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Medicare Advantage: A Policy Primer

A resident in a wheelchair at an assisted living facility in Boston on Sept. 2, 2020. In 2021, 43 percent of Medicare beneficiaries were enrolled in Medicare Advantage plans. Photo: Craig F. Walker/Boston Globe via Getty Images

TOPLINES

Medicare Advantage plans will soon become the dominant form of Medicare coverage. What does this mean for beneficiaries and for the future of the Medicare program?

Our Medicare Advantage policy primer explores the past, present, and future of private plans in Medicare

What is Medicare Advantage?

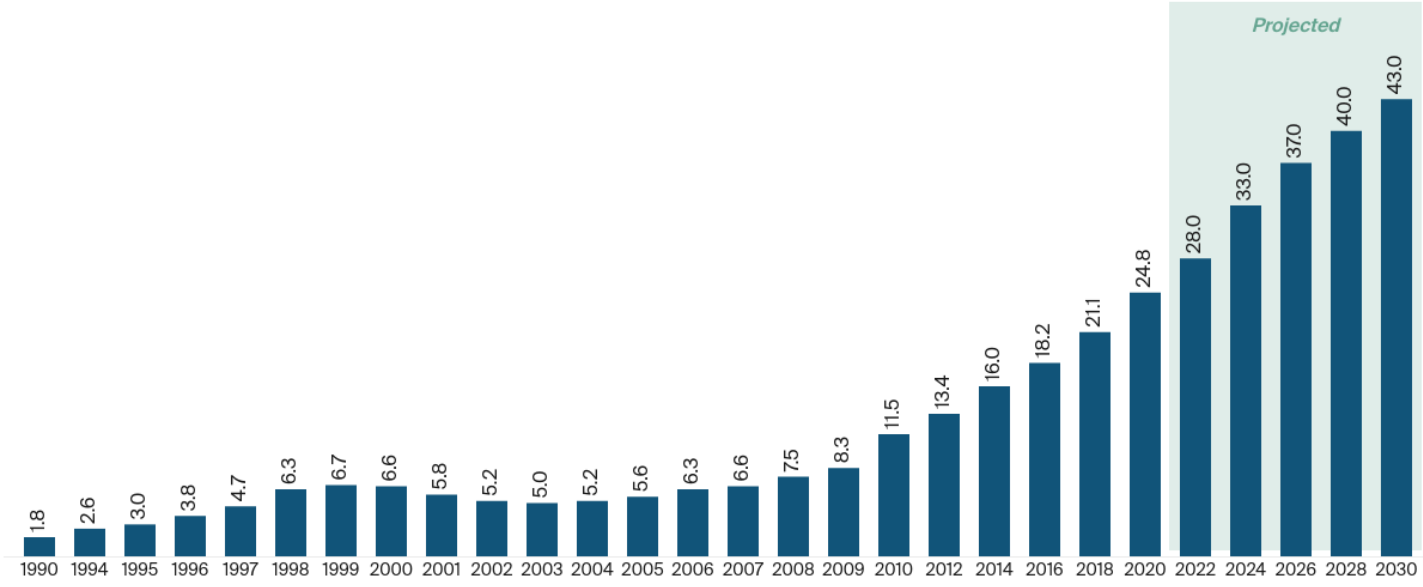
Medicare Advantage plans are private health insurance plans paid by the federal government to provide Medicare-covered benefits as an alternative to “traditional” or “original” Medicare.

Private plans have been an option in Medicare since the 1970s, but enrollment in private plans remained relatively low through the 1990s.[1] Aside from changing the name of Medicare private plans from Medicare+Choice to Medicare Advantage (also referred to as Medicare Part C), the Medicare Modernization Act of 2003 made significant changes that propelled enrollment growth. The Affordable Care Act (ACA) of 2010 also made many changes that enhanced plan enrollment.

Most Medicare Advantage plans are either **HMOs,** which generally cover only care provided by in-network doctors, hospitals, and other health providers, or by **PPOs,** which also offer access to out-of-network providers but at a higher cost than in-network providers. Other types of plans include: Private Fee-for-Service plans, Medicare Medical Savings Accounts, PACE plans, or cost plans, the latter of which do not assume financial risk. Enrollment in these other plan types is relatively low.

Medicare Advantage enrollment has grown rapidly in the past decade.

Medicare Advantage enrollment, past and projected (millions)



Download data

Data: Centers for Medicare and Medicaid Services, Medicare Advantage State/County Penetration File, Mar. 2021. Projected enrollment rates are calculated from CBO projections of Medicare Advantage enrollment and Part A eligibility (July 2021). 2021 Edition of Centers for Medicare and Medicaid Services Statistical Supplement for 1990–2009 data.

Source: Steven Findlay, Gretchen Jacobson, and Aimee Cicchiello, "Medicare Advantage: A Policy Primer," explainer, Commonwealth Fund, May 2022. https://doi.org/10.26099/69fq-dy83

In 2021, 43 percent of Medicare beneficiaries were enrolled in Medicare Advantage plans.[2] By 2025, these plans are projected to account for half of total Medicare enrollment, or 35 million beneficiaries, up from 21.1 million in 2018.[3]

More than 4 million beneficiaries in 2022 were enrolled in Special Needs Plans, which are Medicare Advantage plans designed for people with high health care needs,

including those who are dually eligible for Medicare and Medicaid, have specific chronic conditions, or require an institutional level of care. About 5 million beneficiaries were enrolled in Employer Group Plans, which are Medicare Advantage plans for employers' retirees.

What are the differences between traditional Medicare and Medicare Advantage?

Access to providers. People with traditional Medicare have access to any doctor or hospital that accepts Medicare, anywhere in the United States. That's the vast majority of doctors and virtually all hospitals.

In contrast, Medicare Advantage enrollees can access providers only through more limited provider networks. All Medicare Advantage plans are required to have such networks for doctors, hospitals, and other providers.

Provider participation in these networks can vary greatly. A 2017 analysis found that Medicare Advantage networks included fewer than half (46%) of all Medicare physicians in a given county, on average. The Centers for Medicare and Medicaid Services (CMS), which administers Medicare Advantage plans, has stated that it will strengthen its oversight of plan networks starting in 2024, based in part on an analysis finding that some plans were not in compliance in recent years with "network adequacy" standards.

It's not clear if broader or narrower networks equate to better or worse care. While many experts note that narrow-network plans can have more control over costs and quality of care, some Medicare Advantage plans tout their broader networks. Unfortunately, access to reliable information on plan networks is typically not easy for enrollees or their family members to obtain. That's because provider directories are frequently out of date and formatted in ways that make it difficult to directly compare networks. Moreover, prospective enrollees may be less apt to compare networks for postacute care services like home health and skilled nursing care that they might not anticipate needing.

Managed care. Nearly all Medicare Advantage enrollees are required to obtain prior approval, or authorization, for coverage of some treatments or services — something generally not required in traditional Medicare. Plans that require prior authorization can approve or deny care based on medical research and standards of care. For services not subject to prior authorization, plans can deny coverage for care they deem unnecessary after the service is received, as long as they follow Medicare coverage rules and guidelines.

It's long been a concern that such denials of care via prior authorization, or payment denials after care was delivered, were more widespread than Medicare Advantage plans claimed. A recent government report sheds light on this. It probed coverage denials during one week in June 2019 at 15 Medicare Advantage plans and found that 13 percent of denials were inappropriate and should have been covered under Medicare rules. That extrapolates to some 85,000 denials at those 15 plans for all of 2019. The study also probed payment denials, finding 18 percent were inappropriate and the care should have been paid for. That extrapolates to an estimated 1.5 million wrongful payment denials for all of 2019 at the 15 plans studied. These findings suggest an unacceptably high rate of inappropriate denials of care and payment by some Medicare Advantage plans. Yet, it's important to balance the findings against the well-established and unacceptable level of inappropriate care delivered by providers in traditional Medicare. Both denials of care and inappropriate, unnecessary care can be harmful as well as costly.

Covered benefits. Medicare Advantage plans must cover all services covered by traditional Medicare under Part A (hospital services, some home health, hospice care, skilled nursing care) and Part B (physician services, durable medical equipment, outpatient drugs, mental health, ambulance services). The vast majority of plans (89% in 2022) also cover Part D prescription drug benefits. Most plans offer additional benefits such as eyeglasses, hearing aids, and some coverage of dental care, such as cleanings.[4] For those benefits, about two-thirds of enrollees pay no extra premium, though about 15 percent pay $50 or more a month.

In 2020, the government began allowing Medicare Advantage plans to include a wide range of telehealth benefits as part of their basic benefit package. Some plans also cover fitness club memberships, caregiver support, meal delivery, or acupuncture.

Traditional Medicare has notable gaps in coverage. For example, it does not cover eyeglasses, hearing aids, basic dental care, or long-term care. It also requires cost sharing for most services. Traditional Medicare also does not have prescription drug coverage, and beneficiaries must choose a separate "stand-alone" Part D plan if they want drug coverage. Part D coverage is offered entirely through private insurance plans; there is no government-run option.

Because of those gaps, many people with traditional Medicare buy Medigap or Medicare Supplemental coverage as well as Part D prescription drug coverage. Medigap plans cover many of the additional costs not covered by traditional Medicare — for instance, the 20 percent copayment for most routine Part B doctor's services. Some Medigap plans also include services not covered by traditional Medicare, such as access to dental care or eyeglasses.

Medigap coverage is provided through private insurers. The premium that enrollees pay is in addition to the Medicare Part B premium and the Part D premium for those who choose to buy prescription coverage.

In most states, Medigap insurers are required to issue policies to any interested beneficiaries only during certain enrollment windows; at all other times, Medigap insurers can deny coverage or set premiums for policies based on health status (underwrite) of new policyholders. These limited enrollment windows are known as "guaranteed issue" rights. Medigap insurers are prohibited from selling policies to Medicare Advantage enrollees.

Out-of-pocket costs. Like other Medicare beneficiaries, Medicare Advantage enrollees must pay their Part B premium ($170.10 per month in 2022, with higher amounts for higher-income people). A small number of Medicare Advantage plans pay all or a portion of Part B premiums.

As mentioned, Medicare Advantage plans also can charge an additional monthly premium, which typically includes Part D prescription drug benefits. The average premium for a Medicare Advantage plan that includes Part D coverage in 2022 is $19 per month. Some plans cost nothing, while others can be $100 or more. About two-thirds of Medicare Advantage enrollees had no premium in 2021; about 15 percent paid $50 or more per month.

Since 2011, the government has required Medicare Advantage plans to limit enrollees' out-of-pocket expenses for services covered by Parts A and B. In 2022, the maximum is $7,550 for in-network services (for HMOs, and for PPOs if only in-network services are used) and $11,300 for in-network and out-of-network services combined (for only PPOs, when out-of-network services are used).

Some Medicare Advantage plans compete for enrollees by offering a lower-than-required cap on out-of-pocket expenses for doctor and hospital services. In 2021, the average out-of-pocket limit was $5,091 for in-network services.[5]

Traditional Medicare has no out-of-pocket maximum for doctor or hospital service costs. As a consequence, most beneficiaries in traditional Medicare have Medigap, to make their out-of-pocket expenses more manageable and predictable, or another form of supplemental coverage, such as coverage from a former employer or Medicaid. In 2020, the average Medigap premium was about $138 per month; in 2022, the average monthly premium for a stand-alone Part D plan is $44.

Many factors influence whether a beneficiary would pay more with traditional Medicare or with a Medicare Advantage plan. Those factors include: health status and

health care use; supplemental coverage and premiums for that coverage; Medicare Advantage plan benefits and cost sharing; and plan provider networks.

Quality of care. Most evidence shows that the quality of care delivered through Medicare Advantage plans and through traditional Medicare is equivalent overall. However, some studies suggest that Medicare Advantage plans, on average, are associated with better-quality care on certain metrics, particularly those related to preventive care and unnecessary hospital admissions.[6] Other evidence suggests that Medicare Advantage does not outperform traditional Medicare on several significant measures, including mortality, readmission rates, patient experience, and racial and ethnic disparities.[7]

CMS rates Medicare Advantage plans based on more than 40 quality measures. In 2021, 80 percent of enrollees were in plans with an overall quality rating of four or more stars out of five stars, partly because rules changed during the COVID-19 pandemic.[8] That's up from 57 percent of enrollees who were in plans rated four or more stars in 2015.

But some critics have raised questions about the star rating program and whether it is appropriately achieving its objective — incentivizing plans to meaningfully improve care. In a 2021 report, the Medicare Payment Advisory Commission, or MedPAC, concluded that "the current quality program is not achieving its intended purposes and is costly to Medicare."[9]

Do Medicare Advantage plans cost government and taxpayers less or more?

Traditional Medicare and Medicare Advantage can be compared in many ways, including benefits provided, quality of care, patient outcomes, and costs. Policymakers have focused mainly on comparing costs in traditional Medicare with those in Medicare Advantage, largely because the original impetus for allowing private insurers to provide Medicare benefits was to reduce costs while maintaining or improving quality of care.

Older and more recent studies alike have largely found that Medicare Advantage plans cost the government and taxpayers more than traditional Medicare on a per beneficiary basis.[10] In 2022, that additional cost was about 4 percent, down from a peak of 17 percent in 2009.[11]

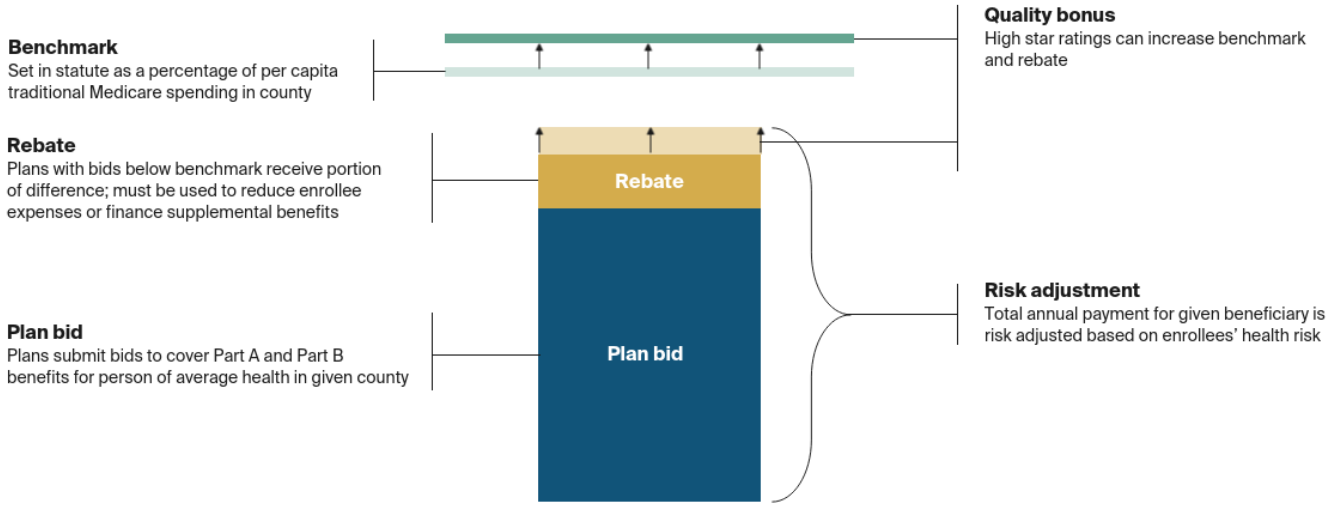
Why do Medicare Advantage plans cost more, and how are they paid?

The government pays Medicare Advantage plans a set rate per person, per year (around $12,000 in 2019, not including Part D–related expenses) under what is called a "risk-based" contract.[12] That means that each plan agrees to assume the full risk of providing

all care for that inclusive amount. This payment arrangement, called capitation, is also intended to provide plans with flexibility to innovate and improve the delivery of care.

But there are layers of complexity built into and on top of that set rate that allow for various adjustments and bonus payments. While those adjustments have proved useful in some ways, they can also be problematic and are the main reason for the extra cost of Medicare Advantage vis-à-vis traditional Medicare.

Medicare Advantage payments are based on a system of benchmarks, bids, and quality incentives.



Source: Steven Findlay, Gretchen Jacobson, and Aimee Cicchiello, "Medicare Advantage: A Policy Primer," explainer, Commonwealth Fund, May 2022.
https://doi.org/10.26099/69fq-dy83

Benchmarks. Plan benchmarks are the maximum amount the federal government will pay a Medicare Advantage plan. Benchmarks are set in statute as a percentage of traditional Medicare spending in a given county, ranging from 115 percent to 95 percent. For counties with relatively low spending, benchmarks are set higher than average spending for traditional Medicare (for example, 115%); for counties with relatively high spending, benchmarks are set lower than average traditional Medicare spending (for example, 95%). Special Needs Plans and other Medicare Advantage plans are paid in the same manner, with the same benchmarks.

Bids. Health insurance companies bid every year to enroll Medicare beneficiaries in their Medicare Advantage plans. That bid is based on companies' assessment of their costs to provide Part A and Part B services to the average beneficiary. According to MedPAC, 92 percent of bids in 2022 were below traditional Medicare spending and below the county benchmark. Additionally, the vast majority of bids were below the county benchmark.

Rebates. If a plan's bid is *below* the local benchmark — as is the case for the majority of plans — then the plan keeps part of the difference between the bid and benchmark. This amount is known as the "rebate" and is equivalent to a shared savings between the federal government and plans. Plans are required to use the rebate to lower patient cost sharing, lower premiums, or provide some coverage for benefits not included in traditional Medicare. Rebate dollars also can be used to pay for administrative expenses and profits associated with providing additional benefits.

Rebates, along with the bid amount, are adjusted for enrollees' health status. This means that plans with sicker enrollees, who cost more to treat, receive higher rebates. In 2022, rebates used to provide additional benefits to enrollees were at an historic high of $164 per enrollee per month.[13]

If a plan's bid exceeds the benchmark, the plan can charge a premium for coverage of Part A and Part B benefits, in addition to premiums for supplemental benefits and Part D coverage. Plans that receive rebates can also charge premiums for supplemental benefits and Part D coverage.

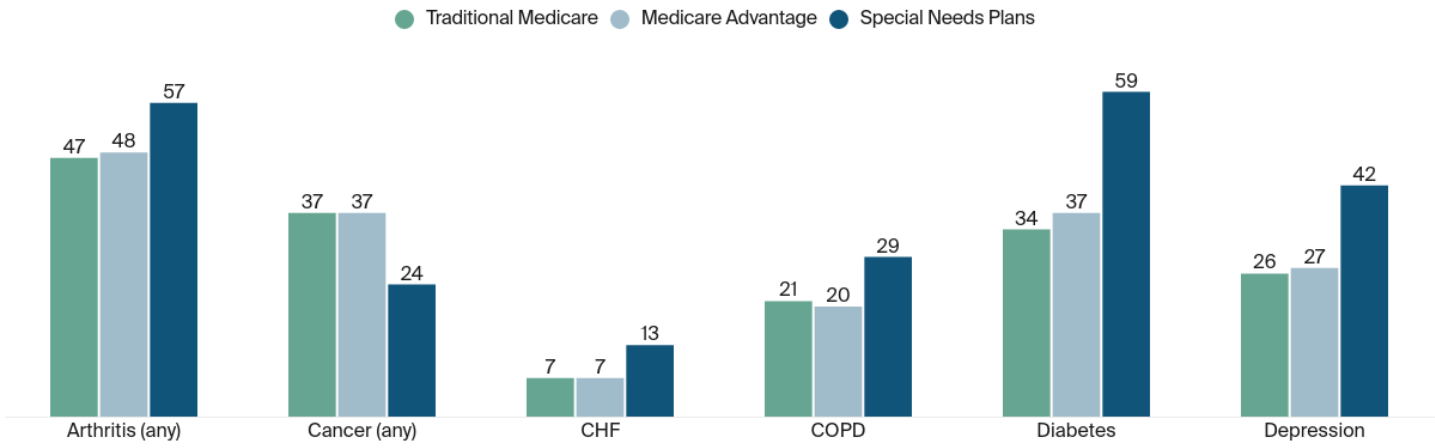
Quality adjustments. Quality ratings affect benchmarks as well as rebate size. Benchmarks are raised by 5 percent for plans with four or more stars and are increased by 10 percent for plans with high ratings in certain counties. For the rebate, plans with three stars or fewer receive 50 percent of the difference between the bid and the benchmark; plans with three-and-a-half or four stars receive 65 percent of the difference; and plans with four-and-a-half or five stars receive 70 percent of the difference.

Risk adjustment. Both the rebate and the bid amount are "risk adjusted" to account for enrollees' health status. Without risk adjustment, Medicare Advantage plans would have an incentive to select the healthiest, lowest-cost beneficiaries and avoid enrolling the sickest, highest-cost beneficiaries.

In general, it's a good thing that private insurers are given strong incentives to collect data on Medicare Advantage enrollees' health status and medical diagnoses. Such information helps insurers identify people's health care needs and can spur innovation in delivering care more efficiently to sicker patients. There are no similar incentives in traditional Medicare, where about one-third of beneficiaries each year do not have a doctor's visit during which this information could be collected.

The prevalence of many chronic conditions is similar for enrollees in traditional Medicare and Medicare Advantage, after separating out Special Needs Plans.

Percentage of beneficiaries with chronic condition



Download data

Notes: Medicare Advantage plans as shown do not include Special Needs Plans (SNPs). CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease, emphysema, and/or asthma. Across all listed chronic conditions, differences between SNPs and other types of Medicare coverage are significantly different, p<.05. Data represent community-dwelling beneficiaries. Beneficiaries in SNPs were determined using plan identifiers reported in the Medicare Current Beneficiary Survey.

Data: Analysis of the Medicare Current Beneficiary Survey, 2018, as cited in Gretchen Jacobson et al., *Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ?* (Commonwealth Fund, Oct. 2021).

Source: Steven Findlay, Gretchen Jacobson, and Aimee Cicchiello, "Medicare Advantage: A Policy Primer," explainer, Commonwealth Fund, May 2022. https://doi.org/10.26099/69fq-dy83

In addition to more complete coding, patients may be coded for conditions that have no bearing on their health expenditures. Critics have also asserted that many Medicare Advantage plans have been "upcoding"— that is, systematically assessing enrollees as having more health conditions and being sicker on average than is actually the case.[14] This inappropriately raises total payments to plans. Medicare Advantage insurers counter that their coding is more accurate and complete.

In response to the upcoding debate, Congress required CMS to adjust risk scores down 3.4 percent beginning in 2010 and 5.9 percent in 2018 and future years. The CMS administrator has the authority to increase the adjustment, but no administrator has chosen to do so.

Some experts argue that a fundamental redesign of Medicare Advantage risk-adjustment methods is needed, with recent studies suggesting that enrollees are no sicker than those in traditional Medicare.[15] According to one estimate, fixing Medicare Advantage overpayments could save $600 billion between 2023 and 2031.

Medical loss ratios. Since 2014, Medicare Advantage and Part D prescription drug plans have been required to have "medical loss ratios" no lower than 85 percent. This means that plans' administrative expenses and profits, or margins, can be no higher than 15

percent of the total revenues that plans receive from the federal government (in the form of payments) and enrollees (in the form of premiums).

Plans that do not meet this requirement must remit payments to CMS. If this requirement is not met for three consecutive years, the plan may not be permitted to enroll new beneficiaries, and if it is not met for five consecutive years, the plan may be terminated. The minimum medical loss ratio requirement was intended to create incentives for plan sponsors to limit administrative costs and profits.

Margins are higher for dual-eligible and chronic-condition Special Needs Plans than for other plans. Margins have historically also been higher for institutional Special Needs Plans, though they were lower in 2020, likely because of COVID-19.

Margins for dual-eligible and chronic-condition Special Needs Plans are higher compared to other Medicare Advantage plans.

Medicare Advantage plans' margins, by plan type, 2020

Download data

Notes: MA = Medicare Advantage; SNP = Special Needs Plan; D-SNP = dual-eligible SNP; C-SNP = chronic condition SNP; I-SNP = institutional SNP. Margin calculation excludes quality improvement and fraud reduction activities as medical expenses. This figure excludes Part D and the following plan categories: employer group plans, the Medicare–Medicaid demonstration plans, cost-reimbursed plans, Program of All-Inclusive Care for the Elderly, and medical savings account plans.

Data: Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report," in *Report to the Congress: Medicare Payment Policy* (MedPAC, Mar. 2022).

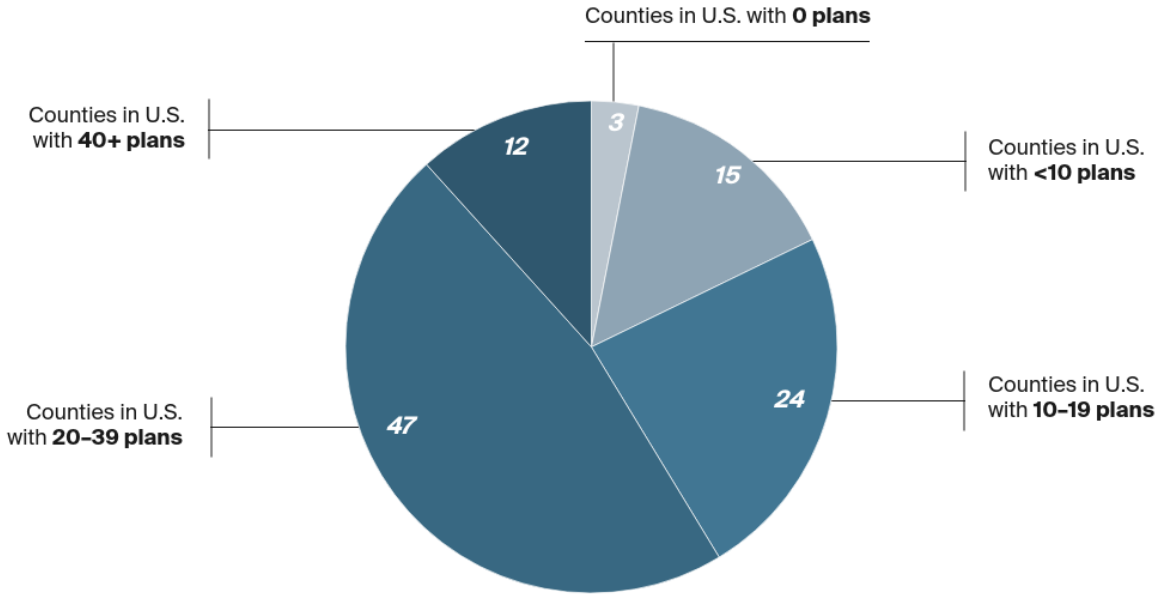
Source: Steven Findlay, Gretchen Jacobson, and Aimee Cicchiello, "Medicare Advantage: A Policy Primer," explainer, Commonwealth Fund, May 2022. https://doi.org/10.26099/69fq-dy83

How much choice and competition is there between Medicare Advantage plans and traditional Medicare?

Medicare beneficiaries have a lot of Medicare Advantage plans to choose from each year. The average beneficiary had access to 39 plans in 2022, double the number in 2017.[16]

In about 60 percent of U.S. counties, beneficiaries have a choice of 20 or more Medicare Advantage plans.

Percentage of U.S. counties with selected number of available Medicare Advantage (MA) plans



Download data

Average number of MA plans = 39

Notes: Data for the following organization types are included: local Coordinated Care Plans (CCP); Regional CCP; Medical Savings Accounts (MSA); Private Fee-for-Service (PFFS); Demonstrations; National PACE; 1976 Cost; HCPP–1933 Cost; Employer Direct PFFS.

Data: Centers for Medicare and Medicaid Services, Medicare Advantage Landscape Source File, 2022.

Source: Steven Findlay, Gretchen Jacobson, and Aimee Cicchiello, "Medicare Advantage: A Policy Primer," explainer, Commonwealth Fund, May 2022. https://doi.org/10.26099/69fq-dy83

For Medicare beneficiaries, the choice between traditional Medicare and a Medicare Advantage plan, or between individual Medicare Advantage plans, can be frustrating, complex and confusing.[17] Many beneficiaries seek advice from their doctor, a broker, a State Health Insurance Assistance Program (SHIP), or other experts.[18] To complicate matters, brokers are not required to offer all Medicare Advantage or Part D plans and typically offer a subset of the plans available. In addition, brokers are typically paid more to help people enroll in Medicare Advantage plans than traditional Medicare.[19]

Switching between Medicare Advantage and traditional Medicare remains uncommon. A 2016 analysis found that from 2007 to 2014, only between 9 percent and 11 percent of Medicare Advantage enrollees voluntarily switched plans each year.[20] And only 2 percent of Medicare Advantage plan enrollees each year switched to traditional Medicare. Notably, the people who switched to traditional Medicare have been shown in multiple studies to be disproportionately dually eligible for Medicare and Medicaid, living in rural areas, in poorer health, needing more help with activities of daily living, and to use more health care services than people who do not switch, raising questions about plans' provider networks and quality of care for sicker populations. There is

speculation that the ability of Medigap insurers to deny or set premiums based on health status in most states hinders more people from switching to traditional Medicare.

What does the future look like for Medicare Advantage?

Medicare Advantage plans are an integral part of the Medicare program. They provide beneficiaries a multitude of options and offer additional benefits to enrollees. As the popularity of these plans continues to grow and enrollment rises, however, the Medicare program will face several challenges. First, higher costs relative to traditional Medicare will strain federal spending and the solvency of the Hospital Insurance (Part A) trust fund. Second, increased enrollment could necessitate changes to the payment system for Medicare Advantage plans. Third, questions remain about the quality of Medicare Advantage plans relative to traditional Medicare.

With Medicare Advantage plans predicted to soon become the dominant form of Medicare coverage, it will be important to assess beneficiaries' experiences and the long-term sustainability of the program to ensure Medicare Advantage plans provide effective, efficient, and equitable care.

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