Medicare Advantage: History, Current Status and Future Expectations

May 17, 2013

Presentation to the National Health Policy Forum Meeting: “Getting the Price Right: Ensuring Access and Promoting Efficiency in Medicare Advantage”

Reserve Officers Association, Washington, DC

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Under the MMA, Medicare Advantage (MA) grew rapidly and is now larger than ever (28% penetration)

Despite restrictions in MIPPA and payment cuts under the ACA, MA enrollment continues to grow in all payment quartiles

ACA’s payment changes provide more incentive to manage and become more efficient—if plans don’t game or circumvent them

Evolving budget policy may ultimately have more effect than the ACA on Medicare—and MA
Since 2006, MA Enrollment Has Growth Rapidly

In millions

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<thead>
<tr>
<th>Year</th>
<th>Percent of Medicare Beneficiaries</th>
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<td>2013</td>
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Note: Includes cost and demonstration plans, and enrollees in SNPs as well as other MA plans.

Share of Medicare Beneficiaries Enrolled in MA Plans, by State, 2013

Note: Includes cost and demonstration plans, and enrollees in SNPs as well as other MA plans.

MA Enrollment, by Plan Type, 2013

Total MA enrollment, 2013 = 14.4 million

Note: PFFS is private fee-for-service plans, PPOs are preferred provider organizations, and HMOs are health maintenance organizations. “Other” covers cost and demonstration plans, including enrollees in SNPs as well as other MA plans.

MA Markets

- Individual coverage (no subsidized supplement)
- Groups: retiree plans
- SNPs (particularly for dual eligibles)
- Presentation focuses mainly on “plain vanilla individual MA,” in which most enrollment is concentrated
Medicare has 30+ years experience with such plans, including:

- 1970s cost contract “work around”
- 1982 Medicare risk (HMO) program
- 1997 Medicare+Choice (BBA): more choice and payment reform
- 2003 MA: more choice and higher payments (2006 Part D)
- 2009 MIPPA: more requirements for new choices
- 2010 ACA: tighter payments, quality bonus
Recent Critical Influences on the Market, Pre-ACA

- Network requirements for (most) PFFS plans (2011)
  - Some shrinkage in firms participating (starting in 2010)
  - Others hedged their bets: network PFFS (opt out) plus new coordinated care plans

- SNP requirements tightened

- CMS reviewed bids to eliminate low enrollment or nondistinct plans and to encourage greater financial protection for heavy users
ACA Provisions with Direct Effects on MA

- 2011 rate freeze with 2012+ phase in of changes to shrink overpayments over time (by 2017)
  - Counties divided into four FFS cost quartiles for payment purposes
  - After phase in, benchmark will range from 95% of traditional Medicare (highest cost quartile) to 115% of traditional Medicare (lowest cost counties)
  - Quality ratings (stars) effect bonuses, rebates more prominent under CMS demonstration

- Medical loss ratio (85%+) starting in 2014

- Traditional Medicare benefits improved (donut hole, preventive services)
Most Medicare Beneficiaries Have Access to MA Plans

Share of Medicare beneficiaries with access to one or more MA plans, by plan type, and urban/rural county, 2013

Note: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). The total includes cost and MSA plans, which are not shown separately. Plans in the territories are included in the total, but not in the urban/rural categories.

Payment Levels Are Important to Firms’ Ability to Provide Attractive Benefits

- Firms develop benefit packages taking into account payments and expected costs by county.

- Appeal of benefit package influenced by payment level, since there is little evidence that most plan types are more efficient than Medicare.

- Limited payment growth under M+C led to benefit reductions and disruptive plan withdrawals but context a bit different now.

- Since the mid 1980s, out of pocket cost sharing has grown well beyond original “nominal” levels (risk to beneficiaries), though CMS tries to limit ability to discriminate against the sick.
MedPAC analysis, all plan bids 2009
- Benchmarks were 118 percent of plan bids
- MA payments were 114 percent of plan bids
- Average plan bid was 102% of traditional program; only HMOs were below traditional Medicare on average

On average, $3 PMPM more to MA than if the patient were in traditional Medicare, or $1.30 subsidy per $1 of enhanced benefits
MA-PD Plan Bid Costs to Medicare FFS Costs, by Geographic Area, Cost Quartiles, High to Low, 2009

Notes:  FFS = fee-for-service; HMO = health maintenance organization; LPPO = local preferred provider organization; PFFS = private fee-for-service.

Source: Mathematica analysis of publicly available MA data under a grant from the Commonwealth Fund.
Most Medicare Beneficiaries & MA Enrollees Live in Higher Cost Counties

Note: Includes cost and demonstration plans, and enrollees in SNPs as well as other MA plans. Numbers may not sum to 100% due to rounding.

Little Change in Enrollee Distribution by County Cost Quartile, 2011–2013

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<tr>
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<th>2011 Enrollment</th>
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### MA Enrollment and Penetration Rates in HMOs and Other Plan Types, by Counties’ Costs, 2011-2013

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A Few Large Firms/Affiliates Dominate MA Enrollment

Total MA enrollment in 2013 was 14.4 million

United Healthcare 21%

Humana 17%

BCBS 17%

Aetna 4%

Kaiser Permanente 8%

All others 26%

Other national insurers 7%

Other includes firms with less than 3% of total enrollment. BCBS are Blue Cross/Blue Shield affiliates and include Wellpoint BCBS plans that make up 4% of all enrollment (558,833 enrollees) in MA plans; approximately 47,000 beneficiaries are enrolled in other Wellpoint plans. Other national insurers includes 1,228,443 enrollees across the following firms: Cigna (438,252), Coventry (305,584), Wellcare (252,563), Universal American (127,340), Munich American Holding Corporation (57,697), and Wellpoint non-BCBS plans (47,007).

Firms Vary in Their Market Coverage

**Percent of Medicare beneficiaries with one or more MA plans available from particular firms, 2013**

- **Humana**: 81%
- **BCBS Affiliates**: 74%
- **United Healthcare**: 70%
- **Aetna**: 30%
- **Universal American**: 27%
- **Wellcare**: 25%
- **Coventry**: 17%
- **Kaiser Permanente**: 16%
- **Cigna**: 17%

Note: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Cigna includes plans offered by Healthspring.

Market Share, Top Three Firms by State, 2013

Weighted Average Monthly Premiums for MA-PD Plans, Total and by Plan Type, 2010-2013

Note: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes only MA plans that offer Part D benefits. The total includes cost plans (not shown separately). The premiums for a subset of sanctioned plans were not available in 2011. These plans were excluded from this analysis.

MA-PD Enrollees’ Out-of-Pocket Limits, by Plan Type, 2011-2013

Note: Excludes employer group health plans, SNPs, and MA plans that do not offer prescription drug coverage. Percentages may not sum to 100% due to rounding.

Looking to the Future

- Greater market concentration among leading firms (national and local)
- More pressure for good care management but also to game or circumvent rules (coding, politics)
- Cost sharing will continue to grow (subject to OOP limit, any discrimination rules)
- Low premiums still a factor behind enrollment, though market may segment
- Broader Medicare pressures/politics will influence how market evolves
For More Information

- Contact: MGold@Mathematica-MPR.com or 202-484-4227

- Links to available analyses
  - www.mathematica-mpr.com (Search Publications, Gold, Health-Medicare)
  - www.Kaiser Family Foundation.org (MA Spotlights, MA Tracker)
  - www.healthaffairs.org (November 24, 2010, articles on MA by Gold and others)