Medicare’s Private Plans: A Report Card On Medicare Advantage

MA has brought much more choice but also added complexity, higher costs, no apparent quality gains, and uneven benefits.

by Marsha Gold

ABSTRACT: With higher payments and expanded private-plan authority, Medicare Advantage (MA) has caused the market to grow. One in three Medicare beneficiaries with Part D now gets this coverage through MA. Analysis of the sources of and reasons for enrollment growth suggest a troubling report card. Clearly, the Medicare Modernization Act (MMA) has expanded choice and the private-sector role. But it also has added to Medicare’s complexity and costs and has created potential inequities, without apparent improvements in quality. However the debate ends, a stronger system of performance monitoring and accountability is needed to meet Medicare’s essential fiduciary requirements and oversight responsibilities. [Health Affairs 28, no. 1 (2009): w41–w54 (published online 24 November 2008; 10.1377/hlthaff.28.1.w41)]

With the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Congress sought to expand the role of Medicare’s private health plans through Medicare Advantage (MA).¹ In this paper I review the available evidence, to assess the outcomes of these provisions.

Such analysis is vital, particularly when perspectives on private plans reflect ideological differences within Congress about what Medicare is and should be.² The current Bush administration and Republicans in Congress believe that private-sector competition and expanding health plan choice will benefit Medicare in the long run, whatever its current costs. By contrast, Democrats view private-sector insurers mainly as a source of potential delivery innovation, useful only if they improve care and reduce, or at least not increase, Medicare costs. Republicans won important concessions from Democrats in MMA, but the Democrats countered when the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 modified MA, capturing savings needed to stop mandated re-

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ductions in Medicare’s physician fees. As the baby-boom generation swells Medicare rolls and health care costs continue to rise rapidly, the debate over MA will continue when a new administration and Congress take office.

This analysis builds on more than ten years of work by my colleagues and me in analyzing the role of private plans in Medicare. We documented the failure of the Balanced Budget Act (BBA) of 1997 to increase the role of private plans through Medicare+Choice (M+C); we found that slow growth in plan payments and the challenges in establishing managed care in rural and other areas were major barriers to expansion. In analyzing MMA, we found changes that might alter past experience, particularly the support for increased MA payments and the simultaneous addition of Part D pharmacy benefits under a private-plan model.

Our analysis of MA’s early experience documented the initial effects of these changes, including an enhanced role for private plans in Medicare through growth of private fee-for-service (PFFS) plans, rather than expansion of coordinated care via regional preferred provider organizations (RPPOs), as MMA intended.

This paper delves more deeply into the current growth in MA choice and enrollment, from MMA’s enactment in late 2003 through mid-2008. I identify the sources of enrollment growth and explore the reasons why growth has been concentrated in particular sectors, especially in PFFS plans bought by individuals and retiree groups, and in Special Needs Plans (SNPs). I assess the effects of these trends and their implications for Medicare.

Study Data And Methods

This analysis relied on both quantitative and qualitative data. The former consists of files created at the contract-county level from publicly available data on MA contracts and enrollment (the Centers for Medicare and Medicaid Services’ [CMS’s] Monthly State-Contract-County file, supplemented with other information). The analysis of MA plan benefits and premiums used a file developed with publicly available data from the CMS’s Medicare Options Compare, used to support beneficiary choice. The research team also conducted telephone discussions with nineteen MA plan sponsors between mid-February and early May 2008. These firms have a total MA enrollment of more than 3.5 million; they are diverse and include seven with national or near-national scope, six with a large local base, and six with a specialized policy interest.

Study Findings

■ Expansion of choice nationwide. As documented elsewhere, MA plans are now widely available nationwide as a result of MMA, including in rural areas, where such choice previously was limited. By 2008 all beneficiaries, whether in urban or rural areas, had multiple MA choices, including plans offered under multiple PFFS contracts, one or more medical savings account (MSA) contracts, and, for 87 percent, at least one RPPO contract.
Although choice has increased in rural areas, residents of those areas still have limited local coordinated care plans (CCPs) available. These network-based plans serve defined aggregations of counties. They include health maintenance organizations (HMOs), for which authority has existed since the 1980s, and local preferred provider organizations (PPOs) and others authorized by the BBA. Although HMO and PPO structures can blur, the former generally are more tightly managed and require that beneficiaries receive care from network-based providers, except for emergencies. PPOs also use networks, but they allow enrollees to go out of network for an additional cost. Historically, support for a private-plan option in Medicare sought to use the network structure, especially in HMOs, to improve quality and care coordination beyond what was regarded as feasible in traditional Medicare.

Establishing network-based plans in rural areas was challenging in the past and remains so, despite MMA. Neither form of CCP is widely available to most rural beneficiaries. In 2008 only 17 percent of them live in counties with three or more local CCP contracts; market penetration in rural counties is only 3.6 percent—not much higher than the 2.4 percent in 1999. In addition, there are no local CCPs in four states (Alaska, New Hampshire, North Dakota, and Vermont), and no HMOs in South Dakota. About half of all rural CCP enrollment is concentrated in thirteen contracts and their distinctive service areas.12

CCPs struggle in rural areas for relatively intractable reasons. In our 2008 discussions, firms said that CCPs were feasible in some rural areas but unlikely in others, where low population density, small numbers of providers, and provider resistance to MA contracting limit financial feasibility. Even where CCPs are feasible, the business opportunities do not necessarily make CCP expansion a high priority. These barriers are unlikely to change over time.

Growth in MA enrollment and market share. Despite some challenges, MA enrollment has grown rapidly under MMA, with 2006 enrollment surpassing the previous high under M+C (Exhibit 1). By mid-2008, 23 percent of Medicare beneficiaries were enrolled in MA or another private plan (for example, cost contracts). Among those selecting a Part D plan for the Medicare prescription drug benefit, 32 percent chose an MA plan rather than a freestanding prescription drug plan (PDP).

MA's growth has been uneven since MMA was enacted in late 2003 (Exhibit 2). PFFS, which is precluded by statute from restricting providers’ care, accounts for 48 percent of the net increase in MA enrollment, a third of this through groups purchasing benefits for their retirees. SNPs account for 24 percent of growth, mostly in HMOs, whose regular enrollment contributed another 15 percent to growth over the period. There are more local PPOs than prior to MMA, but their enrollment remains limited, contributing only 11 percent to MA's growth since 2003; RPPOs contributed even less (6 percent).

The unanticipated emergence of PFFS. Since MMA’s enactment, sponsors’ interest in PFFS options has exploded. Eleven firms offered a PFFS plan in 2006,
EXHIBIT 1
Medicare Private-Plan Enrollment, By Contract Type, Selected Years 1999–2008

<table>
<thead>
<tr>
<th>Year</th>
<th>HMO</th>
<th>PPO/PSO</th>
<th>PFFS</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2005</td>
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<tr>
<td>2006</td>
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</tr>
<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Millions

source: Centers for Medicare and Medicaid Services (CMS) Monthly Summary Report, various years (December), and June 2008.

notes: Totals exclude “pilots.” Health maintenance organization (HMO) counts for 2003 and 2005 include a few enrollees in preferred provider organizations (PPOs) or provider-sponsored organizations (PSOs). “Other” includes Medicare 1876 Cost Plans, 1833 Cost Plans (HCPPs), Program of All-Inclusive Care for the Elderly (PACE), and demonstrations. HMO enrollment increased in 2008 as the CMS reclassified several demonstrations as HMO-SNPs (Special Needs Plans). PFFS is private fee-for-service.

EXHIBIT 2
Estimated Sources Of Growth In Private-Plan Enrollment Under The Medicare Prescription Drug, Improvement, And Modernization Act (MMA), By Plan Type, Year-End 2003–Mid-2008

<table>
<thead>
<tr>
<th>Plan type</th>
<th>M+C enrollment, December 2003</th>
<th>MA enrollment, June 2008</th>
<th>Difference</th>
<th>Contribution to net growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5,324,101</td>
<td>9,982,907†</td>
<td>4,658,806</td>
<td>100</td>
</tr>
<tr>
<td>Local CCP</td>
<td>4,701,254</td>
<td>7,068,824</td>
<td>2,367,570</td>
<td>50</td>
</tr>
<tr>
<td>SNP</td>
<td>0</td>
<td>1,112,745</td>
<td>1,112,745</td>
<td>24</td>
</tr>
<tr>
<td>Regular CCP</td>
<td>4,701,254</td>
<td>5,956,030</td>
<td>1,254,776</td>
<td>27</td>
</tr>
<tr>
<td>HMO</td>
<td>4,659,957</td>
<td>5,351,734†</td>
<td>691,777†</td>
<td>15</td>
</tr>
<tr>
<td>PPO/POS</td>
<td>81,297</td>
<td>604,296†</td>
<td>522,999†</td>
<td>11</td>
</tr>
<tr>
<td>PFFS</td>
<td>25,897</td>
<td>2,263,271</td>
<td>2,237,374</td>
<td>48</td>
</tr>
<tr>
<td>Group</td>
<td>0</td>
<td>600,543</td>
<td>600,543</td>
<td>13</td>
</tr>
<tr>
<td>Individual</td>
<td>25,897</td>
<td>1,662,728</td>
<td>1,636,831</td>
<td>35</td>
</tr>
<tr>
<td>Regional PPO</td>
<td>0</td>
<td>282,821†</td>
<td>282,821</td>
<td>6.1</td>
</tr>
<tr>
<td>MSA</td>
<td>0</td>
<td>3,529</td>
<td>3,529</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Cost</td>
<td>334,378</td>
<td>271,788</td>
<td>-62,590</td>
<td>-1.3</td>
</tr>
<tr>
<td>Other</td>
<td>262,572</td>
<td>92,674</td>
<td>-169,898</td>
<td>-3.6</td>
</tr>
</tbody>
</table>


notes: Cost and “other” plans are other prepaid contracts authorized outside the Medicare Advantage (MA) program. Excludes beneficiaries in pilots (n = 80,934). M+C is Medicare+Choice. CCP is coordinated care plan. SNP is Special Needs Plan. HMO is health maintenance organization. PPO is preferred provider organization. PSO is provider-sponsored organization. PFFS is private fee-for-service. MSA is medical savings account.

†Consists of 1,740,080 group ("800 series") enrollees and 1,189,165 SNP enrollees.

‡Includes the PPO demonstration and five small PPO contracts.

§Includes selected social HMOs classified as “other” in 2003 with about 100,000 enrollees. Also includes about 56,000 enrollees in Kaiser who previously were in regular MA.

‖Includes 1,054,928 enrollees in group plans; most long-standing. HMO and PPO enrollment do not add precisely to CCP totals because CMS data for regular MA and SNP in June 2008 are not fully consistent with one another.

©Assumes 95 percent of the local CCP SNP enrollment is in HMOs, as in 2007. Regular HMO enrollment excludes 1,057,108 SNP enrollees and 55,637 local PPO enrollees in SNPs to avoid double counting.

†Includes 74,148 SNP enrollees and 6,608 group enrollees.
twenty-seven firms in 2007, and almost fifty in 2008. PFFS plans place no restrictions on the providers that a Medicare beneficiary can use, although providers may limit their willingness to see PFFS enrollees. PFFS contracts often have broad service areas. Universal America, Coventry, and Humana, for example, have PFFS plans available to 97 percent, 84 percent, and 82 percent, respectively, of beneficiaries nationwide. In 2008, 82 percent of beneficiaries had PFFS plans available from six or more sponsors, up from 52 percent in 2007. PFFS sponsors tend to be publicly traded companies whose growth and financial objectives must satisfy investors, to whom they report regularly.

Discussions with firms indicate that PFFS has been an attractive option for firms seeking to take advantage of the large Medicare market opened up by MMA. Starting up PFFS has not, so far, required large investments to develop networks and provider contracts. Firms instead pay providers Medicare rates and “deem” them as participating each time they see a Medicare member. PFFS’s indemnity structure is familiar to independent insurance agents, who now play a larger role in marketing MA plans. Because of where they draw enrollment, payments in PFFS are particularly high relative to traditional Medicare (117 percent of per capita FFS costs versus 112 percent for HMOs in 2008).

Originally developed for the individual market, PFFS increasingly is attracting interest from employer and other groups covering retirees. Group enrollment has long existed in MA but previously was used mainly to allow retirees to stay with HMOs in which they had been enrolled during their working years. In contrast, the recent growth in MA group enrollment comes from PFFS plans used by employers as total or near-total replacements for existing retiree coverage for Medicare beneficiaries.

MA firms explained that PFFS is well suited for group retirees with Medicare because the absence of a network allows coverage regardless of where retirees live or travel. Cost and accounting pressures in an environment of rising health care costs make PFFS increasingly attractive to such purchasers. Public purchasers (state and local governments), required to account prospectively for retiree health insurance costs starting in late 2006, find PFFS particularly attractive. Whether PFFS can maintain this advantage in 2010, when MIPPA’s network requirements come into play, remains to be seen.

We also were told that groups with retiree coverage also are attracted to MA by the administrative simplicity of MA’s integrated product that combines Medicare with Medicare supplemental benefits, allowing submission of a single bill. Some employers converting to MA for retirees use it to replace all of their retirees’ coverage, whereas others maintain a separate prescription drug plan, allowing them to receive MMA’s employer subsidy (also known as the retiree drug subsidy). Some consultants also are encouraging employers to shift to defined-contribution health savings accounts (HSAs) as a replacement for group coverage and to make individual-market MA plans available to retirees for purchase. (Such MA en-
rollees count as individual rather than group enrollees.) Because group conversion shifts a large number of beneficiaries at once, a shift of only a few employers can have a major influence on MA enrollment.

Because payments have been high relative to traditional Medicare payments, employers appear able to substitute MA for their current offerings, generate savings, and still retain the same level of retiree benefits, at least in the short term. Employers seeking to purchase such a plan have multiple outlets, since most PFFS contracts have an approved group plan (75 percent in 2007). Group plans typically have a nationwide service area and structure benefits to match MA payment levels. Employers then contract with MA sponsors to customize the generic CMS-approved group plan by augmenting coverage and defining how costs are shared between sponsor and group enrollee. Under current MMA payment policy, Medicare pays more for each group retiree converted to MA than it does under traditional Medicare.

CCPs have limited ability to compete for the group business when it involves geographically dispersed retirees. Although the CMS has indicated that it will be more flexible in reviewing network adequacy outside of the CCP service area for group plans beginning in 2009, this could change with MIPPA's more restricted PFFS provider access standards.

Limited expansion in coordinated care. Although there are more coordinated care contracts now than formerly, CCP enrollment appears to be growing relatively slowly. Although HMOs still dominate MA, with 70 percent of enrollment, HMOs had 84 percent before MMA was enacted; the HMO enrollment level in 2008 is no higher than in 1999, the previous high (see Exhibit 1). Well-established HMOs said that they have been able to retain their current enrollees but are finding it challenging to attract new ones, particularly those not aging into MA from former group coverage. Large established HMOs described a more crowded marketplace, with increasing competition from low-cost PFFS plans with fewer requirements, such as Health Care Effectiveness and Information Set (HEDIS) quality reporting and network adequacy requirements.

MA sponsors’ views on the current MA market appear consistent with our analysis comparing characteristics of lowest-premium MA prescription drug (MA-PD) plans of different types, weighted by enrollment to reflect beneficiary choice (Exhibit 3). In 2008, HMOs’ mean monthly premium was lower than those of other plan types ($18 per month, 64 percent with no premium). HMOs were less likely to have an annual limit on out-of-pocket spending for hospital and physician services, but their enrollees, on average, could still expect spending for such services to be lower than in other plan types, even if they have extensive needs. However, PFFS plans with zero premiums also are common and are attracting a disproportionate share of the PFFS market. Low apparent cost and potential flexibility to see any provider (often without awareness of the uncertainty about whether a particular provider will treat them) probably explains this.
with PFFS plans say that they have experienced only limited problems with provider access; others disagree, and evidence is limited. PFFS’s benefit design appears more competitive, on average, than that of PPOs, especially RPPO plans.

There are many more PFFS plans than HMOs or other CCPs, so HMOs say that it is difficult to distinguish themselves in the marketplace (Exhibit 4). Half of all Medicare beneficiaries have at least twenty-seven PFFS plans available, many more than for other plan types. In many counties, no local CCPs are available, although there are many PFFS plans.

Some PFFS sponsors say that they include care management as part of their products, typically using programs directed at enrollees without involving physi-
EXHIBIT 4
Number Of Medicare Advantage (MA) Plans Offered To Beneficiaries, By Type (Distribution By County And Beneficiary), 2008

<table>
<thead>
<tr>
<th>Distribution of beneficiaries</th>
<th>All MA (excluding SNPs)</th>
<th>Local PPOs</th>
<th>RPPOs</th>
<th>PFFS</th>
<th>MSA</th>
<th>SNPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean number available per beneficiary</td>
<td>44</td>
<td>10</td>
<td>3</td>
<td>2</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>First percentile</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>5th percentile</td>
<td>23</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>10th percentile</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>25th percentile</td>
<td>34</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>50th percentile (median)</td>
<td>43</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>75th percentile</td>
<td>53</td>
<td>15</td>
<td>4</td>
<td>3</td>
<td>36</td>
<td>1</td>
</tr>
<tr>
<td>90th percentile</td>
<td>64</td>
<td>24</td>
<td>8</td>
<td>4</td>
<td>42</td>
<td>1</td>
</tr>
<tr>
<td>Maximum</td>
<td>87</td>
<td>48</td>
<td>18</td>
<td>4</td>
<td>55</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distribution of counties</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean number available per county</td>
<td>35</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>First percentile</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>10th percentile</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>25th percentile</td>
<td>26</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>50th percentile (median)</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>75th percentile</td>
<td>41</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>34</td>
<td>1</td>
</tr>
<tr>
<td>90th percentile</td>
<td>49</td>
<td>10</td>
<td>5</td>
<td>4</td>
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<td>1</td>
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<tr>
<td>Maximum</td>
<td>87</td>
<td>48</td>
<td>18</td>
<td>4</td>
<td>55</td>
<td>2</td>
</tr>
</tbody>
</table>

NOTES: Beneficiary counts used for weights are for June 2008, Group (“800 series”) plans are excluded. The absolute minimum number of plans is omitted because it likely reflects problems linking a few counties to plans and beneficiaries. Separate distributions of plans across beneficiaries and counties were independently developed for each plan type (column). Thus, the row totals are not the sum of their columns. The distinction reflects variation in the locations of different types of plans. SNP is Special Needs Plan. HMO is health maintenance organization. PPO is preferred provider organization. RPPO is regional PPO. PFFS is private fee-for-service. MSA is medical savings account.

PFFS was designed to minimize interference with medical practice. Current PFFS enrollees, particularly in individual plans, are spread over broad geographical areas and can seek care from any provider who will see them; providers decide this on a per visit and per patient basis. Whatever sponsors’ aims, this environment does not favor care coordination and quality enhancement.

Little evidence to date of transition from PFFS to PPOs. One possibility is that PFFS will offer a temporary transition to more managed alternatives, such as PPOs, which have networks but still provide out-of-network access (for a price). MIPPA’s network requirements for PFFS in 2010 build on this assumption, but current experience highlights the challenges.

Current MA sponsors universally said that they could not envision RPPOs (with uniform regional rates and benefits) ever being competitive in a marketplace that included local plans, which set rates county by county; they feared that
RPPOs would be too attractive to beneficiaries in lower-payment areas and lack appeal in higher-payment areas, dooming their financial viability. Consistent with firms’ reports, RPPO offerings have remained largely stagnant since 2006 and have not attracted many enrollees.

The long-term viability of local PPOs remains unclear. Most MA firms said that they theoretically favored more coordinated care and were expanding their PPO offerings, particularly where they had a PFFS or commercial CCP presence. Whether firms are able to overcome historical barriers to generating broadly available network-based options remains to be seen. Although the 2009 MA application process was already well under way when MIPPA was enacted (so 2010 will be the first year reflecting the new legislation), some were already anticipating changes of the type included in MIPPA. Based on our conversations, we expect that the number of local PPOs will increase in 2009, perhaps substantially.

Regardless of availability, current experience suggests that firms likely will be challenged in moving enrollees from PFFS to other MA products. Most firms say that they do not now actively encourage enrollees to make the transition from less managed to more managed care products. Instead, they view the MA market as comprising various beneficiary subgroups (or “segments”), each with unique preferences. They aim to expand enrollment by offering a range of products attractive to these diverse segments. The effects of MIPPA on this marketplace are unknown, but the Congressional Budget Office (CBO) projected that the legislation would curb growth in MA enrollment.27

Uncertain potential for SNPs. Historically, Medicare has required private plans to enroll any beneficiary residing in their service areas, but MMA modified this rule for SNPs serving dual eligibles, institutionalized beneficiaries, or those with severe chronic or disabling conditions.28 The intent was to support specialization to improve care quality and better coordinate with Medicaid to serve particularly vulnerable Medicare subgroups.

In mid-2008 there were 1.1 million enrollees in SNPs—mainly in HMOs, where they constituted 19 percent of individual enrollment. More than 500,000 of these were not necessarily new to the MA sponsor but were previously served through Medicaid plans or as part of Medicare demonstration plans. It is uncertain whether SNPs will grow substantially now that this automatic source of enrollment is less relevant. There were 769 SNPs as of June 2008, but many had low enrollment (more than 38 percent had fewer than 100 enrollees). An SNP most commonly is offered alongside a general MA plan of the same type, although a few firms specialize in SNPs only. Each SNP type has its own plan(s). In 2008, 73 percent of HMO contracts had at least one SNP plan, with SNPs for dual eligibles being the most common (72 percent of SNP enrollment in June 2008).

Although SNPs potentially can improve care to vulnerable beneficiaries, it is not clear that most initial plans were so structured, leading Congress to prohibit SNP expansion in 2009, pending further study. In our discussions, some firms de-
scribed specialized care management within their SNPs, but most did not or used SNPs only to identify high-risk individuals early, so that they could be channeled into existing care management programs.

Most viewed the SNP’s main value less for care delivery than as a way to develop plans with targeted benefit packages to attract and better meet the needs of beneficiary subgroups. For example, a relevant drug might be covered with less out-of-pocket expense, home visits could be allowed, or hearing aids covered; benefits could be designed to complement state Medicaid benefits for dual eligibles.

Given the way Medicare sets MA rates, any SNP savings are targeted to the eligible subgroup, rather than to all enrollees, as in regular MA. SNPs also help firms distinguish their plans in a crowded marketplace. SNPs rely on the “risk adjustment” procedures that the CMS recently phased in as part of MA rate setting. Firms said that they support this risk-adjustment process and that it has made SNPs financially feasible for them. SNPs place added burden on the accuracy of risk adjustment, however, because health care costs are skewed and spending varies within and across risk categories.

Our discussions also confirm what others have found about the variability in whether SNPs for dual eligibles actively coordinate with their respective state Medicaid programs. SNP sponsors said that some states are reluctant to change the way they interact with Medicare. Others said that they designed their dual-eligible SNP benefits to avoid the need to coordinate with states.

MIPPA extends SNP authority through 2010, adding care management requirements and specific new requirements for each plan type. It also lifts the ban on new or expanded SNPs that meet certain requirements. Operationally, the effects will be felt in 2010, and the new requirements are likely to make it harder for plans to qualify for or retain SNP designation.

A complex marketplace. Under MMA, both firms and beneficiaries find MA challenging to navigate. Firms, particularly those with prior program experience, see MA as much more complex after MMA. We heard that “not a day goes by that we don’t get another piece of guidance from [the] CMS.” Complexity is viewed as coming as much from Part D and its associated low-income subsidy (LIS) as it does from MA authority. Under Part D, sponsors must submit separate bids for each plan they offer, and those bids must segregate Parts A and B costs (MA only) from Part D (prescription drug) costs. Many firms offer separate MA-only and MA-PD plans to attract diverse beneficiaries. The LIS adds its own administrative requirements and beneficiary protections. Such complexity adds to firm costs and probably absorbs funds that otherwise could be spent on benefits.

The choices resulting from MMA are at least as demanding for beneficiaries as for MA firms. In 2008, beneficiaries had at least thirty-eight freestanding PDPs from which to choose; 95 percent also could choose from at least twenty-three MA plans, with the mix varying by market. Most had more than twenty-three choices, including PFFS from 14–55 plans. Sixty-three percent of those enrolled in
Part D have less than a high school education, and 54 percent have three or more chronic conditions. Although the CMS provides assistance in choice, making distinctions among these plans could pose inevitable challenges for beneficiaries.

Discussion

When MMA was enacted, few envisioned so large a number of competing firms and associated plans. The predominant concern then was whether any firms would offer the new PDPs and RPPOs, with the hope that beneficiaries would have at least a few choices. Instead, MMA has spawned an industry of plan sponsors, and consultants to support them.

- **Expanded choice and private-sector role.** Our analysis clearly shows the growth in private-plan choice and enrollment as a result of MMA—one in three beneficiaries gets their Part D coverage in MA rather than in a freestanding PDP, and all beneficiaries have a diverse and numerous set of choices. To the extent that such expansion was an important goal of MMA, clearly it has been attained.

- **Cost implications.** A more negative effect, as others have documented, is that the expansion in MA is tied to payment policies that have accelerated, rather than restrained, the growth of Medicare spending. Although proponents argue that such costs ultimately may be offset by gains from competition, this premise is operationally difficult to test, and limited empirical evidence exists to support it.

- **MA’s performance on other goals.** In expanding choice at a cost, MA’s expansion to date affects other potential valued policy outcomes.

  **Administrative efficiency.** It is difficult to make the case that Medicare is more administratively efficient because of MMA. Expanded choice means that in 2008, the CMS has had to review, approve, and oversee almost 4,000 MA plans under more than 700 different MA contracts from a large number of sponsors, each bearing high administrative costs. Even PFFS supporters might agree that having so many plans competing to offer essentially the same product adds to such costs.

  **Expanded benefits for enrollees.** MA’s growth demonstrates its attraction to sizable numbers, if still a minority, of Medicare beneficiaries. Medicare’s high MA payment rates have allowed MA to offer beneficiaries at least temporarily some supplementary coverage at very little additional expense. PFFS means that they might not even have to sacrifice their choice of physicians, although beneficiaries might not understand the limits on MA’s financial protection or on provider access. Supplemental coverage at low cost is likely to be particularly attractive for lower-income beneficiaries priced out of the Medigap market. Whether it is equitable for MA, and not traditional Medicare, to have this advantage in a program designed to be voluntary warrants consideration.

  **Enhancement of basic benefits.** Although all beneficiaries potentially benefit from the Part D expansion, MMA otherwise leaves intact the historical structure of Medicare Parts A and B and the recognized limitations. Higher MA payments generate enhanced benefits for enrollees, but costs are passed on to all beneficia-
ries in the form of higher Part B premiums, and to taxpayers if general funds are required to offset higher Medicare costs. Although plan bids are such that it has little current operational effect, MA’s pricing structure also allows MA plans to charge more than Medicare does for the basic Medicare benefit—a feature that could shift Medicare from a defined-benefit to a defined-contribution plan, especially if changes make a return to traditional Medicare less attractive or feasible.

Enhanced quality. PFFS was deliberately structured to minimize effects on providers and care delivery. Because PFFS dominates MA growth, quality is unlikely to be better; if alleged access problems are real, it could be worse. PFFS’s advantages also seem to have made it harder for HMOs—the most tightly designed form of CCP—to expand.35 Although SNPs have the potential to improve care delivery for vulnerable beneficiary subgroups, the evidence to date suggests that, at best, only a minority of SNPs are being structuring to achieve these gains.

Medicare’s governance and stewardship. Medicare’s structure creates financial incentives for private companies to compete in enrolling beneficiaries, but it does not generate the performance measures needed for accountability in what is, at its core, a publicly funded and congressionally accountable program. This limitation is compounded by inconsistencies in how performance is assessed in both traditional Medicare and MA plans. The traditional program generates detailed transaction-level files from claims, documenting the services for which Medicare pays, but it provides little real-time analysis to monitor performance on HEDIS or other measures. In MA, such transaction data are not required, but HEDIS reports and data have been required, at least for HMOs and other CCPs.

With the growth of MA, it could become more difficult to track Medicare’s overall performance because an increasing share of beneficiaries will not be included in the programwide claims data and research files used extensively for national studies. These files have important limitations in timeliness and their relevance for quality improvement; however, historically they have been a major source of data on health care practices. MA plans are not required to submit claims, based in part on the argument that claims are irrelevant in a prepaid environment. However, the case for exclusion would be stronger if alternative performance measurement were better developed.

Desirable change in MA oversight. Assuming that Congress decides to continue MA in some form, a better system to promote oversight and encourage transparency and accountability would be valuable. One might envision Congress receiving an annual report on MA program performance, including a series of measures using plan-level performance data to address important programmatic concerns. For example, indicators of rapid disenrollment could reveal potential confusion in the marketplace, while complaint data by plan and state could highlight where problems are more likely to occur. HEDIS reporting for all private plans (and traditional Medicare) would support assessment and oversight of relative performance.36

Because it has access to confidential plan data, the CMS is the logical agency to
generate this report. Because of historical tensions between the executive and legislative branches, and the lengthy clearance process at the Department of Health and Human Services (HHS), Congress may wish to complement mandated CMS reporting with reports by the Medicare Payment Advisory Commission (MedPAC) or the Government Accountability Office (GAO). With such an infrastructure and public reporting, Congress would be better able to examine not just where the money goes, but what it buys.

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NOTES
3. Cost contracts, demonstrations, and a few other types of contracts are separately authorized and not technically part of MA. Because the distinction likely is invisible to beneficiaries and these contracts are important in certain markets, we include them here. HR 6331 phases out payment to MA plans for the indirect costs of graduate medical education. Effective in 2010, PFFS plans must establish provider networks for individual and group products except in counties where two or fewer plans operate. MIPPA also modifies SNP provisions and expands requirements for HEDIS reporting to all MA plans.
9. Most contracts offer more than one plan, the unit that defines eligibility (for example, group, SNP, other) and the benefit package. Contract service areas also can be divided into aggregations of counties, each with unique plans. (This is not allowed within regions for RPPOs.)
11. MSAs have high deductibles accompanied by an annual deposit in an interest-bearing checking account that can be used to cover qualified medical expenses. MSAs do not provide drug coverage, but beneficiaries can purchase it through a PDP. MSAs have been available since 2007 (mainly through WellPoint).
13. Ibid.


16. In July 2007, there were about 1.0 million people in group HMOs or cost plans, 50 percent in contracts that began before 1990, and 25 percent in plans starting between 1990 and 1999. The same number—about 1 million—were enrolled in 2008.


22. The 2008 HMO data also include about 160,000 enrollees in state-based dual-eligible demonstrations reclassified by the CMS as HMO-based SNPs in that year.

23. We assumed that all enrollment was in the lowest-premium plan offered by the contract in that county, however, the unweighted data support similar conclusions.

24. We did not examine out-of-pocket spending for Part D because of data constraints and the complexity of such calculations.


26. Blum et al., “An Examination of Medicare Private Fee-for-Service Plans.”


36. MIPPA extends HEDIS reporting requirements to all MA plans, but putting this requirement into operation likely will be challenging.