The Evolution of Private Plans in Medicare

Source: The Evolution of Private Plans in Medicare (commonwealthfund.org)

Medicare Advantage Timeline

The evolution of the Medicare Advantage program reflects an effort to find a balance between the dual goals of improving and expanding health care for beneficiaries, and reducing program spending (or at least, holding it down). The following is a summary of the stages of this evolution from Medicare's beginnings in 1966 through the current year.

1966-1982 – Private health plans, in the form of HMO's, have had a role in Medicare since its inception, but not until 1972, and the passage of that year's Social Security Amendments, were these plans allowed to operate on a risk-sharing basis. This meant that, if the HMO's costs were higher than they would have been under traditional Medicare, it could carry those into subsequent years, and if the costs were lower, part of the savings would be shared between the HMO and Medicare. By 1979, 65 HMOs were contracting with Medicare, although only one had a risk-sharing arrangement. [cite *Commonwealth Fund* Issue Briefs, December 8, 2017 – The Evolution of Private Plans in Medicare].

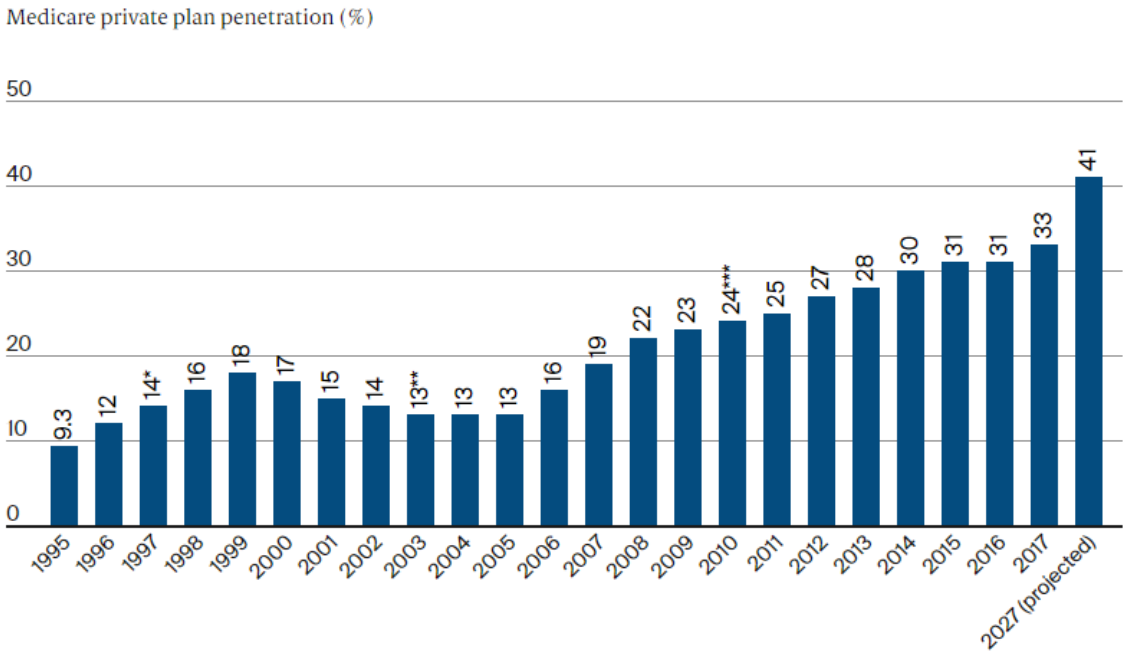
1982 – 1997

During the early 1980s, researchers found that providers in the HMO's appeared to take more conservative approaches to treatment and engaged in more preventive care. Medicare estimated that it paid more for enrollees in Medicare HMOs than in traditional Medicare. Nevertheless, Medicare established higher payment rates to HMOs with the assumption that they would be better at managing utilization of medical services. Plans whose payment rates exceeded the costs of providing traditional Medicare benefits, were required to provide additional benefits to their enrollees. These additional benefits have included reduced premiums, extended allowable hospital days, eye care, dental care, and prescription drug coverage. These risk plans gained in popularity but faced challenges in rural areas where the existence of fewer providers allowed plans little bargaining power to form networks.

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 reduced payment rates to plans, established new measures based on health status, and limited the ability to switch between plans. From 1991 to 2001, the average premium across all plans increased 260 percent. The total number of plans dropped from 407 to 285 and enrollment dropped by nearly 30 percent between 1999 and 2003. Beginning in 2001, plans shifted toward cutting extra benefits and heightening cost-sharing, however, even with considerable cuts and an updated risk-adjustment model, Medicare+Choice did not achieve savings relative to traditional Medicare.

Enrollment in Medicare Private Plans as a Share of All Medicare Beneficiaries



* Balanced Budget Act (BBA) passed in 1997. ** Medicare Modernization Act (MMA) passed in 2003. *** Affordable Care Act (ACA) passed in 2010.

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).

Source: Y. M. Patel and S. Guterman, *The Evolution of Private Plans in Medicare*, The Commonwealth Fund, December 2017.

2003 to 2010

The Medicare Modernization Act of 2003 (MMA) established Medicare Part D and changed how private plans (now named Medicare Advantage) were paid. The MMA raised payments to plans again, allowed plans to include the new drug benefit (MA-PD), and established a bidding mechanism where if a plan's bid comes in lower than a benchmark the plan receives the difference. The plan was then required to provide additional benefits. The MMA also allowed for new regional PPOs, and special needs plans. This had the result of expanding the reach of MA so that, by 2006, 100 percent of Medicare beneficiaries had access to at least one plan and by 2009 94 percent of beneficiaries had access to a zero premium MA-PD plan. To encourage quality improvement, CMS instituted a five-star rating program with financial incentives for improvement in quality measures. By 2009 plans were paid 114% of what traditional Medicare would have spent on the same beneficiaries, amounting to $11.4 billion in excess payments.

2010 to 2017

The ACA was enacted in 2010, and once again reduced rates overall, bringing MA plan payments closer to traditional Medicare spending levels. In addition, it created financial incentives for enhanced quality, required a medical loss ratio to limit administrative overhead, developed new risk adjustment measures, and established out of pocket spending limits for covered services. Enrollment in these plans continued to increase, and Medicare payments to plans relative to traditional Medicare fell dramatically from 114% in 2009 to 100% in 2017. However, due to the risk profile methodology, plans with greater increases in risk scores were paid more.

2017 to 2022

In the last five years, Medicare Advantage enrollment has continued to grow and by 2021 more than 26 million Medicare beneficiaries were enrolled in a Medicare Advantage plan,[1] [try to update for 2022 and get the percentage breakout]. The number of plans has grown to 3,834 (in 2022) [2] and the average Medicare beneficiary has access to 39 Medicare Advantage plans, more than double the number of plans per person in 2017, and the largest number of options available in more than a decade. The vast majority (89 percent) of all Medicare Advantage plans include prescription drug coverage in 2022, and more than half (59%) charged no premium (other than the Part B premium). More than 90% of the individual plans offer extra benefits such as vision, gym memberships, dental, and hearing benefits although the scope of those benefits may vary. As of 2020, Medicare Advantage plans have been allowed to include telehealth benefits beyond what was allowed under traditional Medicare prior to the COVID-19 public health emergency. These costs are built into the bid.

During this era of growth, however, concerns about "widespread and persistent problems related to inappropriate denials of services and payments." [3] [4]have led Congress to pass legislation aimed at addressing some of these concerns. The new rules, issued by CMS on April 5, 2023, are intended to: ensure timely access to care through utilization management requirements, protect Medicare beneficiaries from confusing and potentially misleading marketing, strengthen the Quality Star Ratings Program, advance health equity, and improve access to behavioral health care. [5]

In 2022, payments to Medicare Advantage plans are estimated to be 104% of what traditional Medicare would have spent on these beneficiaries, on average, according to MedPAC. This percentage is lower than in 2010, when Congress made changes to how Medicare Advantage plans are paid, but it has been trending higher since 2017.[6]

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[1] KFF: Medicare Advantage 2022 Spotlight: First Look. November 2, 2021 Medicare Advantage 2022 Spotlight: First Look | KFF

[2] Excludes SNPs, EGHPs, HCPPs, PACE and MMPs which are only available to select populations.

[3] Medicare Advantage Plans Often Deny Needed Care, Federal Report Finds - The New York Times (nytimes.com)

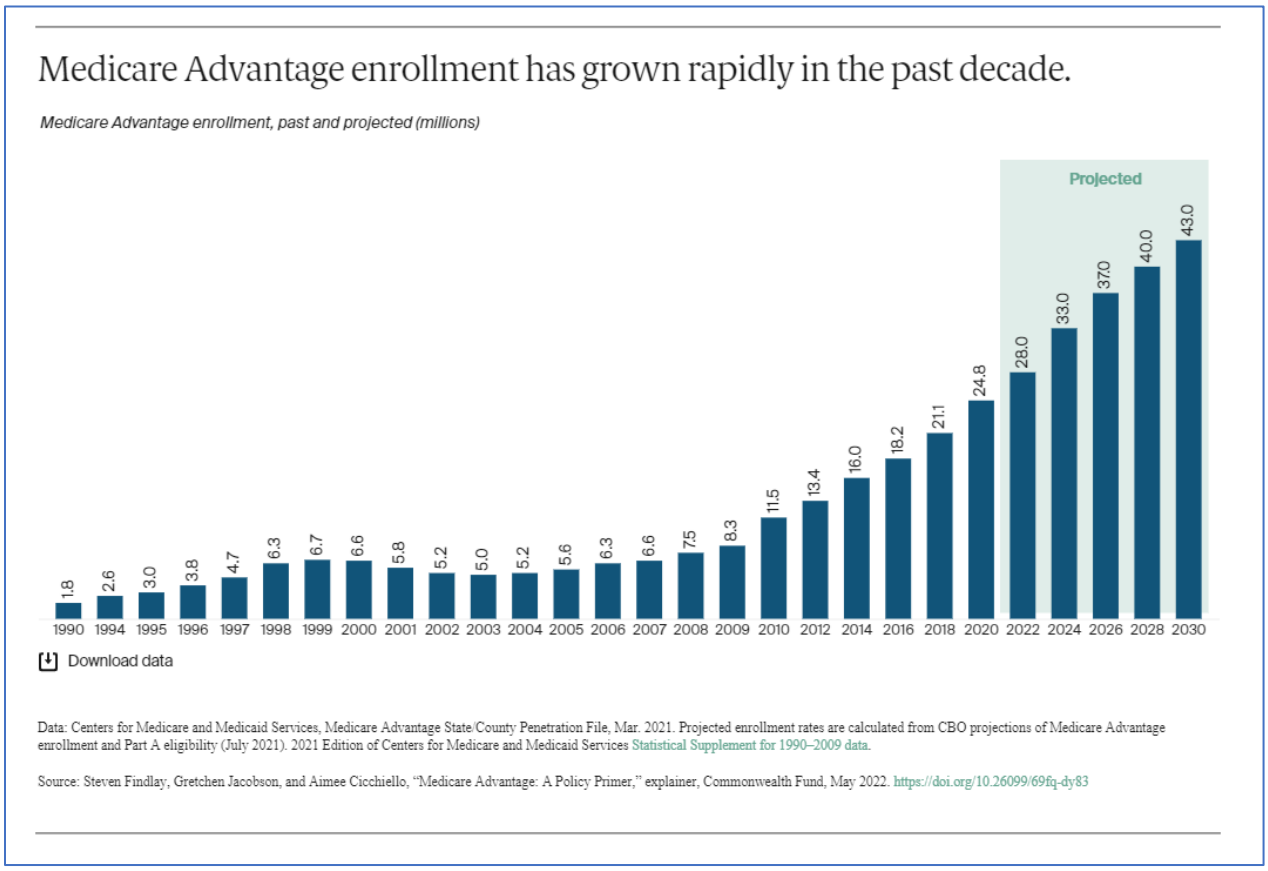
[4] Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (OEI-09-18-00260) (hhs.gov)

[5] 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) | CMS

[6] What to Know about Medicare Spending and Financing | KFF

Conclusion

The Medicare Advantage program has been a way for CMS to try to achieve the dual goals of improving and expanding health care for beneficiaries, while reducing program spending. Changes in the program over the past six decades have either expanded benefits, resulting in growth, or reduced payments to plans, resulting in a decline in the number of plans and enrollment. Nevertheless, Medicare Advantage enrollment is projected to increase to 60% of eligible Medicare beneficiaries by 2031[7].



[7] Medicare - May 2022 Baseline (cbo.gov)