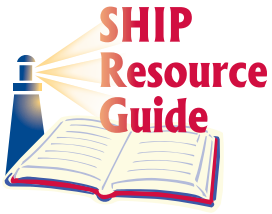

Overview of the Medicare Advantage Program

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History

Medicare Advantage (MA), also called Medicare Part C, is a program that the Medicare Modernization Act of 2003 (MMA) established to replace the Medicare+Choice (M+C) program. **Medicare Advantage is a system for delivering Medicare benefits to beneficiaries who enroll in plans offered by private health insurance organizations**. The intent of the M+C program when it was created in 1998 was to save the Medicare program money. Private Medicare plans agreed to coordinate the care received by beneficiaries and reduce costs by emphasizing prevention and limiting the use of services. The Original Medicare program, in contrast, typically paid for care on a fee-for-service basis, with few incentives (outside of the Part A Hospital Insurance program) to control costs.

Under the M+C program, many beneficiaries had only a few options, other than Original Medicare, available to them. The presence of Medicare health plans varied across the country. Large cities and areas with many Medicare beneficiaries often had several plans, while other areas, including smaller towns and rural communities, had no M+C plans or saw plans quickly come and go. One purpose of the MMA was to provide options for all beneficiaries—all those in Medicare should have access to Medicare Advantage. Thus, the MMA brought new types of MA plans to the marketplace along with increased funding to give beneficiaries access to a wide range of private plans as a way to receive their Medicare benefits. Cost savings is no longer an aim for the program; in fact, Medicare pays 12 percent more, on average, for a beneficiary to have a Medicare Advantage plan than for Original Medicare.

The Basics

Medicare Advantage is a means of receiving Medicare-covered health benefits and other health benefits. Eligible beneficiaries must choose to enroll in an MA plan. That is, eligible beneficiaries must enroll in an MA plan during an applicable enrollment period, and generally agree to stay in the plan for a calendar year, in order to receive coverage through the Medicare Advantage program. As a result, enrollees receive their Medicare benefits through the private MA plan and not through the Original Medicare program. After enrollment in an MA plan takes effect, beneficiaries typically must receive all of the care according to plan rules, respecting provider network, prior authorization, and other limits that plans may use to control spending.

The Centers for Medicare and Medicaid Services (CMS) pays private MA plans a fixed amount per beneficiary to provide care. The amount CMS pays to the plans is not directly related to the quantity or cost of health services they deliver. This payment method is called capitation. It contrasts with Original Medicare's fee-for-service system in which Medicare pays physicians and other healthcare providers for each service they provide to Medicare beneficiaries. Neither system is perfect. Fee-for-service systems encourage providers to furnish more health services to yield a larger profit, while under capitation, the health plans make a larger profit by limiting services.

In 2009, about 23 percent of Medicare beneficiaries were enrolled in Medicare Advantage plans. (See *Medicare Advantage in 2009*, Kaiser Family Foundation Issue Brief, November 2009, available online at http://www.kff.org/medicare/upload/2052-13.pdf.) Since enrollment into a Medicare Advantage plan changes fundamental aspects of how Medicare beneficiaries receive their health care, it is more important than ever for people to have access to timely, accurate, and useable information about these plans before they enroll. SHIPs have an important role in providing thorough counseling and information to Medicare beneficiaries about all their Medicare options so that they can make informed decisions about their benefits.

Highlights in Medicare Advantage History

Here are some highlights in the history of Medicare Advantage and its predecessor programs.

1982: The Tax Equity and Fiscal Responsibility Act (TEFRA) makes it easier for health maintenance organizations (HMOs) to contract with the Health Care Financing Administration (HCFA). HMOs offer coverage to Medicare beneficiaries through risk contract plans and cost plans.

1992: 1.6 million Medicare beneficiaries are enrolled in Medicare managed care plans.

1997: The Balanced Budget Act of 1997 creates the Medicare+Choice program, offering an array of new Medicare managed care and private plan options, including Private-Fee-for-Service (PFFS) plans and Preferred Provider Organizations (PPOs).

1998: 6.9 million Medicare beneficiaries, 17 percent of the total number, are enrolled in one of the 346 Medicare+Choice plans available throughout the country.

2002: Between 1999 and 2001, nearly half of the plans participating in Medicare+Choice program cancel their contracts, completely withdrawing from the Medicare program. Others pull out of certain counties within their service areas. The withdrawals affect 1.6 million beneficiaries as Medicare+Choice enrollment drops to 5.5 million.

2003: The Medicare Modernization Act (MMA) of 2003 renames the program "Medicare Advantage" (MA) and boosts federal funding to stabilize and expand the program. The MMA adds Regional PPOs and Special Needs Plans to the array of private plan options. MA plan enrollment drops to 5.3 million beneficiaries, its lowest point since 1996.

2006 to 2008: Spurred by the MMA's payment increases, Private-Fee-for-Service (PFFS) plan enrollment triples from 765,000 enrollees to 2.3 million. In 2007, reports surface of rampant abuses in the marketing and sale of PFFS and other MA plans.

2008: The Medicare Improvements for Patients and Providers Act (MIPPA) strengthens MA plan marketing rules and places limits on agent and broker compensation for the sale of MA plans. More than ten million Medicare beneficiaries, representing 23 percent of the total Medicare population, are enrolled in MA plans.

2009: Congress considers legislation to restructure the payments to MA plans in order to equalize payments with Original Medicare by 2013.