

The Evolution of Private Plans in Medicare

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ABSTRACT

ISSUE: Since the 1980s, private plans have played an increasingly important role in the Medicare program. While initially created with the goals of reducing costs, improving choice, and enhancing quality, risk-based plans — now known as Medicare Advantage plans — have undergone significant policy changes since their inception; these changes have not always aligned with the original policy objectives.

GOAL: To examine major policy changes to Medicare risk plans and the effects of these policies on plan participation, enrollment, average premiums and cost-sharing, total costs to Medicare, and quality of care.

METHODS: Review of key policy documents, reports, position statements, and academic studies.

FINDINGS AND CONCLUSIONS: Private plans have changed considerably since their introduction into Medicare. Enrollment has risen to 33 percent of all Medicare beneficiaries; 99 percent of beneficiaries have access to private plans in 2017. Recent policies have improved risk-adjustment methods, rewarded plans' performance on quality of care, and reduced average payments to private plans to 100 percent of traditional Medicare spending. As enrollment in private plans continues to grow and as health care costs rise, policymakers should enhance incentives for private plans to meet intended goals for higher-quality care at lower cost.

KEY TAKEAWAYS

- ▶ Private insurance plans have long been part of Medicare, with the goals of improving care quality, controlling spending, and providing additional benefits.
- ▶ While fluctuating over the decades, enrollment in Medicare Advantage plans has increased more than 80 percent since 2009. Today, 33 percent of Medicare beneficiaries are in these plans.
- ▶ Average plan premiums have fallen since 2010, and payments have decreased relative to traditional Medicare. Still, payment parity between Medicare Advantage and traditional Medicare remains elusive.



INTRODUCTION

Private plans have been part of Medicare since the program's inception in 1966. These plans, now known as Medicare Advantage or Medicare Part C, operate under risk-based contracts — the plans agree to assume liability for beneficiaries' health expenses in exchange for a monthly, per-person (also known as capitated) sum.

Medicare began including health maintenance organizations (HMOs) as a way to allow retirees with employer-sponsored health insurance to retain their existing patient-provider relationships.¹ Proponents argued that the efficiencies of HMOs could reduce government expenditures, improve quality, and provide additional benefits beyond those offered by traditional Medicare. They also asserted that plans could provide beneficiaries with greater choice and promote innovations in health care delivery.²

Private plans have achieved some of these goals: plan participation and variety have increased considerably. Recent provisions have sought to better measure plan quality and provide financial incentives for quality improvement. However, plans in many parts of the country are paid more than traditional Medicare would be expected to spend for the same beneficiaries. As a result, the program as a whole has not yet reduced Medicare's costs.³

Given the large and growing proportion of Medicare beneficiaries enrolled in Medicare Advantage plans, policymakers should pay closer attention to the impact of private plans on spending and health care outcomes. This paper describes the major policy changes that have affected Medicare private plans and their enrollees over the years, as well as Medicare Advantage's future challenges.

A PROGRAM IN INFANCY (1966–1982)

Medicare has involved HMOs since 1966. Because these private plans use salaried physicians, they were originally paid on a reasonable-cost basis for services that Medicare otherwise would have paid on a reasonable-charge basis.⁴ Under the 1972 Social Security Amendments, preexisting plans could continue to be paid on a reasonable-cost basis,

but new plans would operate on a risk-sharing contract. The expenses of each plan were compared to the adjusted average per capita cost (AAPCC) for their enrollees under traditional Medicare. If the HMO's costs exceeded the AAPCC, it could carry the excess cost into subsequent years to be offset against any future savings. If the HMO's costs were lower, up to 20 percent of the difference was shared evenly between the HMO and the government (with the government keeping any additional savings).⁵

By 1979, 65 HMOs were contracting with Medicare, although only one had a risk-sharing contract.⁶ Nevertheless, the prospect of an alternative to traditional Medicare spurred continued interest in risk-contracted HMOs within Medicare.⁷

THE RISE OF HMOs (1982–1997)

The 1972 Amendments gave the Health Care Financing Administration (HCFA) — subsequently renamed the Centers for Medicare and Medicaid Services (CMS) — the authority to conduct demonstrations of payment models that might reduce program spending, improve health care quality, or both. During the early 1980s, several HMO payment models were developed and tested.⁸ Demonstrations indicated that providers in HMOs seemed to take more conservative approaches to treatment and engaged in more preventive care and that, compared to people in traditional Medicare, enrollees in HMOs were more likely to be younger and lower-income, report themselves in excellent health, and indicate that a relationship with a single physician was not very important.⁹ However, HCFA estimated that it paid at least 15 percent more for enrollees in Medicare HMOs than for demographically similar beneficiaries in traditional Medicare.¹⁰

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a capitated payment system with prospectively set payment rates per enrollee for private plans (Exhibit 1). TEFRA's capitation payment to HMOs was set at 95 percent of the AAPCC in the enrollee's county of residence with the assumption that HMOs would be better at managing utilization of medical services. The federal government adjusted the rate based on demographic factors such as age and sex, although these characteristics

Exhibit 1. History of Changes in Payment and Quality in Medicare Private Plans

Act	Payment	Quality Improvement and Measurement
TEFRA (1982)	<ul style="list-style-type: none"> • 95% of per capita traditional Medicare costs • Risk adjustment based on demographics 	<ul style="list-style-type: none"> • Evidence of increased preventive care • HEDIS created in 1991
BBA (1997)	<ul style="list-style-type: none"> • Traditional Medicare spending controlled and capitation rate updates reduced by 2.8% • Rates fixed at 1997 level and adjusted to pay highest of floor rate, annual update of 2%, and blended rate • Risk adjustment based on health status and demographics 	<ul style="list-style-type: none"> • No change in quality or quality measurement
BBRA (1999)	<ul style="list-style-type: none"> • Bonus for first risk plan entering market • Increase in traditional Medicare spending, on which plan payment was based 	<ul style="list-style-type: none"> • No change in quality or quality measurement
BIPA (2000)	<ul style="list-style-type: none"> • Minimum update temporarily raised to 3% • Floors in rural and urban counties raised • Risk adjustment based on demographics and diagnostic categories 	<ul style="list-style-type: none"> • No change in quality or quality measurement
MMA (2003)	<ul style="list-style-type: none"> • Highest of urban or rural floor, 100% of average county-level traditional Medicare costs, higher of 2% or national traditional Medicare cost growth update over 2003 rate, and blended rate update • Bidding system with rebate at 75% of difference between benchmark and bid 	<ul style="list-style-type: none"> • Star rating for plan quality instituted in 2008
MIPPA (2008)	<ul style="list-style-type: none"> • No change in payment 	<ul style="list-style-type: none"> • Quality reporting and provider network reporting mandated for PFFS by 2011
ACA (2010)	<ul style="list-style-type: none"> • Counties ranked from lowest to highest traditional Medicare costs and divided into four assemblages: county benchmarks at 115%, 107.5%, 100%, and 95% of county traditional Medicare costs • Rebates at 50% but higher at 65% and 70% for plans with 3.5–4 and 4+ stars, respectively • 5% bonus to benchmarks of plans with 4+ stars • Risk adjustment updated to correct for coding intensity 	<ul style="list-style-type: none"> • Nearly 50% of plans had 4+ stars in 2017 • Enrollment in plans with 4+ stars increased from 37% in 2013 to 67% in 2017

Note: TEFRA = Tax Equity and Fiscal Responsibility Act; BBA = Balanced Budget Act; BBRA = Balanced Budget Refinement Act; BIPA = Benefits Improvement and Protection Act; MMA = Medicare Modernization Act; MIPPA = Medicare Improvements for Patients and Providers Act; and ACA = Affordable Care Act. Data: Authors’ synthesis of main text; G. C. Pope, L. M. Greenwald, D. A. Healy et al., *Impact of Increased Financial Incentives to Medicare Advantage Plans: Final Report* (Centers for Medicare and Medicaid Services, Sept. 2006); G. F. Anderson, J. C. Cantor, E. P. Steinberg et al., “Capitation Pricing: Adjusting for Prior Utilization and Physician Discretion,” *Health Care Financing Review*, Winter 1986 8(2):27–34; R. A. Berenson, “Medicare+Choice: Doubling or Disappearing?” *Health Affairs Web Exclusive*, 2001 Suppl.; Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (MedPAC, March 1999); L. Achman and M. Gold, *Medicare Advantage 2004 Payment Increases Resulting from the Medicare Modernization Act* (Mathematica Policy Research, Feb. 2004); Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (MedPAC, March 2010); B. Biles and G. Arnold, *Medicare Advantage Payment Provisions: Health Care and Education Affordability Reconciliation Act of 2010 H.R. 4872* (George Washington University, April 2010); and T. O’Neill Hayes, *Primer: The Medicare Advantage Star Rating System* (American Action Forum, June 2015).

alone did not adequately reflect enrollees’ health status. As a result, risk plans were again found to have enrolled healthier-than-average beneficiaries, especially in counties with higher traditional Medicare spending.¹¹

Plans were required to submit statements that estimated the cost of providing traditional Medicare benefits and, if their payment rates exceeded those costs, to provide additional benefits to their enrollees equal in actuarial value to the surplus. This requirement became a signature

characteristic of the program. Additional benefits have included reduced premiums, extended allowable hospital days, eye care, dental care, and prescription drug coverage. In fact, before the Medicare Prescription Drug Benefit (Part D) began in 2006, prescription drug benefits were among the most compelling reasons to join risk plans with more limited networks.¹² While risk-contract enrollees represented only 2.8 percent of all Medicare beneficiaries in 1986, 84.7 percent of these enrollees were in HMOs with drug benefits.¹³

With favorable selection and/or effective care management, many HMOs could easily offer additional benefits equivalent to the difference between their costs and rates they were paid. As a result, enrollment skyrocketed. The total number of beneficiaries enrolled in risk plans increased from 530,658 (2.8%) in 1986 to nearly 4.2 million (14%) in 1997.¹⁴

Risk plans gained in popularity, but they had drawbacks. First, the paucity of providers in rural areas allowed plans little bargaining power to form sizable networks, and few rural beneficiaries had access to an HMO or the additional benefits they could provide. Second, even in areas of the country where high Medicare spending presented the greatest opportunities for risk plans to generate savings, the payment formula and plans' tendency to enroll the healthiest beneficiaries prevented Medicare from sharing

in the savings (Exhibit 2). Third, because enrollees could disenroll from plans with only a month's notice, there was little to prevent sick beneficiaries from leaving for traditional Medicare, which has fewer restrictions on provider choice and utilization.¹⁵

MEDICARE+CHOICE: A DECLINE IN OFFERINGS AND ENROLLMENT (1997–2003)

The Balanced Budget Act of 1997 (BBA) made significant changes to how Medicare paid risk plans in the new Medicare+Choice (Medicare Part C) program. It scrapped the previous payment formula and largely reduced payment rates to plans.¹⁶ In response to reports of favorable selection, the BBA established new risk-adjustment measures based on health status and an annual enrollment period, with only one switch allowed outside that period.¹⁷

Exhibit 2. History of Changes in Offerings, Enrollment, and Relative Payments in Medicare Private Plans

Act	Plan Offerings and Enrollees	Payment Relative to Traditional Medicare
TEFRA (1982)	<ul style="list-style-type: none"> Plans abounded in high-cost, urban areas; few in rural areas 14% of all Medicare beneficiaries by 1997 	<ul style="list-style-type: none"> Abundant favorable selection At least 5.7% more than traditional Medicare would have paid for demographically similar beneficiaries from 1987 to 1997
BBA (1997)	<ul style="list-style-type: none"> Introduction of PPO, PSO, PFFS, and MSA 30% of risk plans left market, high provider turnover, large benefit cuts 13% of all beneficiaries by 2003 	<ul style="list-style-type: none"> At least 4% more than traditional Medicare would have paid
BBRA (1999)	<ul style="list-style-type: none"> No change in plan offerings or enrollment 	<ul style="list-style-type: none"> More than traditional Medicare would have paid
BIPA (2000)	<ul style="list-style-type: none"> Payment for certain urban and rural counties doubled; enrollment increased 	<ul style="list-style-type: none"> More than traditional Medicare would have paid
MMA (2003)	<ul style="list-style-type: none"> Introduction of regional PPO and SNP Huge growth in PFFS; 23% of plan enrollees by 2008 Out-of-pocket spending and average premiums reduced 100% of beneficiaries had access to a plan by 2006 24% of all beneficiaries by 2010 	<ul style="list-style-type: none"> Up to 14% more than traditional Medicare would have paid
MIPPA (2008)	<ul style="list-style-type: none"> Plan participation and enrollment in PFFS rapidly dropped 	<ul style="list-style-type: none"> 9% more than traditional Medicare would have paid by 2010; drop due to decline in PFFS
ACA (2010)	<ul style="list-style-type: none"> Required minimum medical loss ratio of 85% Average premiums decreased by 18% from 2010 to 2017 Plan networks covered 50% of hospitals by 2016 99% of beneficiaries had access to a plan by 2017 33% of all beneficiaries by 2017 	<ul style="list-style-type: none"> 0% more than traditional Medicare would have paid by 2017 Remaining 4% difference due to higher plan risk score growth relative to risk adjustments

Note: TEFRA = Tax Equity and Fiscal Responsibility Act; BBA = Balanced Budget Act; BBRA = Balanced Budget Refinement Act; BIPA = Benefits Improvement and Protection Act; MMA = Medicare Modernization Act; MIPPA = Medicare Improvements for Patients and Providers Act; ACA = Affordable Care Act; PPO = preferred provider organization; PSO = provider-sponsored organization; PFFS = private fee-for-service; MSA = medical savings account; and SNP = special needs plan. Data: Authors' synthesis of main text; and G. C. Pope, L. M. Greenwald, D. A. Healy et al., *Impact of Increased Financial Incentives to Medicare Advantage Plans: Final Report* (Centers for Medicare and Medicaid Services, Sept. 2006).

The BBA also established new private plan options, including preferred provider organizations (i.e., plans that, unlike HMOs, allow beneficiaries to obtain services outside their provider network at greater cost to the enrollee); provider-sponsored organizations (i.e., plans operated by a provider group that delivers the covered services); private fee-for-service plans (PFFS) (i.e., private plans that can pay providers the same rates as traditional Medicare); or high-deductible plans with medical savings accounts (i.e., plans under which the enrollee can establish a tax-exempt account into which contributions may be made but is responsible for all covered costs up to a specified threshold).¹⁸

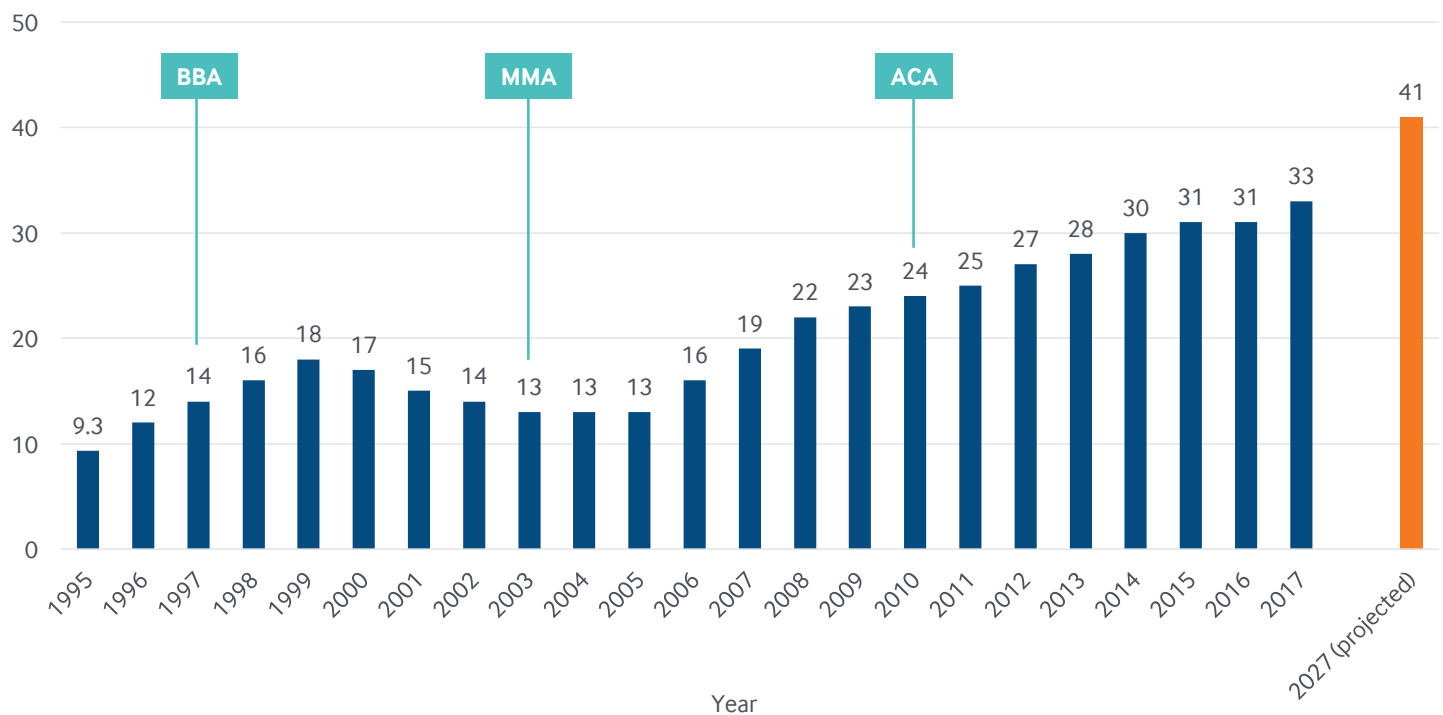
The BBA also contained provisions intended to slow traditional Medicare spending growth. Because the annual increase in payments to Medicare+Choice plans

was linked to the growth rate, payments to private plans were reduced further than anticipated.¹⁹ Although the Congressional Budget Office had projected a 15 percent increase in plan enrollment by 2005, plan participation and enrollment in Medicare+Choice actually declined (Exhibit 3).²⁰ From 1999 to 2001, the number of plans with zero premium (apart from the Part B premium) declined nearly 40 percent; the average premium across all plans increased 260 percent.²¹ Beginning in 2001, plans shifted their strategy toward cutting extra benefits and heightening cost-sharing.

Attempts by Congress to counter the unanticipated effects of the BBA did little to improve plan enrollment. The total number of plans dropped from 407 to 285, and enrollment dropped by nearly 30 percent between 1999 and 2003.²² Even with considerable cuts and an updated

Exhibit 3. Enrollment in Medicare Private Plans as a Share of All Medicare Beneficiaries

Medicare private plan penetration (%)



Note: BBA = Balanced Budget Act; MMA = Medicare Modernization Act; and ACA = Affordable Care Act.

Data: G. Jacobson, A. Damico, T. Neuman et al., *Medicare Advantage 2017 Spotlight: Enrollment Market Update* (Henry J. Kaiser Family Foundation, June 2017); authors' analysis of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2002 Annual Report* (U.S. Government Printing Office, July 2017); and Kaiser Family Foundation, *Total Medicare Advantage Enrollment, 1992–2014* (Henry J. Kaiser Family Foundation, March 2014).

risk-adjustment model, Medicare+Choice did not achieve savings relative to traditional Medicare (Exhibit 4).

A RESURGENCE IN PLANS AND A SURGE IN EXPENDITURES (2003–2010)

In addition to establishing Medicare Part D, the Medicare Modernization Act of 2003 (MMA) significantly altered how private plans (now renamed Medicare Advantage) were paid. The law limited enrollees to one switch per year during the open enrollment period and allowed plans to include the new drug benefit (MA–PD).²³

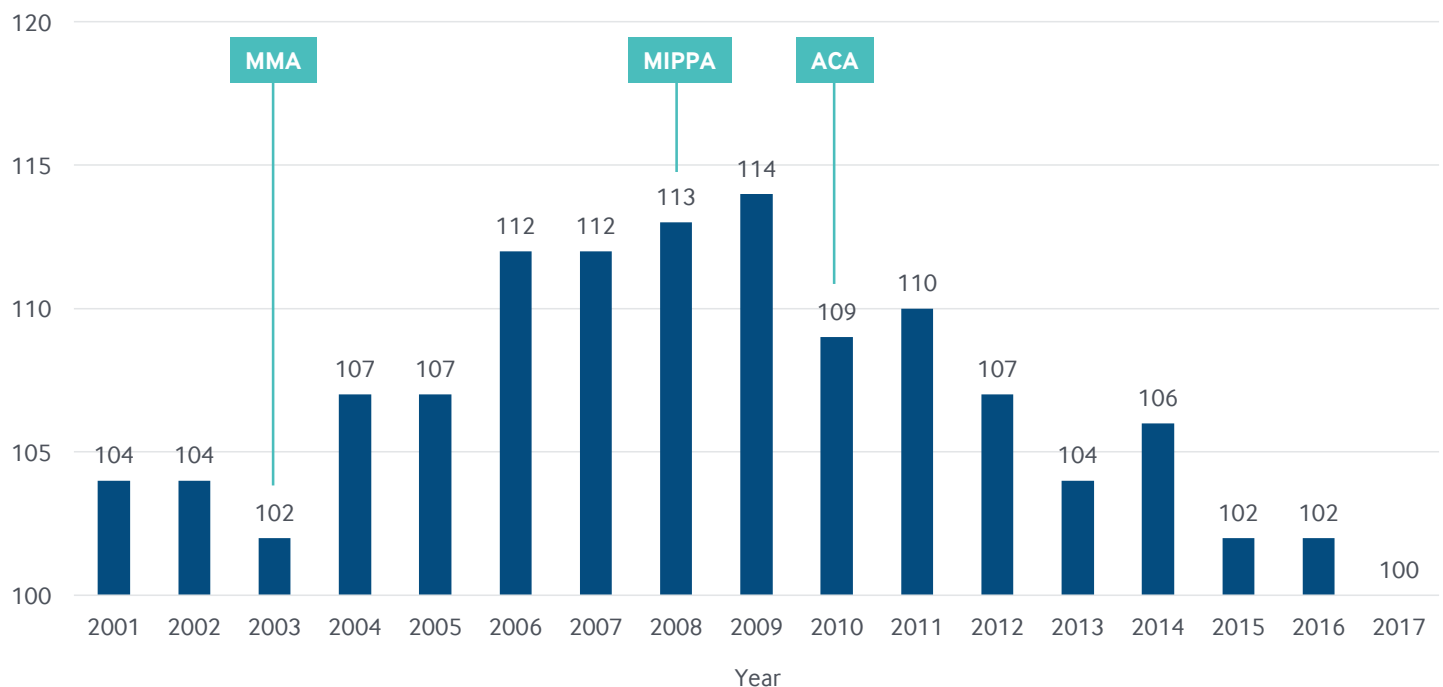
The MMA significantly raised payments to plans to counter the effects of the BBA. Everywhere in the country, Medicare offered rates to private plans that were at least

as high as traditional Medicare spending per enrollee, resulting in a 10.9 percent increase in outlays to risk plans between 2003 and 2004.²⁴ The MMA also established a bidding mechanism, under which each plan submitted a bid representing its estimated cost of providing basic Medicare benefits to enrollees for the coming year, including administrative overhead and profit. If the bid comes in lower than a county-level benchmark based on traditional Medicare spending per enrollee, the plan is paid most of the difference as a rebate or bonus. The plan is then required to provide additional benefits that equaled the actuarial value of the rebate.

Like the BBA, the MMA also created new private plan options. Enrollees could sign up with regional PPOs

Exhibit 4. Medicare Private Plan Payments Relative to Traditional Medicare Spending

Medicare private plan payments relative to fee-for-service costs (%)



Notes: MMA = Medicare Modernization Act; MIPPA = Medicare Improvements for Patients and Providers Act; and ACA = Affordable Care Act. Percentages based on the risk-adjustment system used during publication of each MedPAC report. As a result, Medicare Part C payments relative to traditional Medicare are likely **much higher than reported** from 2001 to 2006 as diagnosis-based risk adjustment had not yet been fully phased in. Payments also are likely **higher than reported** from 2007 to 2009 as adjustment based on coding intensity had not yet been implemented. Payments also are likely **higher than reported** from 2010 to 2017 because of higher Medicare Advantage risk score growth relative to coding intensity adjustments.

Data: Medicare Payment Advisory Commission, *Medicare Payment Policy* (MedPAC, 2001–2017).

(i.e., plans that are required to offer uniform benefits and premiums across designated regions) and special needs plans (SNPs) (i.e., plans designed to accept enrollment from specific vulnerable populations with the purpose of better meeting their needs).²⁵

The impact was evident: by 2006, 100 percent of Medicare beneficiaries had access to at least one plan; by 2009, beneficiaries had an average of 48 plans from which to choose.²⁶ With the integration of a standard drug benefit, 94 percent of beneficiaries had access to an MA–PD plan with zero additional premium.²⁷

With Parts A, B, and D available under one plan, as well as supplementary benefits subsidized by generous payments, enrollment in Medicare Advantage skyrocketed.²⁸ In each year from 2006 to 2011, most new plan enrollees were beneficiaries who had switched from traditional Medicare, many of whom were relatively young.²⁹ By 2010, enrollment reached 11.1 million, representing 24 percent of all beneficiaries (Exhibit 3).³⁰

To encourage quality improvement, CMS instituted a five-star rating for risk plans in 2008, using the Healthcare Effectiveness Data and Information Set (HEDIS), a survey that has assessed plan performance in the private sector since 1991.³¹ Even without direct financial incentives, plans showed improvement in certain HEDIS measures.³²

Before the bidding system went into effect, payments to plans averaged 107 percent of traditional Medicare spending in 2004; by 2009, plans were paid 114 percent of what traditional Medicare would have spent on the same beneficiaries, amounting to \$11.4 billion in excess payments (Exhibit 4).³³

A (PARTIAL) RETURN TO ORIGINAL GOALS (2010–2017)

Payment provisions in the Affordable Care Act (ACA), enacted in 2010, brought Medicare Advantage plan payments closer to traditional Medicare spending levels and reduced rates overall.³⁴

The 2010 reforms created incentives for enhanced quality. Standard rebates were reduced but were set higher for plans rated above 3.5 stars.³⁵ Furthermore, plans rated above four stars received an add-on to their benchmarks, and enrollment in five-star plans was allowed outside the annual election period.³⁶ The reform provisions also required a medical loss ratio, which measures plan spending on medical benefits compared to premiums, of at least 85 percent to limit administrative overhead. This is similar to the ACA requirement for all private insurance plans. Additional requirements included risk-adjustment measures to account for more intensive diagnostic risk coding by plans relative to traditional Medicare, and out-of-pocket spending limits for covered services to protect the sickest enrollees against undue financial burden.³⁷

Many analysts predicted widespread plan withdrawal and disenrollment, as had occurred under the BBA. However, from 2009 to 2017, enrollment increased more than 80 percent, with 33 percent of Medicare beneficiaries enrolled in private plans by 2017 (Exhibit 3).³⁸ By 2017, approximately 50 percent of plans had a rating above four stars, and these bonus-eligible plans comprised 67 percent of enrollment, up from 37 percent in 2013.³⁹

The impact on costs was notable. Average premiums dropped by 18 percent between 2010 and 2017; moreover, aggregate Medicare payment to plans relative to traditional Medicare fell dramatically, from 114 percent in 2009 to 100 percent in 2017 (Exhibit 4).⁴⁰

Even so, payment neutrality has not yet been achieved between Medicare Advantage and traditional Medicare. Although Medicare payment to plans equals 100 percent of traditional Medicare spending overall in 2017, plans have experienced higher growth in their risk profiles relative to coding intensity adjustments instituted by CMS. Because coding intensity adjustment measures have not yet accounted for the full scope of coding that plans have undertaken, plans with greater increases in risk scores because of coding intensity are paid more. This inequity is estimated to have amounted to payments of an additional 2 percent to 4 percent per year to plans from 2010 to 2017.⁴¹

ISSUES FOR THE FUTURE

Growth in private plans in recent years signals that they will continue to play a significant role in Medicare. The Congressional Budget Office's most recent projections estimate that 41 percent of beneficiaries will be enrolled in Medicare Advantage by 2027 (Exhibit 3).⁴²

Original advocates for private plans in Medicare believed they would lower costs, improve quality of care, and provide consumer choice. It is vital that policymakers hold fast to these aims in the future. In addition, quality measures introduced in the past decade must be improved

to ensure broader access to high-quality care. Medicare Part C will not be sustainable if plans are paid more than traditional Medicare. Further, inefficiencies within traditional Medicare may not make it the best standard on which to base payments for Medicare Advantage plans.⁴³

Realigning incentives in Medicare Advantage is no simple task, as history has shown. Recent proposals to reform Medicare support increased roles for private plans.⁴⁴ By drawing upon lessons from risk plans' history, policymakers can continue to reshape the program to achieve its initial objectives.

NOTES

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