



Medicare Advantage

Paulette C. Morgan

Specialist in Health Care Financing

March 3, 2009

Congressional Research Service

7-5700

www.crs.gov

R40374

CRS Report for Congress

Prepared for Members and Committees of Congress

Summary

Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. Eligible individuals may enroll in an MA plan, if one is available in their area. As of January 2009, all Medicare beneficiaries had access to an MA plan and 23% of beneficiaries enrolled in one. Private plans may use different techniques to influence the medical care used by enrollees. Some plans, such as health maintenance organizations (HMOs) may require enrollees to receive care from a restricted network of medical providers; enrollees may be required to see a primary care physician who will coordinate their care and refer them to specialists as necessary. Other types of private plans, such as private fee-for-service (PFFS) plans, may look more like original Medicare, with fewer restrictions on the providers an enrollee can see and minimal coordination of care.

In general, Medicare Advantage plans offer additional benefits or require smaller co-payments or deductibles than original Medicare. Sometimes beneficiaries pay for these additional benefits through a higher monthly premium, but sometimes they are financed through plan savings. The extent of extra benefits and reduced cost sharing vary by plan type and geography, creating an inequity that can frustrate some beneficiaries. However, Medicare Advantage plans are seen by some as an attractive alternative to more expensive supplemental insurance policies found in the private market.

Though plans that manage their enrollees' care have the potential to be less expensive than original Medicare, recent analyses by the Medicare Payment Advisory Commission (MEDPAC) find that Medicare is projected to pay private plans an average of 14% more per beneficiary in 2009 than it does for beneficiaries in the original Medicare program. While some support the higher Medicare expenditures for MA enrollees because funds are used to provide reduced cost sharing or additional benefits, others support paying private plans no more than the cost of covered benefits under the original Medicare program, which may result in less generous MA benefit packages, or reduced access to MA plans. With competing health expenditure priorities, Congress is likely to examine the MA program.

Congress may consider additional issues. First, the Comparative Cost Adjustment (CCA) Program is slated to start in 2010. CCA is designed to test direct competition between MA and original Medicare. As such, the Part B premiums of beneficiaries in original Medicare may be increased or decreased depending on the efficiency of original Medicare relative to MA plans in the area. Second, recent studies show that profits in 2005 and 2006 for MA plans were, on average, higher than estimated because of underestimates in medical spending. If plans had more accurately estimated future medical spending, they could have offered more generous benefit packages without reducing their profits, though some variability in the accuracy of estimates may be expected. Third, marketing behaviors of MA plans and their agents or brokers were a concern in the 110th Congress; it is unclear whether they will continue to be an issue in the 111th Congress.

The Congressional Budget Office (CBO) March 2008 projection of Medicare payments under Medicare Advantage is \$112.8 billion in 2009 for coverage of 11.0 million enrollees, increasing to \$221.2 billion in 2018 for 16.6 billion enrollees. This report is an overview of the Medicare Advantage program, and includes legislative history and analysis of recent trends. It will be updated to reflect significant changes to the program.

Contents

Introduction	1
Background	1
Current Payment System	4
Trends in Availability and Enrollment.....	6
Plan Type and Enrollment	8
Coordinated Care Plans (CCP)	8
Health Maintenance Organizations (HMOs)	9
Preferred Provider Organizations (PPOs)	9
Provider Sponsored Organization (PSO)	10
Specialized Plans for Special Needs Individuals (SNPs).....	10
Private Fee for Service plans (PFFS).....	10
Reasonable Cost Plans (COST)	11
Medical Savings Accounts (MSA).....	11
Health Care Prepayment Plans (HCPP)	11
Availability by Contract Type	11
Enrollment Patterns in Urban and Rural Locations.....	13
Regional and Geographic Variation in Enrollment	14
Rules for Eligibility and Enrollment	16
Eligibility	16
Residency Requirements	16
Enrollment Periods.....	16
Special Election Periods.....	17
Supplemental Benefits.....	17
Premiums.....	18
Coverage for Prescription Drugs	19
Beneficiary Protections	20
Enrollment.....	20
Access to Providers.....	20
Access to Benefits.....	21
Beneficiary Financial Liability Protections.....	21
Quality Standards	21
Consumer Disclosure Requirements	22
Marketing Requirements.....	22
Grievance and Appeals.....	23
Program Standards and Contract Requirements.....	23
Minimum Enrollment Standards	23
Organizational and Financial Requirements	24
Provider Protections and Requirements	24
Protections Against Fraud	24
Prompt Payment Requirements.....	24
Contract Terminations and Sanctions.....	25
Issues for Congress.....	25
Per Beneficiary Expenditure Differences Between MA and Original Medicare.....	25

Medical Expenditures and Profits	27
Comparative Cost Adjustment in 2010	28
Marketing	28

Figures

Figure 1. Number of Coordinated Care and PFFS Contracts in Medicare Part C.....	7
Figure 2. Percentage of Beneficiaries Enrolled in Medicare Private Plans, Actual and Projected.....	8
Figure 3. Percentage of MA Enrollment, by Plan Type, 2008.....	9
Figure 4. Concentration of Medicare Beneficiaries (2007), Medicare Advantage Enrollees (2007), and Medicare+Choice Enrollees (2003) in Urban and Rural Locations.....	13
Figure 5. Percentage of Medicare Beneficiaries Enrolled in Medicare Advantage, by State, January 2008.....	15
Figure 6. Percentage of M+C and MA Enrollees Offered Benefits Beyond Traditional Medicare Covered Services, in the Lowest Premium Package Available, 1999, 2002, and 2005.	18

Tables

Table 1. Changes in Access to Coordinated Care Plans, Private Fee-for-Service Plans, and Both, by Proportion of Counties and Beneficiaries.....	12
Table 2. Shares of Medicare+Choice and Medicare Advantage Enrollment and Medicare Population Residing in Four States	15
Table 3. Changes in Access to or Coverage Under a Medicare+Choice or Medicare Advantage Coordinated Care Plan with a Zero Premium, 1999 to 2006.	19

Appendixes

Appendix. Legislative History, 1997 to 2008.....	30
--	----

Contacts

Author Contact Information	36
Acknowledgments	36

Introduction

Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person amount to provide all Medicare covered benefits (except hospice) to beneficiaries who enroll in their plan. Eligible individuals may enroll in an MA plan, if one is available in their area. As of January 2009, all Medicare beneficiaries had access to an MA plan and 23% of beneficiaries enrolled in one. Private plans may use different techniques to influence the medical care used by enrollees. Some plans, such as health maintenance organizations (HMOs) may require enrollees to receive care from a restricted network of medical providers; enrollees may be required to see a primary care physician who will coordinate their care and refer them to specialists as necessary. Other types of private plans, such as private fee-for-service (PFFS) plans, may look more like original Medicare, with fewer restrictions on the providers an enrollee can see and minimal coordination of care.

In general, Medicare Advantage plans offer additional benefits or require smaller co-payments or deductibles than original Medicare. Sometimes beneficiaries pay for these additional benefits through a higher monthly premium, but sometimes they are financed through plan savings. The extent of extra benefits and reduced cost sharing vary by plan type and geography, creating an inequity that can frustrate some beneficiaries. However, Medicare Advantage plans are seen by some as an attractive alternative to more expensive supplemental insurance policies found in the private market.

The 111th Congress may examine several aspects of the MA program. First, Medicare is projected to pay MA plans more per beneficiary than it does for beneficiaries in original Medicare—an effect of a payment formula designed to encourage plan participation. Though a portion of the higher expenditure results in extra benefits and reduced cost sharing for some enrollees, some argue that private plans should not be paid more than the cost of original Medicare. Second, starting in 2010, the Comparative Cost Adjustment (CCA) Program will test direct competition between MA and original Medicare in selected areas. As such, the Part B premiums of beneficiaries in original Medicare may be increased or decreased depending on the efficiency of original Medicare relative to MA plans in the area. Third, recent studies show that profits in 2005 and 2006 for MA plans were, on average, higher than estimated because of underestimates in medical spending. If plans had more accurately estimated medical spending, they could have offered more generous benefit packages without reducing their profits, though some variability in the accuracy of estimates may be expected. Finally, marketing behaviors of MA plans and their agents or brokers were a concern in the 110th Congress; it is unclear whether they will continue to be an issue in the 111th. All of these issues are discussed in more detail in the “Issues for Congress” section at the end of this report.

The Congressional Budget Office (CBO) March 2008 projection of Medicare payments under Part C is \$112.8 billion in 2009 for coverage of 11.0 million enrollees, increasing to \$221.2 billion in 2018 for 16.6 billion enrollees.

Background

Medicare has a long-standing history of offering its beneficiaries health insurance coverage through private plans. Beginning in the 1970s, private health plans were allowed to contract with

Medicare on a cost-reimbursement basis. Under a cost contract, plans are reimbursed for the actual costs of delivering health care services. In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248), which created the first Medicare risk contracting program. Under a risk contract, participating health plans are paid a fixed monthly payment per enrollee to furnish all Part A and B Medicare-covered services (except hospice) to beneficiaries. This is in contrast to the original fee-for-service (FFS) Medicare, where Medicare pays providers directly for each item or service delivered.

With the passage of TEFRA, payments to private health plans were set at 95% of the cost of providing Medicare benefits in the original FFS program. FFS costs were measured by units called Average Adjusted Per Capita Costs (AAPCCs). By 1997, 15 years after the start of the risk contract program, Medicare private plans covered more than 5 million beneficiaries, or about 14% of beneficiaries. However, despite its lengthy tenure as the basis for private plan payment, the calculation of AAPCCs was criticized for a number of reasons. Principal among these was that payments fluctuated from year to year and varied widely across the country. In an attempt to remedy this problem, Congress, in the Balanced Budget Act of 1997 (BBA, P.L. 105-33), replaced Medicare's risk contract program with the Medicare+Choice (M+C) program. The BBA substantially restructured the system for setting Medicare payment rates to private plans. By establishing a new payment methodology, Congress hoped to reduce Medicare spending, expand access to managed care options, and decrease variation in payment rates across the country. Under the M+C program, the per capita rate for a payment area was set at the highest of three amounts calculated *for each county*:

- a blended rate, which was a blend of an area-specific (local) rate and a national rate;
- a minimum payment (or floor) rate; or
- a rate reflecting a minimum increase from the previous year's rate.

The blended per capita rate was intended to shift payment amounts away from local (generally county) rates, which reflect the wide variations in fee-for-service costs, toward a national average rate. The floor rate was designed to raise payments in certain counties more quickly than would occur through the blend alone; the minimum increase percentage was to protect counties that would otherwise receive only a small increase (if any). This formula was subject to a budget neutrality provision to keep expenditures from exceeding expected expenditures in the absence of the new formula.

Although the intent of the BBA was to increase access to private plans, particularly in markets where availability was limited or non-existent, the program did not work as well as intended. The goal of controlling Medicare spending may have dampened the interest of private plans to develop new markets and add plan options. Their cautious behavior may have been a reaction to a slowdown in the rate of increase in payments. Among plans, there was also a great deal of uncertainty about the future of the M+C program and the stability of payments to sustain the program. Between 1999 and 2003, private plans left the program or reduced their service areas, affecting thousands of enrollees each year. Some enrollees were able to switch to other private Medicare plans, while others had no M+C plans available to them. Despite a small surge in enrollment initially, the percentage of beneficiaries enrolled in M+C dropped from 17% in 1999 to approximately 12% in 2003. To address the decreased plan participation, the 106th Congress inserted provisions in the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) and the Medicare, Medicaid, and SCHIP Benefits, Improvements, and Protection Act of 2000 (BIPA, P.L. 106-554) to increase reimbursement to M+C plans.

In 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), which made substantial changes to Medicare's private plan option. In creating Medicare Advantage (MA) to replace the M+C program, the MMA established an entirely new payment methodology to pay private plans. Under the new payment system, Medicare continues to pay plans a fixed monthly amount per enrollee, but these monthly payments are determined, at least in part, by competitive bidding. In addition, Congress increased payments to plans and introduced regional Preferred Provider Organizations—a popular option in the private health insurance market. Finally, the MMA created a new benefit package for Medicare enrollees: beginning in 2006, beneficiaries have been able to enroll in a Medicare Part D prescription drug plan whether they are in original Medicare or Medicare Advantage. In general, a beneficiary who wants to enroll in an MA plan and receive Part D prescription drug coverage must enroll in an MA-PD plan—an MA plan that includes the Part D coverage. A beneficiary who wants to remain in original Medicare may only enroll in Part D through a Prescription Drug Plan (PDP).

Today Medicare beneficiaries can choose to enroll in several different types of private plans. These include coordinated care plans, also known as managed care plans, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider sponsored organizations (PSOs) as well as plans that do not manage or coordinate the health care of enrollees, such as private fee-for-service organizations (PFFS) and medical savings accounts (MSA). Certain other plan types operate under exceptions or demonstration authority and may or may not manage care. Not all types are available in all locations.

Prior to the passage of MMA, enrollment in private plans fluctuated. Since the passage of the MMA, overall enrollment in private plans has been steadily increasing. In 2009, approximately 10.4 million, or 23%, of Medicare beneficiaries are enrolled in a MA plan, and all Medicare beneficiaries have access to at least one private plan. Despite these successes, reforming the payment methodology for private plans remains a key issue among policymakers. According to the Medicare Payment Advisory Commission (MEDPAC), Medicare is expected to pay private plans an average of 14% more per beneficiary in 2009 than it does for beneficiaries enrolled in the original Medicare program.¹ A comparable analysis for 2008 showed that Medicare was expected to pay private plans an average of 13% more per beneficiary in 2008 than it did for beneficiaries enrolled in original Medicare.² Based on the 2008 analysis, the greater expected payments to plans relative to spending in original Medicare varies by plan type; payments to HMOs are approximately 112% of original Medicare, while payments to PFFS plans are 117% of original Medicare. Since MA payments are based, in part, on historical payment rates, this 13% difference is linked to the 1997 BBA legislation, which created payment floors to attract private plans to certain counties, particularly rural counties. These floors, which exceeded FFS spending levels in many areas, continue to be used in the calculation of MA payment rates today. MA plans use these payments to provide extra benefits to enrollees, but the value of these benefits vary across plan types and across counties. In addition, these higher payments have attracted private plans to areas previously underserved by Medicare private plans, and beneficiaries today have more private plans to choose from than they did 10 years ago.

¹ http://www.medpac.gov/transcripts/MIPPA_MA0109.pdf.

² Medicare Payment Advisory Commission (MEDPAC), *Report to Congress: Medicare Payment Policy*, Chapter 3, Medicare Advantage, March 2008, p. 247, http://www.medpac.gov/chapters/Mar08_Ch03.pdf.

Current Payment System

Beginning in 2006, the Secretary began determining MA payment rates by comparing plan *bids* to a *benchmark*. By the first week of June each year, plans are required to submit their bids for all MA plans they intend to offer in the upcoming year. Each bid represents the plan's estimated revenue requirement for providing required Parts A and B Medicare services to an average Medicare beneficiary. The revenue requirement includes the estimated cost of providing required health care, plus administrative costs and a return on investment. After plans submit their bids, the Secretary has, with one exception, the authority to negotiate the bid amount, similar to the authority of the Director of the Office of Personnel Management (OPM) with respect to the Federal Employees Health Benefits program. The Secretary's authority to negotiate bids does not extend to bids submitted by Private Fee for Service (PFFS)³ organizations. The Secretary then compares each plan's bid to a benchmark. The benchmark amounts represent the maximum amount the federal government will pay a plan for providing required Medicare benefits. If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate of 75% of the difference between the benchmark and the bid. The rebate must be used to provide additional benefits to enrollees, reduce Medicare cost sharing expenses, or reduce a beneficiary's monthly Part B, prescription drug, or supplemental premium (for services beyond required Medicare benefits). The remaining 25% of the difference is retained by the federal government. If a plan's bid is equal to or above the benchmark, its payment is equal to the benchmark amount, and each enrollee in that plan will pay an additional premium equal to the amount by which the bid exceeds the benchmark. Any MA plan that provides Part D prescription drug coverage receives reimbursement for premiums and cost-sharing reductions for its qualifying low-income enrollees.

Additional payments may be available to certain types of plans in specific areas, or for enrollment of certain beneficiaries. The MMA increased payments to MA regional plans in three ways. First, the MMA established a regional plan stabilization fund to encourage plans to serve at least one entire region or even all regions, and to encourage plans to stay in regions they might otherwise leave. Originally, \$10 billion was to be made available to this fund for years 2007 through 2013, with additional money entering the fund from savings in the regional plan bidding process. However, subsequent legislation reduced the initial \$10 billion to one dollar. Money from the regional plan bidding process continues to flow into the fund and will be available for distribution in 2014. Second, the MMA allows the Secretary to provide an increased payment in special circumstances for certain hospitals that provide inpatient hospital services to MA regional plan enrollees. Third, Medicare shared risk with MA regional plans in 2006 and 2007. If a plan's costs fell outside of a specified range or "risk corridor," plans assumed only a portion of the risk for unexpectedly high costs and plans were required to return a portion of the savings to Medicare for unexpectedly low costs.

In general, the MA benchmarks in each local area (county) are updated annually by a minimum increase over the previous year's rate. The minimum increase is set at the larger of either 2% or the overall growth in Medicare expenditures, otherwise known as the National MA Growth Percentage, subject to a budget neutrality adjustment. In certain years (known as *rebased years*),

³ Private fee for service plans (PFFS) are one type of private plan that may participate in the Medicare Advantage program. PFFS plans are defined as those that (1) reimburse providers on a fee-for-service basis without placing providers at a financial risk, (2) do not vary rates for a provider based on utilization related to that provider, and (3) do not restrict the selection of providers among those who are lawfully authorized to provide services and agree to the plan's terms and conditions of participation.

plan payments are updated by the greater of the minimum increase or 100% of fee-for-service (FFS) costs, with adjustments. Statutorily required adjustments to the 100% of FFS amount include (1) exclusion of the direct cost of medical education, (2) phase-out of the indirect cost of medical education, and (3) adjustment to reflect the additional per capita payments that would have been made in the area if individuals entitled to benefits under Medicare had not received services from the Department of Defense or the Department of Veterans Affairs. (As of CY2009, CMS had been unable to make the third of these adjustments.) According to statute, the Secretary is required to rebase FFS costs at least once every three years. However, CMS has chosen to rebase more frequently. The Secretary opted to rebase FFS rates for 2007 and 2009, but not 2008. In rebasing years, all benchmarks are either equal to or greater than the estimated adjusted average spending in original Medicare in that county. In a non-rebasing year, it is possible for spending in original Medicare in a county to exceed the benchmark amount. But in general, benchmarks are set at or above spending in original Medicare. According to MEDPAC, benchmarks are, on average, 18% greater than expected spending in original Medicare.⁴ The National MA Growth Percentage rate (prior to the budget neutrality adjustment discussed below) is 5.7% in 2008 and 4.2% in 2009.

The benchmark is calculated differently for local MA plans than for regional MA plans. The local benchmark is based solely on statutorily or administratively defined increases. The regional benchmark is competitive in that the benchmark consists of two components: a statutorily determined increase and a weighted average of plan bids. The latter component introduces a new form of competition among regional plans, by basing a portion of the benchmark amount on bids submitted by the plans.

After determining the annual update, the Secretary adjusts payments for the health status of enrollees and for budget neutrality. To adjust for health status, the Secretary calculates a risk score for each enrollee based on the beneficiary's previous health care utilization. (This is known as *risk adjustment*.) Previously, payments to managed care plans were adjusted for a combination of demographic factors such as age, gender, and institutional status. In 1999, Congress urged the Secretary to implement a more clinically based risk adjustment methodology to supplement the existing demographic adjustment factors. It was fully phased in by 2007. The methodology was to be implemented without reducing overall payments to managed care plans. Typically, risk adjustment would have the effect of lowering payments to plans enrolling healthier beneficiaries and raising payments to plans enrolling sicker beneficiaries. To prevent overall payments to managed care plans from going down, the Secretary applied a budget neutrality adjustment. Under budget neutrality, total payments to managed care plans using 100% risk adjusted rates must be equal to total payments to plans using 100% demographic rates. When Congress passed the Deficit Reduction Act of 2005, it included a provision mandating the phaseout of this budget neutrality adjustment by 2011. As a result, the MA benchmark update for 2008 was, on average, 3.5%. The update for 2009 is an average of 3.6% for all areas that did not receive a rebased amount.

MA plans offering prescription drug coverage receive a separate benchmark payment for Part D prescription drug benefits. The benchmark for Part D benefits is based on an adjusted average of all plan bids for the area and is therefore competitively determined.

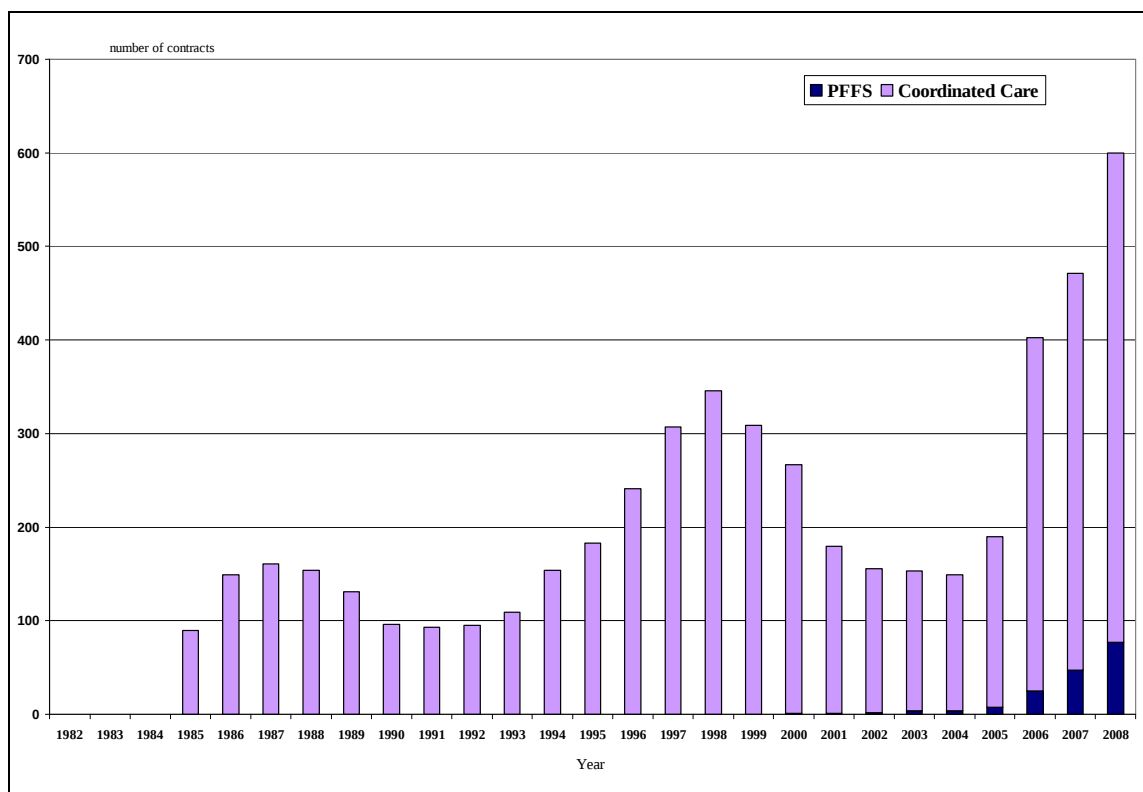
⁴ Medicare Payment Advisory Commission (MEDPAC), *Report to Congress: Medicare Payment Policy*, Chapter 3, Medicare Advantage, March 2008, p. 247, http://www.medpac.gov/chapters/Mar08_Ch03.pdf.

Trends in Availability and Enrollment

Over time, the number of contracts under MA and its predecessors has fluctuated. From 1987 to the early 1990s, many risk plans terminated existing contracts, decreasing the number of available contracts from 161 in 1987 to 93 in 1991. The number of Medicare risk plans began increasing again in 1992, more than tripling from 110 in 1993 to 346 in 1998. With the implementation of the M+C program in 1999, M+C organizations withdrew from the Medicare program or reduced the size of their service area. As shown in **Figure 1**, the number of contracts dropped from a high of 346 in 1998 to a low of 146 in March 2003. With the passage of the MMA in 2003, the trend began to reverse. The number of MA contracts more than doubled between 2005 and 2006. This increase coincides with the start of the Part D prescription drug program and may reflect an overall increased interest in private plan participation in Medicare at that time. There were 600 MA coordinated care and PFFS contracts in 2008, increasing to 623 in 2009.

Organizations withdrawing from the program or reducing their service area between 1998 and 2004 cited several reasons for leaving the program: inadequate payments, increasing regulatory burden, and difficulty developing or maintaining provider networks. The withdrawals may have reflected strategic business decisions that transcended payment issues. Other factors may have contributed to withdrawals, such as low enrollment and market competition. For each year between January 1999 and January 2003, from 4% to 15% of M+C enrollees either had to change plans or leave the program because of plan withdrawals and service area reductions. Some beneficiaries were required to switch plans multiple times between 1999 and 2003. Of those beneficiaries that lost their plans, between 7% and 24% lost access to any M+C plan each year.

Figure 1. Number of Coordinated Care and PFFS Contracts in Medicare Part C
(1985 to 2008)

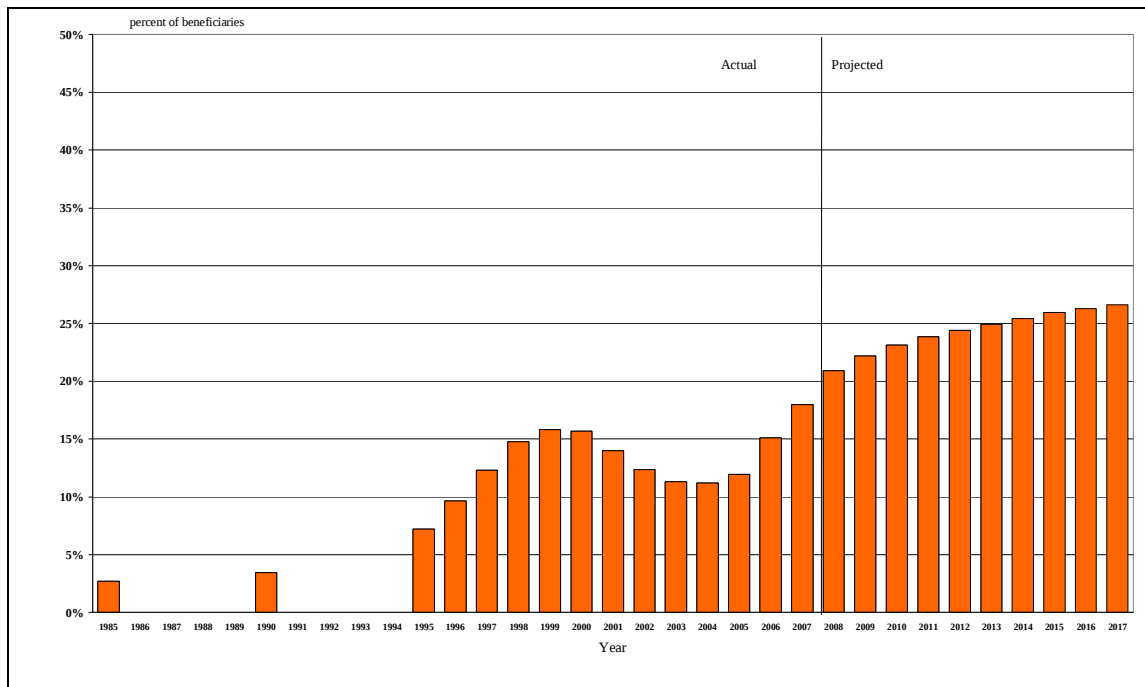


Source: Prepared by the Congressional Research Service based on April CMS Medicare Managed Care Contract (MMCC) Monthly Reports through 2005, and CMS Medicare Advantage Monthly Summary Reports for 2006 to 2008.

Notes: Medicare managed care contracts include risk contracts through 1998, Medicare+Choice contracts beginning in 1999, and Medicare Advantage contracts beginning in 2006. This figure does not contain data for reasonable cost contracts, demonstrations, Health Care Pre Payment (HCPP) plans, PACE plans, Medical Savings Accounts, employer sponsored plans, or pilot projects.

Enrollment in Medicare private plans has fluctuated over time. As shown in **Figure 2**, in 1990 about 3% of Medicare beneficiaries were enrolled in the program, but by 1998 this figure had increased to 15% of Medicare beneficiaries, covering just over 6 million enrollees. With the implementation of the M+C program, enrollment increased through 1999, but declined steadily to a low of 11% (4.7 million enrollees) in 2003 and 2004. Enrollment has since increased each year, reaching a recent high of 23% in 2009. The 2008 Annual Report of the Board of Trustees projects further enrollment increases reaching about 27% of all beneficiaries in 2017, covering about 15 million enrollees.

Figure 2. Percentage of Beneficiaries Enrolled in Medicare Private Plans, Actual and Projected
(selected years, 1985 to 2017)



Source: Prepared by CRS based on 2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund. Enrollment from 2008 to 2015 is estimated.

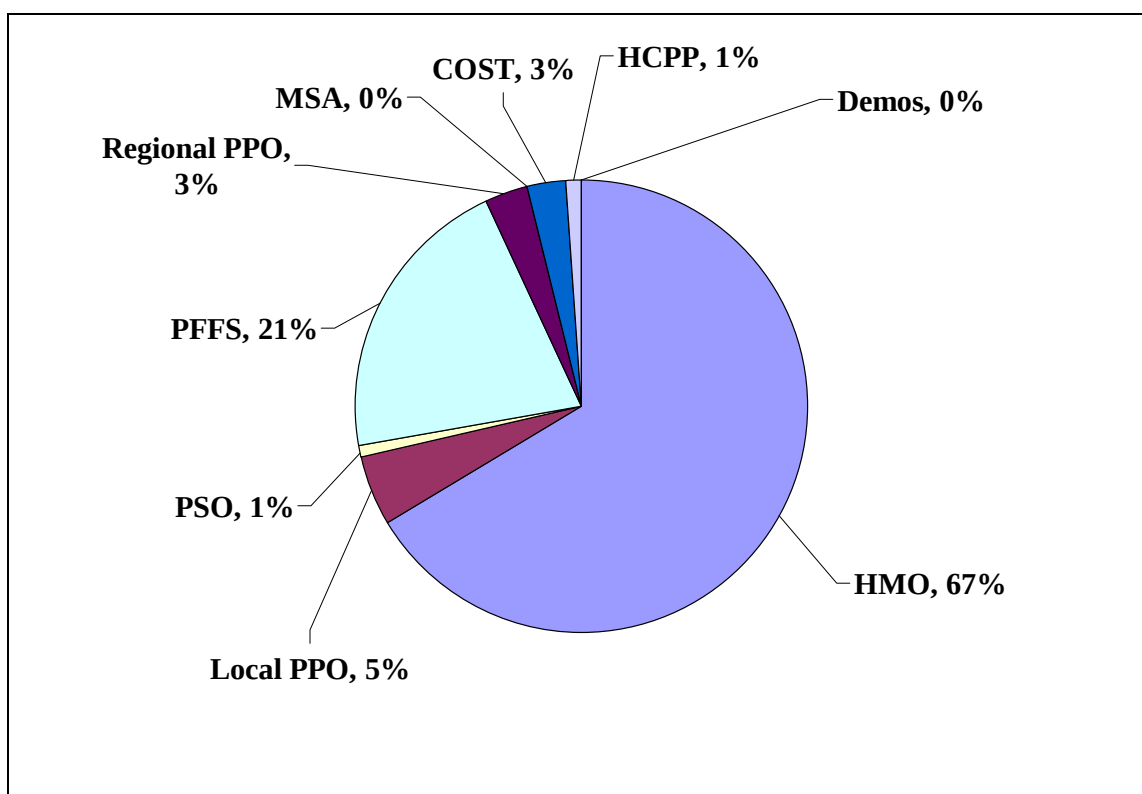
Notes: Medicare plans include risk plans through 1998, Medicare+Choice plans beginning in 1999, and Medicare Advantage plans beginning in 2006.

Plan Type and Enrollment

Though a variety of plan types are authorized under Medicare, national enrollment in MA is concentrated in two types: health maintenance organizations (HMOs), with 67% of enrollment, and private fee-for-service (PFFS) plans, with 21% of enrollment (**Figure 3**). All other remaining plan types make up 13% of enrollment. Characteristics of the different plan types and enrollment specifics follow.

Coordinated Care Plans (CCP)

Coordinated Care Plans (CCPs) are those plans that have a network of medical providers under contract to provide approved health care benefits to plan enrollees. CCPs may use mechanisms to coordinate care or control health care utilization, such as primary care “gatekeepers,” and financial incentives with plan providers to encourage cost-effective health care. CCPs include the following specific types of plans: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Provider Sponsored Organizations (PSOs). Three-quarters of all MA enrollees are in a coordinated care plan.

Figure 3. Percentage of MA Enrollment, by Plan Type, 2008

Source: Prepared by CRS based on CMS data.

Notes: HMOs: health maintenance organizations; Local PPO: local preferred provider organizations; PSO: provider sponsored organizations; PFFS: private fee-for-service organizations; Regional PPOs: regional preferred provider organizations; MSA: medical savings accounts; COST: reasonable cost organizations; HCPP: health care pre-payment organizations; Demos: organizations that operate under CMS demonstration authority. May not sum to 100% due to rounding.

Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) offer services to plan members in designated areas. Beneficiaries are generally required to obtain services from hospitals and doctors in the plan's network. Some plans offer a point-of-service option under which an individual may elect to obtain services from a non-network provider; in such cases, the individual generally pays a greater out of pocket cost for out-of-network care. In 2008, approximately 6 million Medicare beneficiaries (67%) were enrolled in an MA HMO.

Preferred Provider Organizations (PPOs)

A Preferred Provider Organization (PPO) is a plan that has a network of providers; however, enrollees are not restricted to the providers in the PPO network. Generally, enrollees are required to pay greater cost sharing when receiving care outside of the PPO network. Two types of PPO plans are authorized under Medicare: local PPO plans and regional PPO plans. Local PPO plans may choose their service area, while regional PPO plans must agree to serve one or more regions designated by the Secretary. There are 26 PPO regions consisting of states or groups of states. In

addition to the service area requirements, the benefit packages for regional PPO plans are required to have a unified Part A and B deductible and a catastrophic out-of-pocket limit, which are not required of local PPO plans. In 2008, 5% of all MA enrollees were in a local PPO plan (approximately 470,000) and 3% of MA enrollees were in a regional PPO plan (approximately 230,000).

Provider Sponsored Organization (PSO)

A Provider Sponsored Organization (PSO) is a coordinated care plan established or organized by a group of medical providers in which the providers furnish the majority of the health care and share in the financial risk of providing the health care to plan enrollees. In 2008, 1% of MA enrollees were in an MA PSO plan (approximately 54,000).

Specialized Plans for Special Needs Individuals (SNPs)

A Specialized Plan for Special Needs Individuals (SNPs) is any MA coordinated care plan that exclusively enrolls or enrolls a disproportionate percentage of special needs individuals. Special needs individuals are any MA eligible individuals who are either institutionalized as defined by the Secretary, eligible for both Medicare and Medicaid, or have a severe or disabling chronic condition and would benefit from enrollment in a specialized MA plan. Since SNP plans may be any type of CCP, SNP enrollees are included in the enrollment estimates above. In 2008, 1.1 million Medicare beneficiaries were enrolled in a SNP: 70% were enrolled in a SNP for beneficiaries eligible for both Medicare and Medicaid, 17% were enrolled in a SNP for beneficiaries with chronic conditions, and 13% were enrolled in a SNP for institutionalized Medicare beneficiaries.

Private Fee for Service plans (PFFS)

Private Fee for Service plans (PFFS) are plans that (1) reimburse hospitals, physicians, and other providers on a fee-for-service basis without placing providers at risk; (2) do not vary rates for a provider based on the utilization relating to that provider; and (3) do not restrict the selection of providers among those who are lawfully authorized to provide services and agree to accept the terms and conditions of payment established by the plan. In 2008, 21% of MA participants were enrolled in a PFFS plan (approximately 1.9 million).

PFFS contracts and enrollment have seen a steeper increase over recent years. First authorized in the BBA, the first contract was offered in 2000, the second following in 2002. However, between 2004 and 2008, MA PFFS contracts grew from 4 contracts in 2004 to 77 contracts in 2008. Enrollment in PFFS grew from 31,550 in 2004 to 1.9 million in 2008. Several factors may have contributed to the recent growth. First, prior to 2011, PFFS contracts are not required to establish provider networks and are therefore less expensive to establish in non-urban areas. Starting in 2011, PFFS plans sponsored by employers or unions will be required to have contracted provider networks. All other PFFS plans will be required to establish provider networks in areas where at least two other network-based plans operate. Second, enrollees can choose to see any provider willing to accept the terms and conditions specified by the PFFS plan—an attractive feature for beneficiaries. Third, PFFS plans tend to be paid more than coordinated care plans. Medicare pays 13% more per beneficiary in MA than in original Medicare. This varies by type of MA plan, with a 12% increase for HMOs and 17% for PFFS. Fourth, PFFS contracts have fewer statutory requirements, resulting in reduced operation costs. And fifth, employer and union groups have

historically found MA PFFS plans an attractive option for providing retiree coverage, though this may change with the new network requirements.

Reasonable Cost Plans (COST)

Reasonable Cost Plans (COST) are private MA plans that are paid on the basis of the reasonable costs actually incurred to provide Medicare covered benefits to enrollees. Unlike other types of private plans that participate in Medicare, Cost plans are not “at risk” for the actual cost of providing care to their enrollees. In 2008, 266,000 beneficiaries were enrolled in a cost plan, representing 3% of total MA enrollment.

Medical Savings Accounts (MSA)

A Medical Savings Account (MSA) under MA is a combination of a health insurance policy with a high deductible and a savings account for health care expenses. CMS pays premiums for the insurance policy and makes contributions to the savings account. Beneficiaries use money from the savings account to pay for their health care before the high deductible of the insurance policy is met. The maximum deductible is set by law. For 2008, the deductible may not exceed \$10,050. In 2008, slightly more than 1,000 people were enrolled in an MA MSA. They represented less than 0.01% of MA enrollees.

Health Care Prepayment Plans (HCPP)

A Health Care Prepayment Plan (HCPP) is a private plan that covers only physician services. In 2008, 1% of MA enrollees were in an HCPP in 2008.

Availability by Contract Type

Enrollment in a plan is open only to eligible beneficiaries living in the plan’s service area. Plans define a service area as a set of counties and county parts, identified at the zip code level. In 2009, an MA plan is available to every beneficiary in the United States. However, this widespread availability is a recent event. In the early part of the M+C program, a Medicare private plan was not available in the majority of counties (**Table 1**). In 1997, approximately a quarter of counties had an M+C plan available, increasing to 29% by 1999. (In 1997, 76% of counties were without a plan, decreasing to 71% in 1999.) In 2000, the first PFFS plan focused primarily on rural and suburban areas that were less often served by managed care; this greatly increased the proportion of counties with access to a private plan. Between 2001 and 2003, approximately half of counties had access to a PFFS plan, but for over 40% of counties, PFFS was the only private option available. The proportion of counties served by managed care decreased over this period, from 20% of counties in 2001 to 17% of counties in 2003. (In 2001, 10% of all counties were served by only a coordinated care plan, while 10% of all counties were served by both a managed care and a PFFS plan, summing to 20%. In 2003, 9% of all counties were served by only a coordinated care plan, while an additional 8% of counties were served by both a CCP and a PFFS plan, summing to 17%.) Access to private plans through Medicare has increased substantially since 2004, and now nearly all counties are served by at least one type of private plan, though for half of all counties, PFFS is the only plan type available as of 2008.

Medicare beneficiaries, however, are not equally distributed by counties. This occurs because the population and plans are not distributed equally across counties, but rather they are concentrated in the more urban counties. In 2007, while half of all counties were served by only PFFS plan options, the beneficiaries in those counties represented only 17% of all Medicare beneficiaries (**Table 1**). The proportion of beneficiaries with access limited to PFFS plan options has remained stable since 2001 (prior to the MMA) at between 17% and 20%.

Availability can further be examined taking into account the MA plans set up by employers for their retirees. Though only the retirees of the sponsoring company are eligible to join the plan, their increased popularity in recent years has provided additional options for this subset of Medicare beneficiaries. In 2007, taking into account employer sponsored plans, 96% of all beneficiaries had access to both a coordinated care plan and a private fee for service plan, and 4% of all beneficiaries had access to only a PFFS plan, though again, not all beneficiaries would be eligible to enroll in an employer sponsored plan.

Table 1. Changes in Access to Coordinated Care Plans, Private Fee-for-Service Plans, and Both, by Proportion of Counties and Beneficiaries
(selected years 1997 to 2007)

Year	No Existing Plans in County		Managed Care Only		Private Fee-for-Service Only		Both Managed Care and Private Fee-for-Service	
	% of counties	% of beneficiaries	% of counties	% of beneficiaries	% of counties	% of beneficiaries	% of counties	% of beneficiaries
1997	76%	NA	24%	NA	0%	NA	0%	NA
1999	71%	NA	29%	NA	0%	NA	0%	NA
2001	37%	18%	10%	43%	43%	18%	10%	21%
2002	38%	21%	10%	43%	44%	18%	8%	18%
2003	37%	21%	9%	42%	46%	20%	8%	17%
2004	31%	16%	13%	42%	44%	19%	12%	23%
2005	4%	2%	4%	21%	53%	18%	39%	58%
2006	1%	1%	3%	18%	54%	19%	42%	62%
2007	0%	0%	0%	0%	50%	17%	50%	82%

Source: MedPAC Computations based on CMS public data for 1997 and 1999; CRS analysis of CMS data for 2003-2003; CMS analysis for 2004-2007.

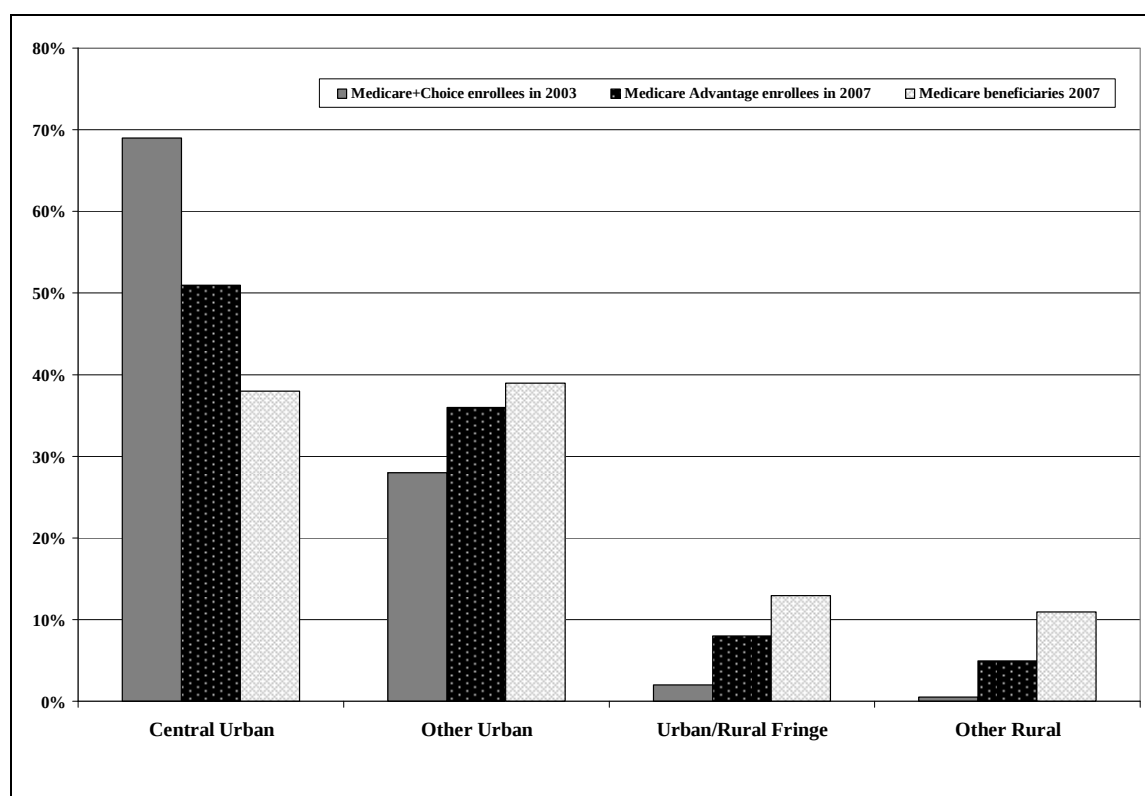
Notes: NA = not available. The table does not include demonstration plans, cost plans, employer-sponsored plans, regional MA plans, or plans serving Puerto Rico. Medicare managed care includes risk plans through 1998, Medicare+Choice plans through 2003, and Medicare Advantage plans starting in 2004. Managed Care includes the PPO demonstration for 2004 and 2005. Regional MA plans cover 38 or 39 states in 2007, but accounted for less than 2% of enrollment. To determine access to managed care plans regardless of access to PFFS plans, add the percentages for "Managed Care Only" and "Both Managed Care and Private Fee-for-Service." Because of rounding and data technicalities, 100% access or 0 plans are not absolute numbers and should be taken as accurate approximations.

Enrollment Patterns in Urban and Rural Locations

Patterns of Medicare Part C enrollment are not uniform across urban and rural locales, and have varied over time as shown in **Figure 4**. The geographic areas are defined as follows:

- Central urban—central counties of metropolitan areas of at least 1 million population.
- Other urban—either fringe counties of metropolitan areas of at least 1 million population or counties of metropolitan areas up to 1 million population.
- Urban/rural fringe—urban population of at least 2,500 adjacent to a metropolitan area.
- Other rural—includes urban population of at least 2,500, not adjacent to a metropolitan area, and rural areas (defined as places with a population of less than 2,500).

Figure 4. Concentration of Medicare Beneficiaries (2007), Medicare Advantage Enrollees (2007), and Medicare+Choice Enrollees (2003) in Urban and Rural Locations



Source: Prepared by CRS based on CMS data.

In 2003, most M+C enrollees resided in central urban areas; about 69% of the M+C population lived in a central urban area in 2003. This percentage decreased to 51% in 2007. However, a smaller proportion, only 39% of all Medicare beneficiaries reside in the central urban areas. (The urban and rural pattern of beneficiary residence as defined above remained the same from 2003 to 2007.) In all geographic areas, except central urban areas, the percentages enrolled in private

plans are less than the percentage of Medicare beneficiaries overall. (For example, 13% of Medicare beneficiaries live in the urban/rural fringe areas, but MA enrollees in those areas made up only 8% of total private plan enrollment in 2007, up from 2% of private plan enrollment in 2003.) This means that a larger proportion of the Medicare population in the central urban areas choose to enroll in Medicare private plans relative to other geographic areas; conversely, a lower proportion of beneficiaries choose to enroll in private plans in non-central urban areas, though that trend is decreasing.

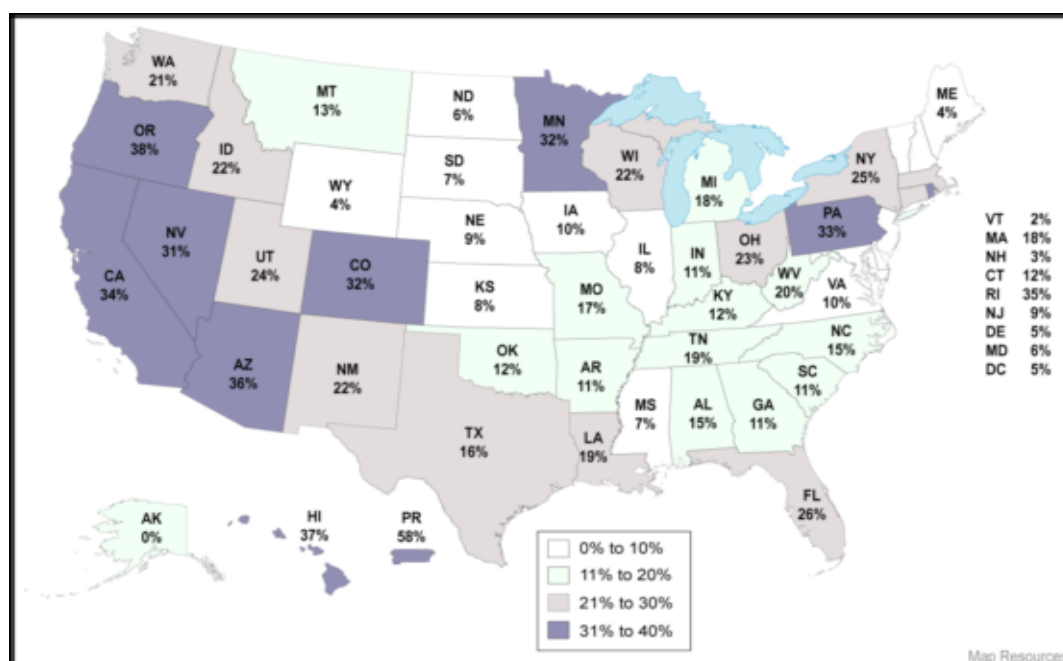
Historically, the high enrollment trend in central urban areas occurred because of a combination of interrelated factors, such as historic patterns of managed care enrollment in the non-Medicare market, availability of different plans, and plan benefits. More recently, with greater availability of private plans in suburban and rural areas, more beneficiaries living in those areas are enrolling in MA plans; the urban concentration of MA enrollment is decreasing.

Regional and Geographic Variation in Enrollment

In addition to rural and urban variations, enrollment patterns also vary on a regional basis, though not by as much as in previous years. MA enrollment is slightly higher in western and southwestern states, as shown in **Figure 5**. Approximately 36% of the beneficiaries in Arizona, 34% of the beneficiaries in California, and 38% of the beneficiaries in Oregon are in MA plans. The highest levels of enrollment in the eastern states are in Rhode Island (35%), Florida (26%), Pennsylvania (33%), and New York (25%). Only one state, Alaska, has less than 1% of beneficiaries enrolled in MA. Seventeen states have enrollment of 10% or less. A total of 34 states have enrollment of less than the national average of 21%.

MA enrollees are more concentrated geographically than Medicare beneficiaries as a whole, though this trend has decreased from 2003 to 2008. In 2003, the four states with the highest percentage of beneficiaries enrolled in Medicare Part C accounted for over half of all enrollment: California, Florida, Pennsylvania, and New York. These four states accounted for 59% of all enrollees in 2003, but they are home to only 30 % of all Medicare beneficiaries. In 2007, enrollment has become slightly less concentrated, with enrollment in those four states accounting for 41% of all MA enrollment. **Table 2** compares the percent of Medicare Part C enrollment to the percent of the total Medicare population for each of these four states.

Figure 5. Percentage of Medicare Beneficiaries Enrolled in Medicare Advantage, by State, January 2008



Source: Prepared by CRS based on data from the Centers for Medicare and Medicaid Services.

Notes: State numbers represent percentages.

Table 2. Shares of Medicare+Choice and Medicare Advantage Enrollment and Medicare Population Residing in Four States
(January 2003 and 2008)

State	% of Total Medicare Population	% of Total M+C Population in 2003	% of Total MA Enrollment in 2008
California	10	28	16
Florida	7	12	9
Pennsylvania	5	10	8
New York	7	9	8
Total	30	59	41

Source: Prepared by CRS based on data from CMS.

Notes: Numbers may not add due to rounding. Proportion of total Medicare population in each state remained the same from 2003 to 2008.

Rules for Eligibility and Enrollment

The MA program includes specific rules regarding eligibility to enroll in a private plan, and when enrollment can take place. The following is a description of those requirements.

Eligibility

Medicare beneficiaries are eligible to enroll in any MA plan that serves their area, with the following restrictions: (1) beneficiaries must be entitled to benefits under Part A of Medicare and enrolled in Part B of Medicare and (2) beneficiaries who qualify for Medicare solely on the basis of end-stage renal disease (ESRD) may not enroll in an MA plan. Three exceptions apply to individuals with ESRD: (1) a beneficiary enrolled in an MA plan who later develops ESRD may continue to remain enrolled in that plan; (2) if a plan terminates its contract or reduces its service area (for an enrollee this is referred to as an involuntary termination), ESRD enrollees may enroll in another MA plan; and (3) an individual with ESRD may elect to enroll in an MA SNP as long as the plan has opted to enroll ESRD individuals. Members of an Employer Group Health Plan (EGHP) may also elect their employer's MA plan even if the individual resides outside the MA plan service area provided the plan meets certain access requirements.

Residency Requirements

An MA eligible individual may only enroll in an MA plan that serves the geographic area in which the individual resides, with two exceptions: (1) a plan may allow an individual to remain in a local plan, even if he or she no longer resides in the service area, so long as the plan provides reasonable access within that geographic area to the full range of basic benefits, with reasonable cost sharing, and (2) a local MA organization that eliminates a payment area previously within its service area may choose to offer enrollees in all or part of the affected area continued enrollment in the plan, under certain conditions. Local HMOs may determine their own service area, consisting of counties or equivalent areas. Nothing prevents a local plan from being offered in more than one MA area.

Enrollment Periods

In general, MA organizations can enroll Medicare eligible individuals during four enrollment periods: (1) initial coverage election period, (2) annual election period, (3) open enrollment period, and (4) special election periods. The initial coverage election period applies to newly eligible Medicare beneficiaries, who are allowed to enroll in an MA plan up to three months prior to their Medicare entitlement date. During the annual coordinated election period (November 15-December 31), all MA eligible beneficiaries can enroll or disenroll from any MA plan, or switch from original Medicare to MA, or MA to original Medicare. Changes in elections are made during the open enrollment period. The open enrollment period allows individuals to make one change during the first three months of the year. Beneficiaries in original Medicare can enroll in an MA plan, and individuals enrolled in an MA plan can either switch to a different MA plan or return to original Medicare. However, during the three-month open enrollment period, beneficiaries cannot change their drug coverage. For example, an individual enrolled in a MA-PD plan can elect only to enroll in another MA-PD plan. Similarly, an individual enrolled in original Medicare and a stand-alone PDP can change only to an MA-PD plan. The reverse is true as well.

Individuals enrolled in original Medicare without drug coverage can enroll only in MA plans that do not offer drug coverage. Eligible beneficiaries who are institutionalized may change their election any time during the year.

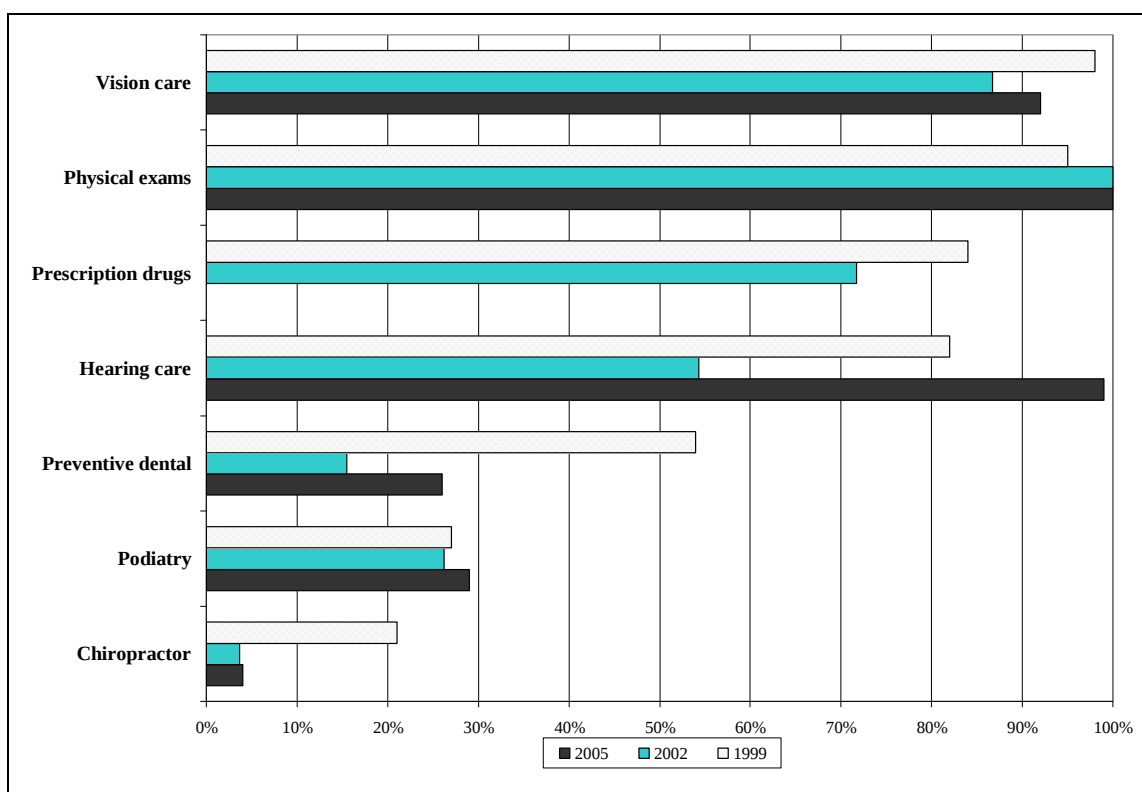
Special Election Periods

Outside the annual coordinated election period and open election period, beneficiaries can change their enrollment status only under special circumstances, called Special Election Periods (SEPs). The Secretary has created SEPs for the following instances: (1) when the organization has terminated its contract or discontinued offering its plan in the resident's service area, (2) the resident moves to a new service area, (3) the beneficiary can demonstrate that the plan has violated the terms of its contract (i.e., fails to provide medically necessary care or misrepresents the plan in its marketing materials), or (4) the individual meets other exceptional circumstances provided by CMS.

Supplemental Benefits

Nearly all plans offer some benefits to enrollees beyond those in original Medicare. All supplemental benefits are paid for either with (1) a rebate earned by the plan through the bidding process, (2) directly by the enrollee through a supplemental premium, or (3) some combination of a plan rebate and supplemental premium. A Government Accountability Office (GAO) analysis of MA plan supplemental benefits (as projected by the plans in their 2007 bid documents) indicated that, overall, rebates paid for 77% of supplemental benefits, and additional premiums paid for the remaining 23%. However, the proportions varied by plan. Other analyses have examined supplemental benefits offered to enrollees in the lowest premium package offered by each participating organization; benefits in these packages would be more likely to be paid for through savings rather than a supplemental premium. These analyses found that in 2005, most MA enrollees were offered vision care (92%) and hearing coverage (99%), while all were offered routine physicals (100%) (**Figure 6**). Prescription drug coverage was a popular supplemental benefit prior to the start of the new Medicare Part D prescription drug program; with the Part D program, some type of prescription drug coverage is available to all enrollees who choose to join an MA plan that covers drugs. **Figure 6** shows that the percentage of enrollees offered these benefits has fluctuated for all services between 1999 and 2005. However, the figure does not show how the extent of benefits or the level of cost sharing may have changed over the time period.

Figure 6. Percentage of M+C and MA Enrollees Offered Benefits Beyond Traditional Medicare Covered Services, in the Lowest Premium Package Available, 1999, 2002, and 2005.



Source: Chart prepared by CRS based on Mathematica Policy Research analysis of CMS data.

Premiums

All MA enrollees are required to pay the Part B premium, although plans may pay this for their enrollees as a supplemental benefit. Plans are permitted to charge enrollees additional out-of-pocket fees, such as premiums and coinsurance, depending on which plan the individual elects. Any supplemental premium charged to plan enrollees is a consolidation of any of the following three charges: (1) a premium to cover basic Part A and B benefits if a plan bid was above the benchmark, (2) a premium to cover supplemental benefits not paid for through a plan rebate, and (3) a premium for Part D prescription drug coverage. However, plans have an incentive to minimize supplemental premiums in order to remain competitive in local markets.

Between 1999 and 2003, the percentage of beneficiaries nationally with access to a zero premium coordinated care plan declined. As shown in **Table 3**, the availability of these plans dropped by half, from over 60% to just under 30%. Between 2003 and 2006, access to a zero premium plan doubled, again achieving the previous high of 61%. The percentage of beneficiaries enrolled in a zero premium coordinated care plan has fluctuated as well, but changes in the methodology make a comparison of this measure over time difficult. In 2006, just over half of MA coordinated care plan enrollees were in a plan with a zero combined premium for Part C and Part D benefits.

Table 3. Changes in Access to or Coverage Under a Medicare+Choice or Medicare Advantage Coordinated Care Plan with a Zero Premium, 1999 to 2006.

Year	Overall Medicare Population with Access to Zero Premium Coordinated Care Plan	Enrollees with Zero Premium Coordinated Care Plan
1999	61	68
2000	53	61
2001	39	45
2002	34	39
2003	29	38
2004	40	48 ^a
2005	42	58 ^a
2006	61	52 ^b

Source: Centers for Medicare and Medicaid Services. Analysis of submitted bids from Health Plan Management System (HPMS) data; data development by the Office of Research, Development and Information.

Notes: This table does not include Private Fee-or-Service or employer sponsored plans. It includes Special Needs Plans, Health maintenance Organizations, Preferred Provider Organizations, and Provider Sponsored Organizations.

- a. Enrollment in zero premium plan reflects actual enrollment as reported by the plan. In prior years, enrollees were assigned to the zero premium plan if one was available.
- b. For 2006, zero premium refers to the combined part C and part D premium.

Coverage for Prescription Drugs

Prior to 2006, one of the advantages of Medicare private plans over original Medicare was that most plans included some outpatient prescription drug coverage. The MMA added the Medicare Part D prescription drug program, making some type of drug coverage available to all beneficiaries. With one exception, every MA organization in an area is required to offer at least one Medicare Advantage-Prescription Drug (MA-PD) plan, one that offers qualified Part D prescription drug coverage. PFFS plans are not required to offer a plan with qualified prescription drug benefits. If a beneficiary enrolls in a PFFS plan that does not provide prescription drug coverage, he or she can enroll in a stand-alone Part D prescription drug plan in addition to the PFFS plan. Beneficiaries who choose any other MA plan without drug coverage can not enroll in a stand alone Part D plan.

MA organizations offering prescription drug coverage receive a direct subsidy for each enrollee in an MA-PD plan equal to the plan's adjusted standardized bid amount for its prescription drug benefit (reduced by the base beneficiary Part D premium). The plan also receives the reinsurance payment amount of 80% of the costs for drugs exceeding the annual out-of-pocket threshold for an enrollee (\$4,050 in 2008). Finally, MA-PD plans receive reimbursement for premium cost-sharing reductions for their qualifying low-income enrollees.

Beneficiaries who enroll in an MA plan offering Part D must pay the plan the standard Part D premium. However, MA-PD plans that receive a rebate in the bidding process may use all or part of that rebate as a credit toward the MA monthly prescription drug premium.

Beneficiary Protections

The MA program includes requirements designed to limit beneficiaries' financial liability and to assure beneficiaries of certain rights. Among these beneficiary protections are standards to ensure access to Medicare benefits and providers, beneficiary liability standards, health care quality standards, consumer disclosure and plan marketing requirements, and a grievance and appeals process.

Enrollment

In general, MA organizations cannot deny enrollment on the basis of health status-related factors. These factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. However, an organization may deny enrollment if it has reached the limits of its capacity. Organizations may terminate an enrollee's election only for failure to pay premiums on a timely basis, disruptive behavior, or because the plan ends for all MA enrollees.

Access to Providers

Coordinated care plans such as HMOs and PPOs are required to form provider networks to meet Medicare access requirements. In accordance with network requirements, each provider has a written contract or agreement to furnish services to plan enrollees. Care is generally not covered or is partially covered if received from a provider who is not in the plan's network. Regional PPOs, despite being coordinated care plans, can use methods other than written agreements to meet access requirements with the Secretary's approval.

Prior to 2011, however, PFFS plans are not required to establish networks of providers. PFFS plans must permit enrollees to obtain services from any Medicare participating provider that agrees to the plans' terms and conditions. PFFS plans meet access requirements by (1) establishing payment rates that are not less than those under original FFS Medicare or (2) having signed (direct) contracts with a sufficient number and range of providers in a particular category. Most PFFS plans are meeting access requirements by paying providers the same rates as original Medicare. Starting in 2011, PFFS plans sponsored by employers or unions are required to establish contracted networks of providers to meet access requirements. Non-employer-sponsored MA PFFS plans are required to establish contracted networks of providers in network areas defined as areas having at least two plans with networks (such as HMOs, PSOs, or local PPOs). In areas without at least two network based plans, the non-employer PFFS plans retain the ability to establish access requirements through establishing payment rates that are not less than those under original Medicare.

Enrollees in PFFS plans may obtain covered services from any Medicare eligible provider who is willing to furnish services and accepts the plan's terms and conditions of participation. However, the lack of a written agreement between the plan and provider (in areas where PFFS plans do not have a contracted network of providers) means that the providers are not required to treat plan enrollees. Providers may determine on a case-by-case or visit-by-visit basis whether to serve a plan's enrollees.

Other access requirements include developing written standards to ensure that access to care is timely; developing policies and procedures in the areas of coverage, payment, and utilization; and establishing written requirements for ensuring beneficiary input in a treatment plan. Plans must also ensure that services are available 24 hours a day 7 days a week and provide access to ambulance and emergency services.

Access to Benefits

CMS reviews and approves MA plan benefit offerings, including mandatory and optional supplemental benefits, to ensure that plans are providing all Part A and B covered services (except hospice), do not discriminate against beneficiaries, do not discourage enrollment or encourage disenrollment, do not steer subsets of Medicare beneficiaries to certain MA plans, or inhibit access to services. CMS also reviews mandatory supplemental benefits (i.e., benefits not covered under original Medicare, reduced Medicare premiums, or cost-sharing amounts) to ensure that they are designed in accordance with CMS's guidelines and requirements.

Beneficiary Financial Liability Protections

Enrollees in MA-coordinated care plans (i.e., HMOs and PPOs) are likely to experience the least amount of out-of-pocket costs (compared to other MA plans). Cost sharing per enrollee (excluding premiums) for covered services cannot be more than the actuarial value of the deductibles, coinsurance, and co-payments under traditional Medicare. However, while the aggregate amount of cost sharing in an MA plan must be equal to the aggregate amount of cost sharing in original Medicare, the plan may set different amounts for specific services, such as a lower (or higher) deductible for hospital inpatient services or skilled nursing facility services.

Balance billing under Medicare generally refers to an amount billed by a provider in excess of Medicare's recognized payment amount (which includes beneficiary cost sharing). Original Medicare prohibits balance billing by Medicare-"participating physicians" but allows non-participating physicians to balance bill up to 115% of the non-participating Medicare fee-schedule amount, which is 9.25% above the recognized amount for participating providers.

Providers participating in coordinated care MA plans, such as HMOs, are prohibited from balance billing. However, providers participating in PFFS plans are allowed to balance bill enrollees up to 115% of the plan's fee schedule, subject to the terms and conditions of the plan. This means that if a PFFS plan allows providers to balance bill, the beneficiary would be responsible for any balance billing charges in addition to any cost-sharing required by the plan. If the PFFS plan does not allow balance billing, the beneficiary is not responsible for balance billing charges, but would be responsible for any cost-sharing requirements under the plan. Balance billing rules under PFFS plans may apply to all types of Medicare providers. PFFS plans are obliged to inform beneficiaries of these balance billing amounts, and hospitals are required to provide PFFS enrollees advanced notice of balance billing charges.

Quality Standards

All MA organizations are required to have a quality improvement program. As part of the quality improvement program, plans must collect, analyze, and report data to measure health outcomes and other indices. Specific requirements include designing a chronic care improvement program,

conducting quality improvement projects, and encouraging providers to participate in CMS and HHS quality initiatives. Plans are required to annually assess the impact and effectiveness of their quality improvement programs and take timely action to correct any systemic problems that come to their attention.

CMS requires that MA plans collect and report on a subset of performance measures from the National Committee for Quality Assurance's (NCQA's) Health Plan Employer Data and Information Set (HEDIS), the Consumer Assessment of Health Plans Study (CAHPS), and the Medicare Health Outcomes Survey (HOS).

Consumer Disclosure Requirements

MA organizations must disclose to each enrollee (at the time of enrollment and at least annually) information on their service area, benefits, the number, mix, and distribution of providers, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, plan grievance and appeals procedures, the quality improvement program, disenrollment rights and responsibilities, and cost-sharing obligations. MA organizations must make a good faith effort to provide enrollees with written notice of a provider's termination from the plan's network at least 30 days prior to the termination date. Medicare-eligible enrollees are also allowed to request from the plan information on procedures used by the organization to control utilization, the number of grievances and appeals, a description of physician compensation practices, and descriptions of the plan's financial performance. When an MA organization terminates its contract with CMS, it must provide and pay for advance written notice to each of its enrollees, along with a description of alternatives for obtaining benefits.

Marketing Requirements

MA organizations are required to submit marketing brochures and enrollment forms to CMS for review and approval at least 45 days before distribution. If using CMS model materials, the approval time is reduced from 45 to 10 days. As part of the review process, CMS must ensure that the information provided to beneficiaries is not inaccurate or misleading. MA organizations are also required to develop marketing materials that provide an adequate description of plan benefits, providers, and fees; an explanation of the grievance and appeals process; notification of the open enrollment period; and a statement indicating that either the plan or CMS can terminate the contract, thereby resulting in the beneficiary's disenrollment from the plan.

CMS has also developed standards for regulating the marketing conduct of MA organizations. These standards include prohibitions against door-to-door soliciting, providing cash or other monetary rebates to induce enrollment, and conducting misleading or confusing activities, such as claiming that the MA organization has been endorsed by CMS or Medicare. Further, providers cannot distribute information to beneficiaries comparing benefits across plans or allow beneficiaries to complete enrollment applications in provider offices.

CMS issued a proposed rule in May 2008 changing some marketing standards into regulations. Prior to the issuance of a final rule, MIPPA established the following new prohibitions on the marketing activities of MA plans. Except in instances where the beneficiary initiates contact, plans will be prohibited from soliciting beneficiaries door-to-door or on the phone. Cross-selling of non-health products, providing meals to prospective enrollees, marketing or selling plans at educational events or in areas where health care is delivered (i.e., physician offices or

pharmacies), and using sales agents that are not state licensed are also prohibited. MIPPA required that by November 15, 2008, the Secretary establish limitations on other plan marketing activities such as co-branding, the scope of marketing appointments with prospective enrollees, and agent compensation and training. MA plans will be required to provide states with information on (1) agent and broker terminations and (2) at state request, performance and licensing of agents, brokers, and any third party representing the plan. After January 1, 2010, MA plans will be required to include the plan type in all plan names. Some provisions included in the CMS proposed rule were not included in MIPPA but may be addressed in the final rule, including (1) a requirement that, upon CMS's request, MA plans would be required to provide any information necessary to conduct oversight of marketing activities, and (2) development of a memorandum of understanding between states and CMS to share compliance and oversight information.

Grievance and Appeals

An MA organization must have procedures for hearing and resolving grievances between the organization and enrollees. It also must maintain a process for making timely organization determinations, which are plan decisions related to enrollees' benefits and payment. Beneficiaries have 60 days from the date of service to file a grievance with their MA plan. Beneficiaries have the right to a timely resolution to their grievance (no later than 30 days) as well as the right to request an appeal or reconsideration of an organization determination. In certain circumstances, beneficiaries may also request an expedited determination, which requires a decision be rendered in 72 hours. All MA organizations are required to provide written information to enrollees about these processes. They are also required to inform beneficiaries about how to initiate quality of care complaints to their local Quality Improvement Organization (QIO). The QIO complaint process is distinct from the MA organization's grievance procedure, and beneficiaries have the right to file a complaint with the MA organization and QIO simultaneously. All quality-of-care complaints and adverse organization determinations must be responded to in writing.

Program Standards and Contract Requirements

The MA program requires the private health plans that participate to meet minimum program standards and contracting requirements. These requirements include minimum enrollment standards, organizational and financial requirements as specified by states, provider protections, and prompt payment requirements. The Secretary is required to conduct audits of at least one-third of MA participating organizations each year. In the event that organizations violate the standards and requirements, the Secretary had the authority to terminate the contract or impose sanctions.

Minimum Enrollment Standards

Contracts between MA organizations and CMS are made for at least one year and are automatically renewable, unless either party gives notice to terminate the contract. MA organizations must enroll at least 5,000 individuals (1,500 in the case of a PSO) or at least 1,500 individuals (500 in the case of a PSO) if the organization serves individuals residing outside of urbanized areas. These minimum requirements may be waived during the first three years of the

contract, if the organization can demonstrate to CMS that it can administer and manage an MA contract and also manage the level of risk required under the contract.

Organizational and Financial Requirements

In general, an MA organization must be licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers an MA plan. An MA organization must assume full risk for Medicare benefits on a prospective basis. However, this does not preclude an organization from obtaining insurance or making other arrangements to cover certain costs, such as medically necessary services provided by non-network providers and part of the costs exceeding its income. The organization also may make arrangements with providers to assume some or all of the financial risk for covered benefits they provide; however, PFFS organizations cannot put providers at risk.

Provider Protections and Requirements

Each MA organization (other than a PFFS) must establish physician participation procedures that provide (1) notice of the participation rules, (2) written notice of adverse participation decisions, and (3) a process for appealing adverse decisions. The organization must consult with contracting physicians regarding the organization's medical policy, quality, and medical management procedures.

Although plans may include providers only to the extent necessary to meet the needs of their enrollees, they cannot discriminate with respect to providers who are acting within the scope of their license or certification under applicable state law, solely on the basis of such license or certification. Restricting communications between providers and their patients (a gag clause) is prohibited. The use of physician financial incentive plans, (compensation arrangements between organizations and individual or groups of physicians that may reduce or limit services) is also limited.

Protections Against Fraud

The Secretary is required to conduct annual audits of the financial records of at least one-third of the MA participating organizations (including data relating to utilization, costs, and computation of the plan's bid). The Secretary also has the right to inspect and audit the quality, appropriateness, and timeliness of the services provided to enrollees, as well as any records pertaining to the organization's ability to bear risk. In addition, HHS, GAO, or their designee has the right to audit and evaluate an MA organization's records and those of its subcontractors that pertain to the services provided under the contract. This right extends for 10 years from the termination date of the final contract. If CMS suspects potential fraud, the agency may conduct an inspection or audit of the MA organization at any time.

Prompt Payment Requirements

MA PFFS plans are required to pay 95% of "clean claims" within 30 days of receipt. This 30-day rule also applies to claims submitted to any MA organization by a provider who does not have a written contract with the plan. MA organizations are required to pay interest on "clean claims" that are not paid within 30 days. All other claims from non-contracted providers must be paid within

60 days. MA organizations that do contract with providers (i.e., HMOs and PPOs) must include a prompt payment provision in their contracts. CMS defines a clean claim as a claim that has no defect or impropriety, and is submitted with all the required documentation.

Contract Terminations and Sanctions

The Secretary has the authority to terminate an annual contract with an MA plan if the MA organization fails substantially to carry out the terms of its contract. Reasons for termination can be severe financial difficulties, failing to comply with required grievance and appeals procedures, failing to implement an acceptable quality assessment and performance improvement program, failing to comply with CMS marketing requirements, and committing fraud. Except in instances where the MA organization is experiencing severe financial hardship, CMS is required to provide the organization with an opportunity to develop a corrective action plan (CAP) to correct any deficiencies before terminating the contract. MA organizations have the right to appeal a termination. MA organizations also have the right to terminate their contract with CMS if CMS fails to substantially carry out the terms of its contract.

The Secretary has the authority to impose sanctions, including civil monetary penalties, on MA organizations in the following eight instances: (1) failing to provide medically necessary services, which result in an adverse outcome for the patient; (2) charging excess beneficiary premiums; (3) expelling or refusing to reenroll individuals in violation of stated requirements; (4) denying or discouraging enrollment of individuals whose medical condition requires future services; (5) misrepresenting or falsifying information to the Secretary or others; (6) interfering with practitioners advice to enrollees; (7) failing to comply with rules regarding physician participation and balance billing; and (8) contracting with excluded providers. In addition to civil monetary penalties, the Secretary can temporarily suspend enrollment in the plan, stop payment, and restrict the MA organization's marketing activities. The civil monetary penalties may range from \$10,000 to \$100,000, depending on the nature of the violation.

Issues for Congress

The 111th Congress may examine several aspects of the Medicare Advantage program, including the difference in expenditures per beneficiary between MA and original Medicare, profits reported by MA plans, the Comparative Cost Adjustment Program mandated under the MMA, and marketing issues.

Per Beneficiary Expenditure Differences Between MA and Original Medicare

Medicare-managed care plans may have the potential to provide better quality care at less cost than original Medicare.⁵ In fact, prior to the BBA, private plans were paid 95% of the cost of

⁵ For the House Budget Committee, CMS Administrator Mark McClellan testified that MA plans brought "greater value to our overall health care system, in terms of enabling beneficiaries to get more up-to-date, higher-quality care at a lower cost." However, his argument defined costs more broadly than program by including beneficiary out-of-pocket costs as well. http://budget.house.gov/hearings/2007/06.28mcclellan_testimony.pdf.

Medicare, in part because of this presumed greater efficiency. However, the current payment mechanism does not encourage plans to be more efficient than original Medicare, because it pays plans at least as much as the cost of Medicare, and on average, more. According to the Medicare Payment Advisory Commission (MedPac), Medicare is expected to pay private plans an average of 14% more per beneficiary in 2009 than it does for beneficiaries enrolled in the original Medicare program. In 2008, the *maximum* amount Medicare was willing to pay MA plans to provide Medicare covered benefits was, on average, 18% higher than the estimated cost of providing those same benefits under original Medicare.⁶ MA health maintenance organizations were the only plan type that, on average, estimated their cost of providing Medicare-covered benefits at below the cost of original Medicare; this suggests MA health maintenance organizations can be more cost effective than original Medicare.

MA plans use at least part of the payments (above the cost of original Medicare) to provide extra benefits and reduced cost sharing to enrollees. In addition, these higher payments have attracted private plans to areas previously underserved by Medicare private plans, and beneficiaries today have more private plans to choose from than they did 10 years ago. However, the higher payments (1) allow inefficient plans to continue participating in Medicare, (2) contribute to the financial instability of the program in the long-run, and (3) increase Part B premium costs for all beneficiaries in the Medicare program. Moreover, the reported quality data for MA plans are limited and variable.⁷ Both MA payments and quality measures are to be addressed in upcoming MedPac reports to Congress.⁸ Specifically, MedPac is to study how comparable measures of performance and patient experience can be collected and reported by 2011 for MA and original Medicare. The second study requires MedPac to study the relationship between plan bids and per capita spending in original Medicare, alternatives to county level payments, and the accuracy and completeness of county-level spending estimates.

Congress may choose to reexamine MA payments and whether the amount paid to MA plans above the cost of original Medicare should remain part of the MA payment, or whether that money should be used for other priorities. If Congress chooses to reduce spending in the MA program, there are many different ways of achieving these savings. Reducing payments, regardless of the method, may result in reduced supplemental benefits or reduced access to plans. However, each individual option would have different pros and cons.

One provision included in the House-passed H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007, would have phased in MA benchmarks equal to per capita fee-for-service (FFS) spending in each county, effectively decreasing MA benchmarks in all areas where it exceeded average Medicare spending. MA plans would need to be as efficient as original Medicare in order to continue serving Medicare beneficiaries. This provision was not taken up by the Senate. The Congressional Budget Office (CBO) estimated that setting benchmarks equal to spending in original Medicare could save \$55 billion over 5 years and \$157 billion over 10 years.⁹ Though this method would eliminate the unequal expenditures between MA and original

⁶ Medicare Payment Advisory Commission, *Report to Congress*, March 2008, pp. 249-251, http://www.medpac.gov/chapters/Mar08_Ch03.pdf.

⁷ Medicare Payment Advisory Commission, *Report to Congress*, March 2008, pp. 249-251, http://www.medpac.gov/chapters/Mar08_Ch03.pdf.

⁸ CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*

⁹ Congressional Budget Office, *Budget Options*, December 2008, pp. 119-123, <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>.

Medicare—sometimes referred to as “creating a level playing field”—it could result in decreased access to MA plans in rural and some urban areas, thus increasing a geographic difference that was prevalent through all but the most recent years of the program.

Other options would reduce payments while allowing for some differences between MA and original Medicare. Some argue that certain costs faced by private plans, such as administrative costs and payments to health care providers, are not the same as those of original Medicare, and therefore, the maximum amount Medicare pays private plans should not be as low as original Medicare in some areas.¹⁰ In such case, benchmarks could take into account the estimated costs of MA plans, much like the Regional MA plans. The CBO estimated that basing benchmarks on plan bids could save \$35 billion over 5 years and \$158 billion over 10 years.¹¹ This option would not create a level playing field between MA and original Medicare. However, it would still achieve some savings and might not have as severe an effect on access to plans, as the cost to plans of serving a particular area would be used to calculate the benchmark for the area.

Another option would be an across-the-board percentage cut in benchmarks. In higher benchmark areas where the benchmark is more likely based on per capita FFS spending, the reduction may resemble the payment policy prior to the BBA when plans were paid a percentage of spending in original Medicare. Depending on the size of the reduction, it is possible that benchmarks for many rural and some urban areas would remain above spending in original Medicare. Again, this option would not create a level playing field between MA and original Medicare. Another disadvantage is that it does not incorporate information from the plans to gauge the cost of doing business in a particular market. However, the largest reductions would occur in high payment rate areas where some of the tools of managed care, such as establishing provider networks and coordinating patient care, may be easier to employ.

Medical Expenditures and Profits

Other issues have arisen with respect to MA plan payments. Recent congressional attention has focused on the profits earned by MA plans. Two analyses by the Government Accountability Office found that MA organizations generally spent less on providing medical services than the plans had estimated they would.¹² As a result, the profit margins for these plans was higher, on average, than plans had predicted. These findings held for 2005 and 2006, resulting in over \$1 billion in additional profits to MA plans each year. The 111th Congress may opt to consider whether to limit MA plan profits in an effort to either reduce overall Medicare spending, or to increase the extra benefits and reduced cost sharing these plans offer to enrollees.

The House-passed CHAMP Act of 2007 included a provision that would have required the Secretary to publish the percentage of plan revenues that were spent on clinical services, as distinct from administration and profit. This amount is often referred to as the Medical Loss Ratio

¹⁰ Robert A. Berenson, "From Politics to Policy: A New Payment Approach to Medicare Advantage," March 2008, pp. w156-w163.

¹¹ Congressional Budget Office, *Budget Options*, December 2008, pp. 119-123, <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>.

¹² Government Accountability Office, *Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005*, GAO-08-827R, June 24, 2008, <http://www.gao.gov/new.items/d08827r.pdf>, and Government Accountability Office, *Medicare Advantage organizations: Actual Expenses and Profits Compared to Projections for 2006*, GAO-09-132, December 8, 2008, <http://www.gao.gov/new.items/d09132r.pdf>.

(MLR).¹³ The bill also required plans with MLRs below a specified level to face reduced benchmarks, limited enrollment, and possible termination. These provisions in CHAMP were not taken up in the Senate.

Comparative Cost Adjustment in 2010

Beginning in 2010, the Secretary will establish a program for the application of comparative cost adjustment (CCA) in CCA areas. The six-year program will begin January 1, 2010, and end December 31, 2015. The program is designed to test direct competition among local MA plans, as well as competition between local MA plans and fee-for-service Medicare. This program will occur only in a limited number of statutorily qualifying areas in the country.

The benchmark for MA local plans in a CCA area will be calculated using a formula that weights (1) the projected FFS spending in an area (with certain adjustments for demographics and health status) and (2) a weighted average of plan bids.

For Medicare beneficiaries in traditional Medicare, Part B premiums in CCA areas will be adjusted either up or down, depending on whether the FFS amount is more or less than the CCA area benchmark. If the FFS amount is greater than the benchmark, beneficiaries in traditional Medicare FFS will pay a higher Part B premium than other FFS beneficiaries in non-CCA areas. If the FFS amount is less than the benchmark, the Part B premium for FFS beneficiaries will be reduced by 75% of the difference. These increases and decreases are subject to a 5% limit; that is, adjustments to Part B premiums in CCA areas cannot exceed 5% of the national part B premium. Beneficiaries in traditional Medicare FFS with incomes below 150% of poverty, who qualify for low-income subsidies under the Medicare prescription drug program, will not have their Part B premium increased.

In the 110th Congress, the House passed legislation to repeal the CCA demonstration, but that provision was not taken up by the Senate. Historically, potential cost saving programs have generated opposition resulting in delays or cancellations.¹⁴ Generally, Members have not supported demonstrations or programs that have the potential to adversely affect companies or beneficiaries in their districts. The Secretary has not announced the locations of the CCA demonstrations.

Marketing

Questionable marketing practices by MA plans, their agents, or brokers has attracted congressional attention. During the 110th Congress, several committees held hearings identifying the allegedly deceptive and aggressive sales practices of some MA plans, such as door-to-door solicitations, misleading beneficiaries about plan coverage, and signing beneficiaries up for a plan without their knowledge. Hearings also investigated factors that may have encouraged aggressive

¹³ For a discussion on the interpretation of medical loss ratios, please see, James C. Robinson, "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance: This accounting tool was never intended to measure quality or efficiency," *Health Affairs*, July/August 1997, pp. 176-187.

¹⁴ For a brief discussion of the Medicare Competitive Pricing Demonstrations during the 1990s, see, Robert A. Berenson, "From Politics to Policy: A New Payment Approach to Medicare Advantage," *Health Affairs*, March 2008, pp. w160-w161.

marketing practices, such as the structure of agent and broker compensation. Though many of the behaviors identified in the hearings were prohibited by CMS guidance, they were not explicitly prohibited by statutes or regulations. On May 16, 2008, CMS issued a proposed rule to codify into regulations some of the marketing policies already in the marketing guidance. Following the proposed rule, Congress passed the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), which codified into statutes some of the provisions in the proposed rule, including (1) prohibiting door-to-door solicitations and other agent-initiated contact; (2) clarifying that sales activities are only permitted in common areas of health care settings and prohibited in areas primarily used for patient care; (3) prohibiting sales activities (such as distribution of applications) at educational events; and (4) requiring that MA and Part D plans only use state-licensed, certified, or registered marketing representatives in states that require using such agents. MIPPA also directed the Secretary to establish guidelines on agent commissions to ensure that commissions encouraged agents to enroll beneficiaries in plans that best met their health care needs. A revised interim final rule established compensation levels for agents and brokers based on historical compensation levels in the same market, adjusted for whether or not this was the first year the beneficiary had enrolled in a particular plan type. Compensation would be decreased if the beneficiary disenrolled from the plan within the first year. It is unclear whether marketing issues for Medicare private plans will garner congressional attention going in the 111th congress. While it appears that the legislation resolved many of the issues, Congress will have to wait and see whether or not those conducting the abusive practices are able to circumvent the changes to the law.

Appendix. Legislative History, 1997 to 2008

This section summarizes major legislation enacted into law that modifies Medicare Part C, beginning in 1997. The summary highlights major provisions; it is not a comprehensive list of all Medicare amendments. Included are provisions that had a significant budget impact, changed program benefits, modified beneficiary cost sharing, or involved major program reforms. Provisions involving policy changes are mentioned the first time they are incorporated in legislation, but not necessarily every time a modification is made. The descriptions include either the initial effective date of the provision or, in the case of budget savings provisions, the fiscal years for which cuts were specified.

Balanced Budget Act of 1997 (BBA, P.L. 105-33)

The BBA established a new part C of Medicare called Medicare+Choice (M+C). It was built on the existing Medicare Risk Contract Program, which enabled beneficiaries to enroll, where available, in health maintenance organizations (HMOs) that contracted with the Medicare Program. It expanded, beginning in 1999, the private plan options that could contract with Medicare to other types of private health care organizations (e.g., PPOs and PSOs), PFFS, and, on a limited demonstration basis, high deductible plans (called MSA plans) offered in conjunction with savings accounts.

Prior to BBA, the payment for private plans was based on 95% of the average adjusted per capita cost (AAPCC) of beneficiaries in original Medicare in each county. BBA replaced that payment methodology with a formula that calculated the highest of three amounts calculated *for each county*: (1) a blended rate, which was blend of an area-specific (local) rate and a national rate; (2) a minimum payment (or floor) rate; or (3) a rate reflecting a minimum increase from the previous year's rate. Payment rates under this formula were subject to a budget neutrality provision such that the total amount of payments under the formula methodology could not be greater or less than the payments in the absence of the formula. The blended per capita rate was intended to shift payment amounts away from local (generally county) rates, which reflected the wide variations in fee-for-service costs, toward a national average rate. The floor rate was designed to raise payments in certain counties more quickly than would occur through the blend alone, and the minimum increase percentage was to protect counties that would otherwise receive only a small (if any) increase.

BBA established an M+C Competitive Pricing Demonstration Project in seven payment areas. Under the demonstration, payments to M+C organizations would be determined competitively, as determined by the Secretary in consultation with an advisory committee.

Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113)

BBRA contained several provisions designed to facilitate the implementation of M+C. It changed the phase-in of the new risk adjustment payment methodology based on health status to a blend of 10% new health status method/90% old demographic method in 2000 and 2001, and not more than 20% health status in 2002. It provided for payment of a new entry bonus of 5% of the monthly M+C payment rate in the first 12 months and 3% in the subsequent 12 months to organizations that offer a plan in a payment area without an M+C plan since 1997, or in an area where all organizations announced withdrawal as of January 1, 2000. The BBRA reduced the

exclusion period from five years to two years for organizations seeking to reenter the M+C Program after withdrawing. It allowed organizations to vary premiums, benefits, and cost sharing across individuals enrolled in the plan so long as these are uniform within segments comprising one or more M+C payment areas. BBRA provided for submission of adjusted community rates by July 1 instead of May 1. It provided that the aggregate amount of user fees collected would be based on the number of M+C beneficiaries in plans compared to the total number of beneficiaries. It also delayed implementation of the Medicare+Choice Competitive Bidding Demonstration Project, until 2002 at the earliest.

Medicare, Medicaid, and SCHIP Benefits Improvements, and Protection Act of 2000 (BIPA, P.L. 106-554)

BIPA established multiple floor rates, based on population and location. It applied a 3% minimum update in 2001, which returned to the existing law minimum update of 2% thereafter. BIPA increased the M+C payment rates for enrollees with ESRD to reflect the demonstration rate of social health maintenance organizations' ESRD capitation demonstrations. BIPA extended the current risk adjustment methodology until 2003 and, starting in 2004, began to phase-in a new risk adjustment methodology based on data from inpatient hospitals and ambulatory settings. It permitted M+C plans to offer reduced Medicare Part B premiums to their enrollees as part of providing any required additional benefits or reduced cost-sharing. It extended the application of the new entry bonus for M+C plans to include areas for which notification had been provided, as of October 3, 2000, that no plans would be available January 1, 2001. It required payment adjustments to M+C plans if a legislative change resulted in significant increased costs. It precluded the Secretary from implementing, other than at the beginning of a calendar year, regulations that imposed new, significant regulatory requirements on M+C organizations. BIPA required the Secretary to make decisions, within 10 days, approving or modifying marketing material used by M+C organizations, provided that the organization used model language specified by the Secretary. A provision allowed an M+C organization offering a plan in an area with more than one local coverage policy to use the local coverage policy for the part of the area that was most beneficial to M+C enrollees (as identified by the Secretary) for all M+C enrollees enrolled in the plan. BIPA expanded the M+C quality assurance programs for M+C plans to include a separate focus on racial and ethnic minorities. The Secretary was given authority to waive or modify requirements that hindered the design of, offering of, or enrollment in certain M+C plans, such as M+C plans under contract between M+C organizations and employers, labor organizations, or trustees of a fund established by employers and/or labor organizations. BIPA extended the period for Medigap enrollment for certain M+C enrollees affected by termination of coverage. It allowed individuals who enrolled in an M+C plan after the 10th day of the month to receive coverage beginning on the first day of the next calendar month. It permitted ESRD beneficiaries to enroll in another M+C plan if they lost coverage when their plan terminated its contract or reduced its service area. It required an M+C plan to cover post-hospitalization skilled nursing care through an enrollee's "home skilled nursing facility" in certain situations. BIPA mandated review of ACR submissions by the HCFA (now CMS) Chief Actuary.

Public Health Security and Bioterrorism Preparedness and Response Act (P.L. 107-188)

P.L. 107-188 moved CMS's annual announcement of M+C payment rates from no later than March 1 to no later than the second Monday in May, effective only in 2003 and 2004. It

temporarily moved the deadline for plans to submit information about ACRs, M+C premiums, cost sharing, and additional benefits (if any) from no later than July 1 to no later than the second Monday in September in 2002, 2003, and 2004. It changed the annual coordinated election period from the month of November to November 15 through December 31 in 2002, 2003, and 2004. It allowed Medicare beneficiaries to make and change elections to an M+C plan on an ongoing basis through 2004. Then beginning in 2005, individuals would be able to make changes only on the more limited basis, originally scheduled to be phased in beginning in 2002.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173)

In 2003, Congress passed the MMA, which made significant changes to Medicare's private plan option. For 2004, the MMA modified payment rates to plans. First, a fourth payment mechanism was added so that plans were paid the highest of the floor, minimum percentage increase, the blend or a new amount equal to 100% per capita fee-for-service for a beneficiary in original Medicare (including the value of indirect medical education.) Second, the blend payment type was not subject a budget neutrality provision. Third, beginning in 2004, the minimum percentage increase is the greater of either 2% or the growth in overall Medicare for the previous year. Beginning in 2005, the floor and blend payment types are eliminated; only the minimum percent increase amount, and in certain years, 100% of per capita FFS would be used to update payments.

Beginning in 2006, the MMA established a new payment methodology to pay private plans. Under the new payment system, Medicare continues to pay plans a fixed monthly amount per enrollee, but these monthly payments are determined, at least in part, by competitive bidding. The Secretary determines MA payments by comparing plan's estimated cost of providing covered Part A and B benefits (the bid) to the maximum amount Medicare is willing to pay a plan to provide covered Part A and B benefits (the benchmark). The benchmark amounts are the former per capita payment rates, and a revised update methodology applies. For plans that bid below the benchmark, the payment equals the bid amount plus 75% of the difference between the bid and the benchmark. The amount above the plan's bid may be used to provide additional benefits, reduce cost sharing, or may be applied towards the monthly Part B premium, or prescription drug premium. The remaining 25% is retained by the government. For plans that bid above the benchmark, the payment is the benchmark and enrollees must pay an additional premium equal to the amount by which the bid exceeds the benchmark.

Also beginning in 2006, MA regional plans are allowed to participate in the program. MA regional plans are coordinated care plans that cover both in- and out-of-network required services. Unlike local MA plans, regional MA plans are required to serve at least one entire region established by the Secretary. (The Secretary established 26 regions made up of states or multiple states.) Each regional plan is required to offer a maximum limit on out-of-pocket expenses and a unified Part A and B deductible. Payments for regional plans are also based on a competitive system described above, but for the regional program, the benchmark for each region is calculated using a statutory formula that includes a weighted average of plan bids for the region. The MMA established several incentives for private plans to participate in the regional program. Initially, \$10 billion was provided in a stabilization fund, and additional amounts were to be added to the fund when regional plans bid below the benchmark. (Half of the 25% retained by the government when a regional plan bids below the benchmark is transferred to the MA regional plan stabilization fund.) During 2006 and 2007, Medicare was to share risk with MA regional plans if plan costs fall above or below a statutorily-specified risk corridor. Beginning in 2006, the

Secretary was allowed to provide for an increased payment for certain hospitals that contract with MA regional plans.

Beginning in 2006, beneficiaries can enroll in a Medicare Part D prescription drug plan whether they were in fee-for-service Medicare or enrolled in Medicare managed care. MA enrollees (except those in PFFS and MSAs) are required to get Part D benefits through their MA plan, if they want the Part D benefit.

MMA established the Medicare Special Needs Plan (SNP) option, which was intended to improve care coordination and service delivery for certain groups of Medicare beneficiaries. Under the SNP option, Medicare managed care plans are allowed to limit enrollment to certain types of beneficiaries such as dual eligibles. SNP plans may choose to better coordinate the care of dual eligibles by contracting with the state Medicaid agency to also provide Medicaid services, but SNP plans are not required to do so.

Starting in 2010, the MMA requires the Secretary to establish a program for the application of comparative cost adjustment (CCA) in CCA areas. The six-year program will begin January 1, 2010, and end December 31, 2015. The program is designed to test direct competition among local MA plans, as well as competition between local MA plans and original Medicare. The program will only occur in a limited number of statutorily qualifying areas.

Deficit Reduction Act (DRA, P.L. 109-171)

Starting in 2007, the DRA changed the way MA benchmarks are calculated to (1) exclude national adjustments for coding intensity, (2) exclude the budget neutral implementation of risk adjustment, (3) omit any adjustments accounting for errors in previous years' projections of the national per capita MA growth percentage, and (4) increase rates based on the MA growth percentage, as under current law. In the report language to the BBRA, Congress urged the Secretary to implement a more clinically based risk adjustment methodology (to supplement the demographic factors) without reducing overall payments to plans. To keep payments from being reduced overall, the Secretary applied a budget neutrality adjustment to risk adjusted rates. However, Administration studies show a difference in the reported health status of MA enrollees compared to the reported health status of beneficiaries in original Medicare. The exclusion of the budget neutral implementation of risk adjustment is being phased-in over four years (2007-2010).

Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432)

TRHCA created a special continuous open enrollment period for beneficiaries in original Medicare to join certain MA plans during 2007 and 2008 outside of the normal enrollment periods. It delayed the initial availability of funds from the MA Regional Plan Stabilization Fund until January 1, 2012, and reduced the amount of funds available to \$3.5 billion.

P.L. 110-48 (An Act to Provide for the Extension of Transitional Medical Assistance, and Other Provisions)

P.L. 110-48 eliminated the special continuous open enrollment period added by TRHCA. It reduced the MA Regional Plan Stabilization Fund, to about \$3.4 billion, and restricted the amount that could be spent in 2012 to \$1.6 billion.

Medicare, Medicaid, and SCHIP Extensions Act of 2007 (MMSEA, P.L. 110-173)

The MMSEA extended the authority of Specialized Medicare Advantage Plans for Special Needs Individuals (SNPs) to restrict enrollment to special needs beneficiaries (defined as eligible enrollees who are institutionalized, are entitled to Medicaid, or would benefit from enrollment in a SNP) until January 1, 2010. Beginning January 1, 2008, it restricts the Secretary from designating other MA plans as SNPs and imposes a moratorium on new SNP plans until January 1, 2010. It extends for one year (to January 1, 2009) the length of time cost-based plans can continue to operate in an area with either two local or two regional MA plans in the same area. MMSEA eliminated \$1.6 billion from the MA Regional Plan Stabilization Fund for 2012. It provided additional funding for State Health Insurance Assistance Programs, Area Agencies on Aging, and Aging and Disabled Resource Centers to provide information and counseling, and assistance to Medicare eligible individuals related to obtaining adequate and appropriate health coverage.

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)

MIPPA requires the value of indirect medical education (IME) to be phased out of all benchmarks starting in 2010. The amount phased-out each year will be based on a ratio of (1) a specified percentage (0.60% in the first year), relative to (2) the proportion of per capita costs in original Medicare in the county that IME costs represent. The effect of the ratio is to phase out a higher proportion of IME costs in areas where IME makes up a smaller percentage of per capita spending in original Medicare. After 2010, the numerator phase-out percentage will be increased by 0.60 percentage points each year. This provision will not apply to PACE plans (Programs of All-Inclusive Care for the Elderly).

Starting in 2011, PFFS plans sponsored by employers or unions are required to establish contracted networks of providers to meet access requirements. Non-employer-sponsored MA PFFS plans are required to establish contracted networks of providers in network areas defined as areas having at least two plans with networks (such as health maintenance organizations [HMOs]). In areas without at least two network-based plans, the non-employer PFFS plans retain the ability to establish access requirements through establishing payment rates that are not less than those under original Medicare.

Beginning in January 1, 2010, PFFS and Medical Savings Account (MSA) plans are required to have a quality improvement program similar to other MA plans. Starting in 2011, data collection, reporting, and analysis requirements for PFFS and MSA plans may not exceed the requirements for local PPO plans, which are limited to those data from providers in the plan's contracted network, but not from out-of-network providers. In 2010, the data requirements for PFFS and MSA plans are limited to administrative data, but must be collected from both in-network and out-of-network providers.

MIPPA extends the time current Special Needs Plans (SNPs) may restrict enrollment to special needs individuals and extends the moratorium on the Secretary's authority to designate new SNPs until January 1, 2011. Starting January 1, 2010, all new enrollees in a SNP will be required to meet the definition of a special needs individual. For institutional SNPs, individuals living in the

community who may need an institutional level of care are not eligible to enroll in the SNP unless it is determined by an entity other than the SNP using a state assessment tool that the individual needs an institutional level of care. Medicaid SNPs are required to have a contract with the state to provide Medicaid benefits, or arrange for benefits to be provided; Medicaid SNPs that do not comply with the contracting requirement will be permitted to participate in 2010, but will not be allowed to expand their service area. Further, Medicaid SNPs are required to provide prospective enrollees with descriptions of benefits and cost sharing under the Medicaid program and which are to be covered by the SNP. Chronic Care SNPs are required to comply with a revised definition of a Chronic Care SNP; the Secretary is also required to convene a panel of clinical advisors to determine which conditions meet the definition of a severe and disabling chronic condition. MIPPA requires all SNPs to comply with certain care management requirements, such as having an appropriate network of providers, performing enrollee health assessments, and arranging for interdisciplinary teams to manage care for enrollees. By no later than January 1, 2010, SNPs are required to collect and report data related to the care management requirements; the Secretary is required to conduct a review of SNPs in conjunction with its periodic financial audit of MA plans. Effective January 1, 2010, Medicaid Special Needs Plans (SNPs) serving dual eligible beneficiaries are prohibited from charging cost-sharing in excess of what would be permitted under Medicaid.

The MA Regional Plan Stabilization Fund is reduced to \$1.00. A portion of the savings from the regional plan bidding process continues to flow into the Fund and is available for expenditures in 2014. MIPPA extends for one year—from January 1, 2009, to January 1, 2010—the length of time reasonable cost plans may continue operating regardless of any other MA plans serving the area. It specifies that to prohibit the cost plan from participating after January 1, 2010, the two plans in the service area must be offered by different organizations. Finally, MIPPA modifies the minimum enrollment requirements for local or regional plans operating within the cost plan's service area. GAO is required to submit a report to Congress on the reasons why cost-based plans may be unable to become MA plans. MIPPA establishes new prohibitions on the marketing activities of MA plans and PDPs and their agents, brokers, or any third-party representatives. Except in instances when the beneficiary initiates contact, plans will be prohibited from soliciting beneficiaries door-to-door or on the phone. Cross-selling of non-health-related products, providing meals to prospective enrollees, marketing in areas where health care is delivered (i.e., physician offices or pharmacies), and using sales agents that are not state licensed are also prohibited. The provision requires that by November 15, 2008, the Secretary establish limitations on other plan marketing activities such as co-branding, marketing appointments with prospective enrollees, and agent compensation.

American Recovery and Reinvestment Act of 2009 (ARRA,P.L.111-5)

ARRA established bonus payments for selected Medicare Advantage HMO-affiliated eligible professionals and hospitals that were meaningful users of electronic health records.

Author Contact Information

Paulette C. Morgan
Specialist in Health Care Financing
pcmorgan@crs.loc.gov, 7-7317

Acknowledgments

Holly S. Stockdale, Analyst in Health Care Financing, contributed to this report.