



White Paper



Medicare Advantage: Brief Overview of History, Regional PPOs, Facts-at-a-Glance

When Congress passed the Balanced Budget Act of 1997, it included changes to the Medicare program. The new law included a section called Medicare + Choice, which provided for new health plan options. Under the Medicare Modernization Act of 2003, Medicare + Choice was given a new name, Medicare Advantage.

This white paper examines the history of Medicare Advantage, regional Medicare Advantage PPOs, local Medicare Advantage plans, participation and enrollment, benefits and premiums, and Medicare Advantage facts-at-a-glance.

The Medicare Modernization Act (MMA) expands the existing options available to Medicare beneficiaries to enroll in private health plans. Currently, about 4.8 million beneficiaries are enrolled in Medicare Advantage local plans. The Medicare Advantage plans, which include both coordinated care plans and private fee-for-service plans, generally provide more benefits at a lower cost to beneficiaries. The MMA expanded the program with the establishment of a new regional contracting option for health plans, called Medicare Advantage regional plans. Local Medicare Advantage plans serve individual counties and groups of counties, whereas regional PPOs will bid to serve an entire region - which may be a state or multi-state area. Both local and regional plans must provide all original Medicare benefits.

According to Center for Medicare and Medicaid Services (CMS) statistics for 2004, Medicare provides health benefits to 41.7 million elderly and disabled Americans. Approximately 88 percent have their health bills paid by the traditional fee-for-service program and 11 percent are covered by managed care plans, including HMOs. HMOs have been an option for Medicare recipients since the 1970s. The Balanced Budget Act of 1997 expanded the role of private plans under "Medicare + Choice" to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) with high-deductible insurance plans. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created another option: regional PPOs.

Regional Medicare Advantage PPOs

The new regional plans, which are authorized beginning in 2006, are structured as preferred provider organizations (PPOs). These plans have a network of doctors and hospitals that contractually agree to provide health care services at a specified rate, but which also allow enrollees to go outside the network for care, usually for an additional charge. PPOs are now the most popular type of coverage in the private market in the U.S. In 2002, 52 percent of Americans covered under group health insurance programs were enrolled in PPOs.



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To help ensure that all Medicare beneficiaries have the opportunity to take advantage of the Medicare prescription drug benefit, the Centers for Medicare & Medicaid Services (CMS) established 26 regions for Medicare Advantage Preferred Provider Organizations and 34 regions for prescription drug plans.

In determining the regions for the Medicare Advantage and prescription drug plans, CMS relied on input from beneficiary and consumer groups, along with health plans and organizations experienced in providing drug coverage -- including pharmacy benefits managers, physicians, hospitals, pharmacists and other interested parties. CMS held a series of public meetings and calls, and reviewed hundreds of written comments.

CMS considered the following factors in setting up Medicare Advantage regions:

Eligible Population: The goal is to make sure all Medicare beneficiaries have the opportunity to enroll in a PPO, including those in small states and rural areas. The regions need to be large enough to support strong networks, yet small enough to support plans entering right away.

Plan Entrants: The goal is to provide beneficiaries the greatest amount of choice by encouraging the largest number of insurers possible to participate. A region needs to have potential plan entrants, especially some with a history in multi-state regions. Also important was the potential availability of plans that already have insurance licenses and are already providing regional services for federal employees or other Americans.

Limited Cost Variations: Lower variations in costs among the states within a region will encourage more plans to participate.

Preserving current Medicare patient flows: In many areas, Medicare beneficiaries cross state lines to seek health care. The Medicare Advantage regions preserve this patient flow as much as possible. Those who enroll in Medicare PPOs will still be able to access providers out of the region in which they reside.

Local Medicare Advantage Plans

The MMA allows for three categories of local Medicare Advantage plans:

Coordinated Care Plans: These include health maintenance organizations (HMOs), with and without Point-of-Service (POS) options, and Preferred Provider Organization (PPO) plans. About 4,755,000 Medicare beneficiaries are enrolled in these coordinated care plans.

Private Fee-For-Service Plans: This plan option is offered by a private insurance company under contract to the Medicare program. Medicare pays a set amount of money every month to the Private Fee-For-Service (FFS) organization to arrange for



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health care coverage for Medicare beneficiaries who have enrolled in the Private FFS plan. About 58,000 Medicare beneficiaries are enrolled in private FFS plans.

Medical Savings Account (MSA) Plans: Under this option, the beneficiary chooses a qualifying Medicare MSA high-deductible insurance plan. Medicare then pays the premium for the MSA plan and generally makes a deposit into the Medicare MSA that is established by the beneficiary. The beneficiary uses the money in the Medicare MSA to pay for services provided before the deductible is met, and for other health care services not covered by the MSA plan. Any remaining funds are allowed to accrue from year-to-year. The MSA option is similar to the health savings accounts (HSAs) the MMA made available for the non-Medicare population. These products are designed to allow participants to play a greater role in their health care purchasing decisions. As more beneficiaries enter Medicare with HSAs, this option will allow them to continue to support their account. Currently, no MSA plans are contracting with Medicare.

Medicare Advantage Participation and Enrollment

Enrollment in Medicare + Choice/Medicare Advantage Plans has varied a great deal between 1990 and 2004. For example, there were 96 Medicare Advantage Plans in 1990. Participation peaked in 1998 with 346 plans, and has steadily dropped to its 2004 level of 145 plans.

Medicare Advantage Benefits and Premiums

Medicare Advantage plans are typically required to provide all Medicare-covered benefits. Plans with costs below their Medicare payments must distribute savings to beneficiaries as lower plan premiums and co-payments or additional benefits or contribute to a reserve fund.

Premiums. Sixty-two percent of Medicare Advantage enrollees in basic plans pay a monthly premium in addition to the Part B premium. The average monthly premium in 2003 was \$37 across all enrollees (up from \$6 in 1999), and \$60.50 among enrollees in plans that charge premiums (up from \$32.11 in 1999). As of 2003, plans are permitted to reduce Part B premiums as an extra benefit. In February 2004, six plans offered this option, making it available to 4% of Medicare beneficiaries.

Out-of-Pocket Spending. Out-of-pocket spending for Medicare Advantage enrollees, including premiums and cost sharing, has nearly tripled since 1999, from \$429 to \$1,260 in 2003.

Prescription Drugs. Nearly one-third of Medicare Advantage enrollees are in plans that do not provide drug coverage. As part of the Medicare prescription drug benefit that begins in 2006, managed care plans (but not PFFS or MSA plans) must offer basic drug coverage to their enrollees and will receive extra payment for that coverage. Plans may also offer a second package with additional benefits.



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Medicare Advantage facts at a glance:

- Five percent of Medicare beneficiaries account for 47 percent of program costs, making the enrollment of healthier individuals more financially attractive to Medicare health plans.
- CMS plans to establish an online database to help beneficiaries compare drug packages, but only 19 percent of seniors currently have access to the Internet. Given the complexity of plan comparisons, many will need individual assistance to make informed decisions.
- From 1997 to 2003, the number of private Medicare Advantage plans decreased by more than half, from 346 plans in 1998 to 155 plans in November 2003.
- In 2004, there were 4.6 million (11 percent) Medicare Advantage enrollees, compared to 6.3 million (16 percent) in 2000.
- In 2004, 60 percent of beneficiaries had access to a private Medicare plan, down from 71 percent in 1999 (MedPAC, 2004).
- Less than 1 percent of Medicare beneficiaries are enrolled in plans in 18 states and D.C.
- 25 percent of Medicare beneficiaries are enrolled in CA, AZ, OR, and RI.
- The majority of Medicare Advantage plans are HMOs.
- Nationwide, more than 25 percent of Medicare HMO enrollees live in California.
- The Administration estimates 31 percent of Medicare beneficiaries will enroll in Medicare Advantage plans by 2009.
- Congressional Budget Office (CBO) estimates a Medicare Advantage enrollment rate of 12 percent in 2009.

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