees, almost half of regional PPO enrollees, one-quarter of local PPO enrollees, and 17 percent of PFFS enrollees

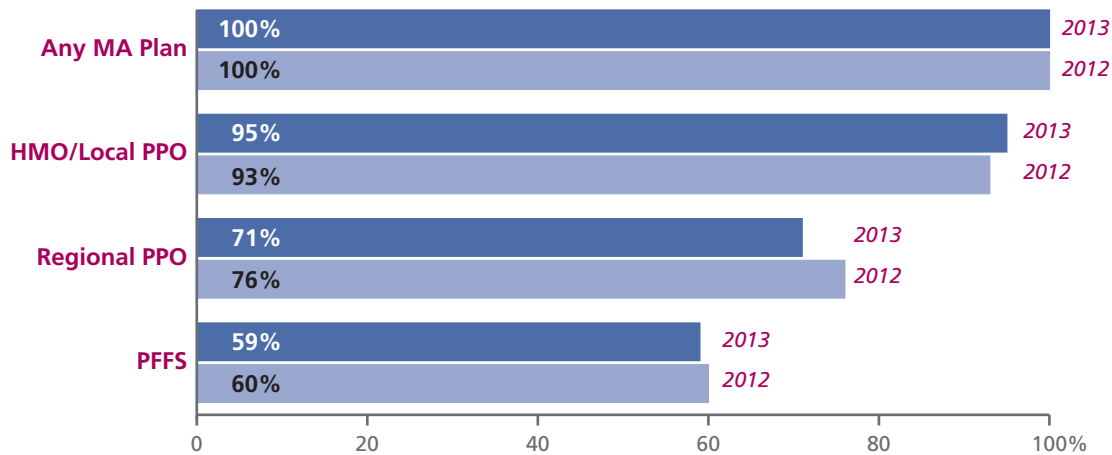
**Figure 1: Medicare Advantage Enrollment, by Plan Type, 2013**



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

Source: Marsha Gold et al., "Medicare Advantage 2013 Spotlight: Enrollment Market Update," *The Henry J. Kaiser Family Foundation*, June 2013, p. 2, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8448.pdf>.

**Figure 2: Availability of MA Plans and Plan Types, 2012 and 2013**



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

Source: Medicare Payment Advisory Commission (MedPAC), “The Medicare Advantage Program: Status Report,” chap. 13 of Report to the Congress: Medicare Payment Policy, March 2013, p. 294, available at [www.medpac.gov/chapters/Mar13\\_Ch13.pdf](http://www.medpac.gov/chapters/Mar13_Ch13.pdf).

are in zero-premium plans in 2013.<sup>15</sup> Among beneficiaries who paid a premium for an MA plan that offered prescription drugs, the average monthly premium across all plan types was \$78.18 in 2013.<sup>16</sup>

MA plans can also cover some portion of beneficiaries’ costs in Medicare’s drug benefit coverage gap, commonly called the “donut hole.” About half of all MA enrollees have a plan that provides some additional coverage in the donut hole, and about 28 percent have brand drug coverage in the donut hole.<sup>17</sup> Coverage in the donut hole varies by plan type, with HMOs and PFFS plans more likely to provide coverage and regional PPOs less likely to provide coverage.<sup>18</sup> The ACA gradually eliminates the coverage gap until it is gone in 2020.

### MA PAYMENTS

CMS pays private plans a monthly, risk-adjusted capitated amount to cover all Medicare Part A and B services, except for hospice benefits, for enrolled beneficiaries. Medicare’s base payment rates (pre-risk adjustment) to MA plans are determined by how each plan’s bid compares to a benchmark amount, which is the maximum amount that Medicare will pay to cover Part A and B services. For local plans, the applicable benchmark is the county-level benchmark

amount, calculated as described in more detail below. For regional PPOs, the applicable benchmark is a combination of the county-level benchmarks in the region plus enrollment-weighted regional plans' bids (described below).<sup>19</sup>

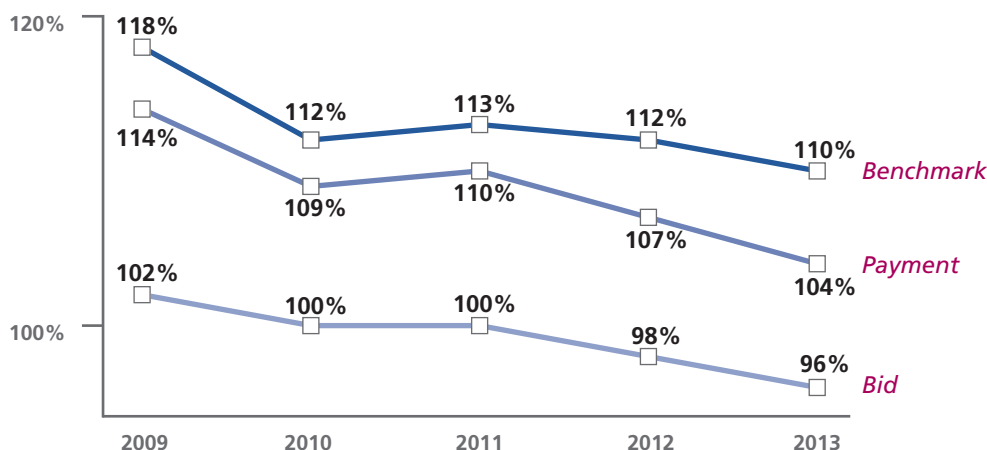
The ACA established the statutory formula for setting county benchmarks, starting in 2012. By 2017, county benchmarks will be 95 percent of the county FFS costs per enrollee in counties in the top quartile of FFS costs; 100 percent of county FFS cost per enrollee in counties in the second highest quartile of FFS costs; 107.5 percent of FFS cost per enrollee in counties in the second lowest quartile of FFS costs; and 115 percent of county FFS cost per enrollee in the lowest quartile of FFS costs.<sup>20</sup> Plan payments determined using the ACA-mandated benchmarks are being phased in by blending them with payments determined under the old benchmark system (described below) starting in 2012. The duration of the phase-in period depends on the size of the change in the county payment rate; larger changes will be phased in over longer periods of time. Some low FFS-spending counties will be fully under the new system in 2013, whereas counties with the greatest differences in payments between the two methods will be phased in through 2016. The ACA also contained a provision to vary each plan's benchmark based on a plan's rating in the MA plan quality measurement system; plans that have higher quality ratings have "bonus amounts" applied to their benchmarks.<sup>21</sup>

To determine the Medicare program's base payment rate to an MA plan, a plan's bid to provide service in a county or region is compared with the applicable benchmark described above. Plans submit bids to CMS in the amount of the monthly cost per enrollee to cover Part A and B services for an average beneficiary, plus administrative costs and profit for the upcoming plan year.<sup>22</sup> Medicare pays plans that bid above the benchmark the benchmark amount, and enrollees in that plan must pay an extra monthly premium (in addition to the Part B premium, which remains the beneficiaries' responsibility in MA) in the amount of the difference between the bid and the benchmark. Plans whose bids equal the benchmark receive the benchmark amount as Medicare payment. Plans that bid below the benchmark receive the plan bid as payment. The difference between the benchmark and the bid is then shared between the plan and the Medicare program. The plan must return its share (called the rebate) to beneficiaries as reduced premiums or cost sharing, or additional benefits. The ACA reduced the plan rebates from 75 percent of the difference

to a share that varies based on plans' quality ratings. Plans with the highest quality ratings (4.5 stars or higher in a 5-star system) receive a 70 percent rebate, plans with 3.5 to 4.5 stars receive a 65 percent rebate, and plans with fewer than 3.5 stars get a 50 percent rebate.<sup>23</sup> This change is phased in between 2012 and 2015.

The ACA changed the formula for determining county benchmarks as first introduced in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the legislation that established the Medicare Advantage program. Prior to implementation of the ACA, benchmarks were based on county-level payment rates that had been used to set plan payments before the benchmark system was implemented in 2006.<sup>24</sup> These rates were *at least* 100 percent of per capita FFS spending in each county. In some counties, the rates were much higher because of earlier legislation that set floor payment rates in counties with lower per-capita FFS spending to encourage plan growth in these primarily rural counties.<sup>25</sup> As a result of the MMA's formula for determining benchmarks and year-to-year rate updates, the Medicare program paid more for beneficiaries in private plans than it would have if they were in traditional FFS Medicare. The Medicare Payment Advisory Commission (MedPAC) calculated that the payments were, on average, 109 percent of Medicare FFS spending in 2010, and benchmarks were 112 percent of Medicare FFS spending (Figure 3).<sup>26</sup> As the ACA benchmark formula has been partially phased in, benchmarks in 2013 were, on average, 110 percent of

**Figure 3: Average MA Benchmarks, Payments, and Bids for All Plan Types as a Share of Estimated FFS Medicare Spending, 2009-2013**



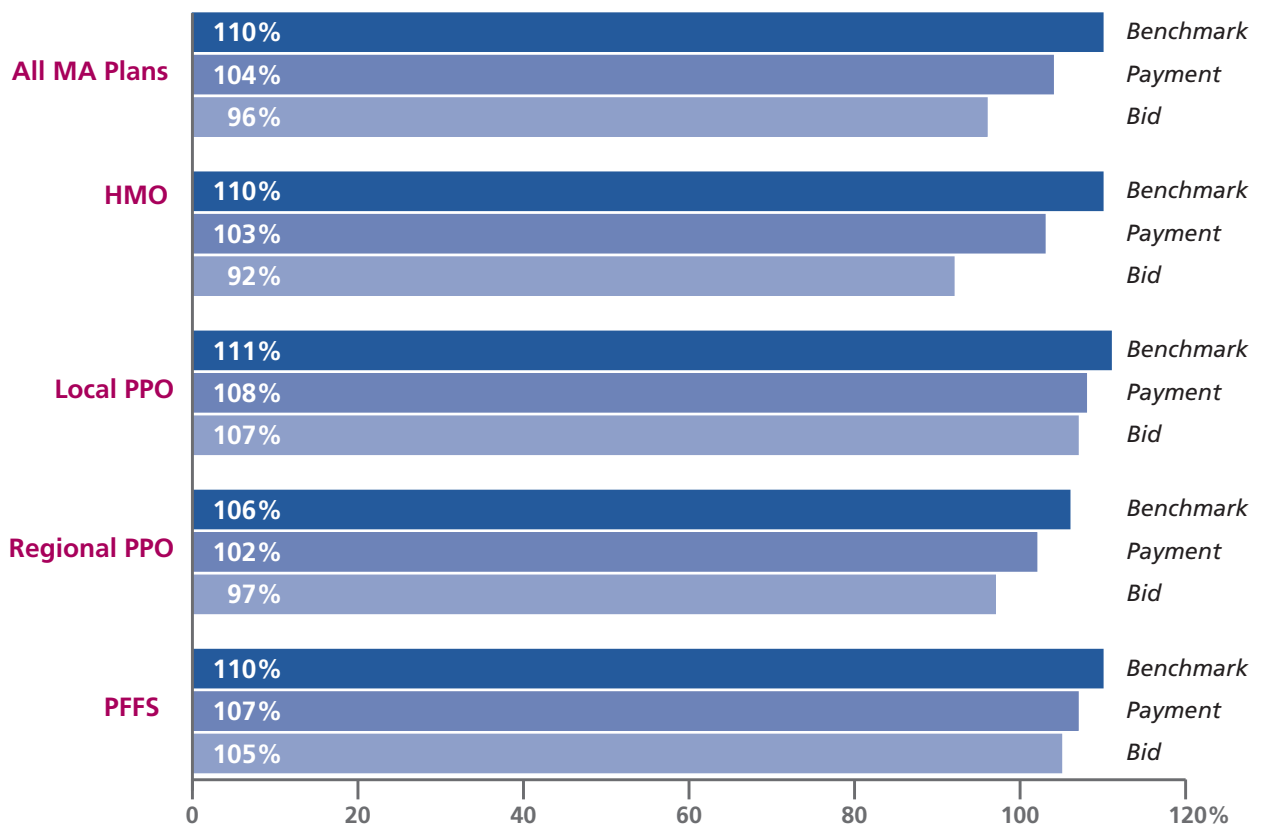
*Note: The numbers are projections for each year, based on bids and FFS spending estimates that were made the previous year. Estimates assume that the risk-adjustment system is adequately adjusting payments for actual differences in MA plans' risk scores.*

*Source: Medicare Payment Advisory Commission, March reports, 2009–2013.*

the Medicare FFS spending and payments were 104 percent of Medicare FFS spending, or about \$6 billion more than the program would have paid to cover the same beneficiaries in FFS Medicare.<sup>27</sup>

Payments and bids vary by type of plan. On average, HMOs have the lowest bids of all MA plan types, at 92 percent of FFS spending in 2013 (Figure 4).<sup>28</sup> In 2013, HMOs and regional PPOs bid below FFS spending and were paid, on average, 103 percent (HMOs) and 102 percent (regional PPOs) of Medicare FFS payment.<sup>29</sup> Averaging 107

**Figure 4: Average MA Benchmarks, Payments, and Bids as a Share of Estimated FFS Medicare Spending, by Plan Types, 2013**



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

The numbers are projections based on bids and FFS spending estimates that were made the previous year. Estimates assume that the risk-adjustment system is adequately adjusting payments for actual differences in MA plans' risk scores.

Source: MedPAC, "The Medicare Advantage Program: Status Report," chap. 13 of Report to the Congress: Medicare Payment Policy, March 2013, p. 294, available at [www.medpac.gov/chapters/Mar13\\_Ch13.pdf](http://www.medpac.gov/chapters/Mar13_Ch13.pdf).

percent of FFS Medicare, local PPO bids continue to be above FFS Medicare spending in 2013 and their payments averaged 108 percent of Medicare.<sup>30</sup> These averages are reductions for local PPOs since 2012, when bids averaged 108 percent of FFS Medicare spending and payments averaged 113 percent of FFS Medicare spending.<sup>31</sup>

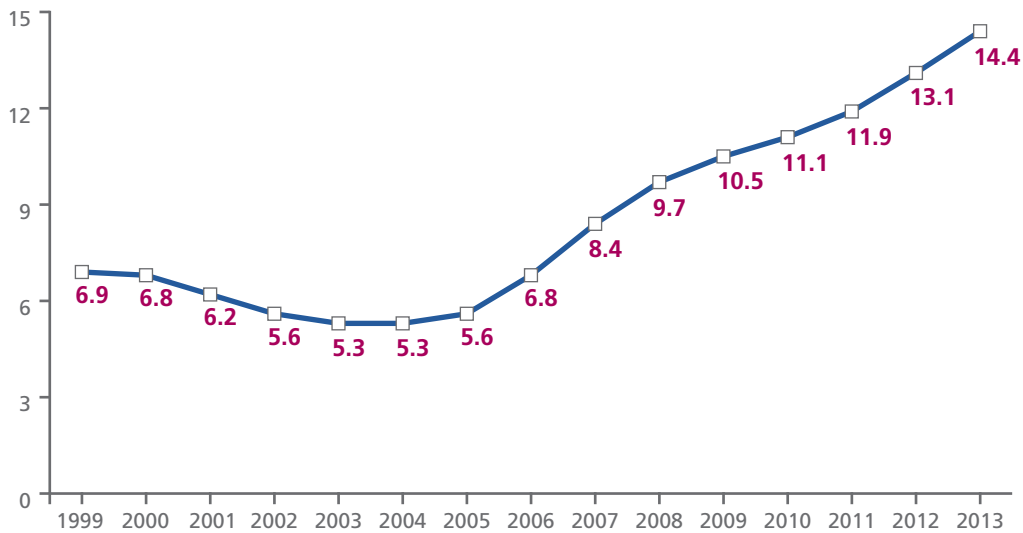
### PROJECTED EFFECTS OF THE ACA

The ACA's reductions to payments have begun to be implemented and plans continue to participate in MA. In 2013, more Medicare beneficiaries were enrolled in a private plan than ever before. Interpreting continued plan participation and growing enrollment in the wake of the ACA payment changes is complicated by a controversial \$8.35 billion quality bonus demonstration that CMS implemented instead of the more modest and targeted quality bonus payment program specified in the ACA. As a result of this demonstration, more than one-third of the ACA's projected reductions to MA payments from 2012 through 2014 were offset, negating a significant portion of the savings expected when the ACA was passed.<sup>32</sup>

In light of evidence on the initial effects of ACA payment changes and enrollment trends, recent government reports project some MA enrollment growth into the near future, but long-term effects are less clear. In its May budget projections, the Congressional Budget Office (CBO) estimated that enrollment in MA and other group health plans will grow each year in the next decade, from 14 million in 2013 to 21 million in 2023.<sup>33</sup> In the annual Medicare Trustees' report, also released in May 2013, the CMS actuaries projected that enrollment will grow through 2014, when the share of Medicare beneficiaries in private plans is expected to peak at 28.8 percent.<sup>34</sup> This projection is a change from earlier years and is the result of higher MA rebates resulting from "relatively low bid trends for 2013 as compared to per capita growth in Medicare FFS."<sup>35</sup> Enrollment is then expected to decrease in 2015 through 2018, when the share of Medicare beneficiaries is expected to reach its low of 23.3 percent. The reduction is attributed to changes the ACA made to the benchmarks and rebates to plans. CMS actuaries then project that enrollment in MA plans will increase each year beginning in 2019 due to the growth in the Medicare population.

Taken together, current plan participation levels and future enrollment projections have allayed some immediate concerns that ACA



**Figure 5: Medicare Private Health Plan Enrollment (in Millions), 1999-2013**

Source: Marsha Gold et al., "Medicare Advantage 2013 Spotlight: Enrollment Market Update," The Henry J. Kaiser Family Foundation, June 2013, p. 2, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8448.pdf>.

payment changes would lead to widespread MA plan withdrawals in a repeat of plan terminations and concomitant declines in enrollment in the period between the passage of the Balanced Budget Act of 1997, which lowered plan payments, and the MMA, which significantly increased the payment rates in an effort to increase the number of beneficiaries enrolled in private plans (Figure 5).<sup>36</sup>

## LOOKING AHEAD

How MA plans will respond to ACA payment changes is a story that is still developing and will be closely watched. Enrollment projections will be revised as additional data become available. As the full ACA payment reductions are phased in over the next several years, plans could become more efficient and continue to participate in the program. Alternatively, plans could withdraw from the program, enrollment could stagnate or decline, or plans could reduce benefits or shift more costs to beneficiaries.<sup>37</sup> Should plans withdraw from the program and beneficiaries lose coverage, policymakers may act to reform the MA payment system as they have in the past. However, any future MA payment policy changes will likely be made in the context of concerns about overall Medicare spending and spending

growth, which could lead policymakers to look for ways to preserve a private plan option for beneficiaries while also seeking greater efficiency in the MA program.

## ENDNOTES

1. This brief contains some material originally included in the Forum Session Announcement for “Getting the Price Right: Ensuring Access and Promoting Efficiency in Medicare Advantage,” a National Health Policy Forum meeting held on May 17, 2013, available at [www.nhpf.org/library/details.cfm/2925](http://www.nhpf.org/library/details.cfm/2925).
2. For additional detail about the different types of MA plans, see Medicare Payment Advisory Commission (MedPAC), “The Medicare Advantage Program: Status Report,” chap. 13 of *Report to the Congress: Medicare Payment Policy*, March 2013, p. 291, available at [www.medpac.gov/chapters/Mar13\\_Ch13.pdf](http://www.medpac.gov/chapters/Mar13_Ch13.pdf).
3. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 31, 2013, p. 161, available at <http://downloads.cms.gov/files/TR2013.pdf>.
4. Marsha Gold *et al.*, “Medicare Advantage 2013 Spotlight: Enrollment Market Update,” The Henry J. Kaiser Family Foundation, June 2013, p. 2, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8448.pdf>.
5. Gold *et al.*, “Medicare Advantage 2013 Spotlight: Enrollment Market Update,” p. 2.
6. MedPAC, “The Medicare Advantage Program: Status Report,” p. 294.
7. MedPAC, “The Medicare Advantage Program: Status Report,” p. 294.
8. MedPAC, “The Medicare Advantage Program: Status Report,” p. 294.
9. Depending on their MA plan, some beneficiaries may pay additional premiums for additional benefits.
10. Gold *et al.*, “Medicare Advantage 2013 Spotlight: Enrollment Market Update,” p. 12.
11. Gold *et al.*, “Medicare Advantage 2013 Spotlight: Enrollment Market Update,” p. 12.
12. Gold *et al.*, “Medicare Advantage 2013 Spotlight: Enrollment Market Update,” p. 12.
13. Gold *et al.*, “Medicare Advantage 2013 Spotlight: Enrollment Market Update,” p. 7.
14. Gold *et al.*, “Medicare Advantage 2013 Spotlight: Enrollment Market Update,” p. 7.

15. Gold *et al.*, "Medicare Advantage 2013 Spotlight: Enrollment Market Update," p. 7.
16. Gold *et al.*, "Medicare Advantage 2013 Spotlight: Enrollment Market Update," p. 11.
17. Gold *et al.*, "Medicare Advantage 2013 Spotlight: Enrollment Market Update," p. 13.
18. Gold *et al.*, "Medicare Advantage 2013 Spotlight: Enrollment Market Update," p. 13.
19. MedPAC, "The Medicare Advantage Program Payment System," Payment Basics, October 2012, available at [www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_MA.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_MA.pdf).
20. Kaiser Family Foundation, "Explaining Health Reform: Key Changes in the Medicare Advantage Program," May 2010, p. 2, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8071.pdf>.
21. MedPAC, "The Medicare Advantage Program Payment System," October 2012.
22. Payments for Part D drug benefits offered by MA plans are determined in a separate process. For a summary of Part D payments see MedPAC, "Part D Payment System," Payment Basics, October 2012, available at [www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_PartD.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_PartD.pdf).
23. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2013 Annual Report*, p. 163.
24. Carlos Zarabozo and Scott Harrison, "Payment Policy and the Growth of Medicare Advantage," *Health Affairs*, 28, no.1 (January/February 2009):w55-w67, available at <http://content.healthaffairs.org/content/28/1/w55.full>.
25. Zarabozo and Harrison, "Payment Policy and the Growth of Medicare Advantage," p. w61.
26. MedPAC, "The Medicare Advantage Program: Status Report," chap. 12 of *Report to the Congress: Medicare Payment Policy*, March 2011, p. 293, available at [www.medpac.gov/chapters/Mar11\\_Ch12.pdf](http://www.medpac.gov/chapters/Mar11_Ch12.pdf).
27. This figure includes payments to plans from the quality bonus payment demonstration.
28. MedPAC, "The Medicare Advantage Program: Status Report," March 2013, p. 295.
29. MedPAC, "The Medicare Advantage Program: Status Report," March 2013, p. 295.
30. MedPAC, "The Medicare Advantage Program: Status Report," March 2013, p. 295.
31. MedPAC, "Medicare Advantage," section 9 of *A Data Book: Health Care Spending and the Medicare Program*, June 2012, p. 146, available at [www.medpac.gov/chapters/Jun12DataBookSec9.pdf](http://www.medpac.gov/chapters/Jun12DataBookSec9.pdf).

32. James Cosgrove, "Opportunities to Improve Medicare Advantage Payment Policies," presentation for the National Health Policy Forum meeting, "Getting the Price Right: Ensuring Access and Promoting Efficiency in Medicare Advantage," May 17, 2013, p. 15, available at [www.nhpf.org/uploads/Handouts/Cosgrove-slides\\_05-17-13.pdf](http://www.nhpf.org/uploads/Handouts/Cosgrove-slides_05-17-13.pdf).
33. Congressional Budget Office, "CBO's May 2013 Medicare Baseline," May 14, 2013, p. 2, available at [www.cbo.gov/sites/default/files/cbofiles/attachments/44205\\_Medicare\\_0.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205_Medicare_0.pdf).
34. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2013 Annual Report*, p. 166.
35. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2013 Annual Report*, p. 167.
36. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2013 Annual Report*, p. 161.
37. Gretchen Jacobson, Patricia Neuman and Jennifer Huang, "Projecting Medicare Advantage Enrollment: Expect the Unexpected?" June 12, 2013, available at <http://kff.org/medicare/perspective/projecting-medicare-advantage-enrollment-expect-the-unexpected/>.