Medicare @50

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MEDICARE AT 50

Medicare Advantage Plans

The Medicare Advantage (MA) program provides the opportunity for Medicare beneficiaries to purchase health insurance coverage from private plans rather than through the traditional fee-for-service (FFS) Medicare program. According to the Centers for Medicare and Medicaid Services (CMS), more than 16 million Medicare beneficiaries (about 30 percent of beneficiaries) are currently enrolled in MA plans. MA plans offer the potential for improved quality of care at lower costs, but whether that potential is met depends on how plans are paid and how plans manage care.

Benefits available under MA plans can exceed those available under traditional Medicare, but coverage for non-network providers may be limited.

MA plans must offer all of the services covered by the traditional Medicare program (except hospice care), and depending on the plan, potentially offer lower premiums or extra benefits, such as vision, hearing, dental, and wellness programs. In contrast to traditional Medicare plans, MA plans have some flexibility on how to structure cost-sharing requirements—very few use the traditional program's cost-sharing structure. In addition, all MA plans must provide an annual cost-sharing limit, thereby providing catastrophic protection not available through the traditional program.

MA plans are generally combined with prescription drug (PD) coverage to form MA-PD plans. Beneficiaries may find it more convenient to purchase an MA-PD plan rather than to enroll separately in traditional Medicare plus a stand-alone prescription drug plan and/or Medicare supplemental coverage (e.g., Medigap).

Additional Resources

MEDICARE AT 50:
Who are the beneficiaries?
http://actuary.org/files/Medicareat50_Beneficiaries_0715.pdf

MEDICARE AT 50:
Is it sustainable for 50 more years?
http://actuary.org/files/Medicareat50_Sustainability_0715.pdf

MEDICARE AT 50:
Does it meet the needs of the beneficiaries?
http://actuary.org/files/Medicareat50_Benefits_0715.pdf

MEDICARE'S FINANCIAL CONDITION:
Beyond Actuarial Balance
http://actuary.org/files/Medicare_Trustees_2014_FINAL_073114.pdf

ESSENTIAL ELEMENTS
Medicare's Long-Term Sustainability Challenge
http://actuary.org/filesEE-MedicareSustainabilityChallenge.pdf

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Whereas beneficiaries choosing FFS Medicare can receive care from any provider that accepts Medicare, MA plan enrollees are limited to the plan's network of providers. Outside the network, an MA plan enrollee could pay more, or even all, of the costs.

MA plans are paid a per-beneficiary rate based on a plan's bid to CMS.

MA plans submit bids to CMS that reflect the revenue required to provide the same benefits that are available in the FFS program. Plan bids are compared to payment benchmarks that are calculated according to a formula established by law and are tied to costs under the FFS program plus any applicable bonuses based on a plan's quality rating (i.e., star rating). If an MA plan's bid exceeds the benchmark, beneficiaries choosing that plan must pay an additional premium. If an MA plan's bid falls below the benchmark, a portion of the difference is paid to the plan in the form of a rebate, and plans with higher quality ratings are allowed to retain a larger share. Plans must use the rebates to reduce premiums, reduce cost sharing, and/or fund benefits in addition to those provided by traditional Medicare. MA plans may choose to offer, at an extra premium, more in benefits than are funded by the rebates.

Payments to MA plans exceed FFS spending for similar beneficiaries, but the difference is narrowing.

Prior to the passage of the Affordable Care Act (ACA), benchmarks for MA plans were often set much higher than what spending would be for similar FFS beneficiaries. For instance, the Medicare Payment Advisory Commission (MedPAC) estimated that payments to MA plans (including rebates) in 2010 were 109 percent of what spending for these beneficiaries would have been in the FFS program. Under the ACA, however, MA benchmarks are transitioning to more closely reflect FFS spending. As a result, MedPAC estimated that payments to MA plans in 2015 are 102 percent of FFS spending. This difference is likely understated, however. Actual payments to MA plans are adjusted to reflect the risk profile of MA enrollees. Evidence suggests that MA plan coding practices result in MA plan beneficiaries having higher risk scores than otherwise similar FFS beneficiaries.[1] Although CMS adjusts MA payments downward to reflect this higher coding intensity, MedPAC analysis has concluded that, based on 2013 data, the adjustments have not been large enough to fully capture the difference.

Paying MA plans more than what beneficiaries would cost in the FFS program is an important issue in light of Medicare's financial challenges. For instance, in their 2015 report, the Medicare trustees estimated that the Hospital Insurance (HI) trust fund will be depleted by 2030. Because enrollment in MA plans continues to grow, the trustees increased projected MA participation rates in the 2015 report relative to the 2014 report and noted that this assumption change added to Medicare's estimated actuarial deficit.

MA provider practice patterns, however, appear to have a spillover effect by bringing cost-effective improvements to FFS practice patterns. As a result, hospital spending in the FFS program is reduced in communities where MA penetration is significant.[2] These spillover effects offset a portion of the higher payments to MA plans.

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1 See chapter 13 of the *MedPAC Report to the Congress: Medicare Payment Policy*. March 2015.

2 See Katherine Baicker, Michael Chernew, and Jacob Robbins, "The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization," *Journal of Health Economics*, 32(6): 1289-1300. December 2013.

About this series

In the *Medicare at 50* series, the American Academy of Actuaries explores various aspects of the Medicare program and potential implications for future policymaking. Together, these papers provide a comprehensive overview of the current status of the Medicare program and of issues that should be considered when making future changes.

MA plans can vary in provider payment arrangements and care management activities.

Compared to traditional Medicare, private plans have more flexibility to implement care management tools and payment and delivery system changes. MA plans are paid on a capitated basis, but plans use a variety of methods to pay health care providers. Some plans pay providers on a fee-for-service basis, which like much of the payments present in the traditional Medicare program can encourage more care, but not necessarily higher-quality care. Plans that directly employ providers or pay capitated rates have the potential to better manage care and contain costs than plans using fee-for-service provider payment structures.

Compared to other types of MA plans, health maintenance organizations (HMOs) are more often structured to employ providers directly or to pay capitated rates. HMOs may also have narrower provider networks and focus on coordinating and managing care. As a result, HMO plans average the lowest bids among MA plans.[3] Preferred provider organizations (PPOs) are less likely than HMOs to pay capitated rates. However they can use other payment tools to manage care, such as bundled payments and accountable-care arrangements.

MA plan quality is improving and for some measures exceeds that of traditional Medicare.

In recent years, especially since the passage of the ACA, setting quality standards and rewarding plans that achieve them has become a major focus of the MA program. There is variation across plans but in general, MA plan quality has improved over time. Although progress has been made, quality differences between MA plans and the FFS program remain very difficult to measure due to, among other reasons, a lack of consistent quality reporting across both systems. However, recent evidence suggests that MA plans can outperform FFS on certain quality metrics, in particular preventive service utilization.[4] MA plans can also contribute to a reduction in racial disparities in health care utilization.[5]

MA plans have greater potential in high-cost areas.

MA plans appear to be especially effective in geographic areas with relatively high health care spending—MedPAC finds that MA plan bids are lower as a share of FFS spending in areas with relatively high FFS spending. This is likely because there is more opportunity to lower costs through better care management. It has been more difficult for MA plans to lower costs in areas that already have lower relative spending. In addition, it has been difficult for MA plans to develop provider networks in rural areas. Increasing payments to MA plans in certain areas in order to boost private plan participation, as was the case prior to the enactment of the ACA, could add to Medicare's financial challenges.

MA plans offer the potential for improved quality of care at lower costs.

Moving away from fee-for-service payment systems is considered by many as necessary for achieving a more sustainable health system focused on the value and efficiency of care rather than on the volume of care. MA plans, which offer beneficiaries an alternative to traditional FFS Medicare, can help facilitate a move in this direction. MA plans can provide care that is more managed and better coordinated, potentially improving the quality of care while also reducing the costs, especially in high-cost areas. However, achieving this goal depends on how MA plans are structured and how they are paid. Managed care plans that move away from FFS payment structures have greater opportunity to improve quality and reduce costs compared to plans that are only loosely managed and continue to pay providers based on fee for service. On the other hand, maintaining MA plan payments that are more than what beneficiaries cost under traditional FFS Medicare continues as one source of financial strain on the Medicare program.

3 The March 2015 *MedPAC Report to the Congress: Medicare Payment Policy* reported that the projected average 2015 bid for HMO MA plans is 90 percent of FFS spending, compared with 107 percent for local PPOs, 97 percent for regional PPOs, and 108 percent for private fee-for-service plans.

4 Marcia Gold and Giselle Casillas, "What Do We Know About Health Care Access and Quality in Medicare Advantage Versus the Traditional Medicare Program?" The Kaiser Family Foundation, November 2014.

5 Joseph P. Newhouse and Thomas G. McGuire, "How Successful Is Medicare Advantage?" *The Milbank Quarterly* 92(2):351-94. June 2014.