Part C: Medicare Advantage plans

With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These programs were known as "Medicare+Choice" or "Part C" plans. Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, "Medicare+Choice" plans were made more attractive to Medicare beneficiaries by the addition of prescription drug coverage and became known as "Medicare Advantage" (MA) plans.

Traditional or 'fee-for-service' Medicare has a standard benefit package that covers medically necessary care members can receive from nearly any hospital or doctor in the country. For people who choose to enroll in a Medicare Advantage health plan, Medicare pays the private health plan a capitated rate, or a set amount, every month for each member. Members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by traditional Medicare (Parts A & B), such as prescription drugs, dental care, vision care and gym or health club memberships.[8] In exchange for these extra benefits, enrollees may be limited on the providers they can receive services from without paying extra. Typically, the plans have a 'network' of providers that you can use. Going outside that network may require permission or extra fees.

Medicare Advantage plans are required to offer coverage that meets or exceeds the standards set by the original Medicare program, but they do not have to cover every benefit in the same way. If a plan chooses to pay less than Medicare for some benefits, like skilled nursing facility care, the savings may be passed along to consumers by offering lower copayments for doctor visits. Medicare Advantage plans use a portion of the payments they receive from the government for each enrollee to offer supplemental benefits. Some plans limit their members' annual out-of-pocket spending on medical care, providing insurance against catastrophic costs over $5,000, for example. Many plans offer dental coverage, vision coverage and other services not covered by Medicare Parts A or B, which makes them a good value for the health care dollar, if you want to use the provider included in the plan's network or 'panel' of providers.

Because the 2003 payment formulas overpay plans by 12 percent or more compared to traditional Medicare <Medicare Payment Advisory Commission Annual Reports to Congress, 2006, 2007, 2008> in 2006 enrollees in Medicare Advantage Private Fee-for-Service plans were offered a net extra benefit value (the value of the additional benefits minus any additional premium) of $55.92 a month more than the traditional Medicare benefit package; enrollees in other Medicare Advantage plans were offered a net extra benefit value of $71.22 a month more.[9] However, Medicare Advantage members receive additional coverage and medical benefits not enjoyed by traditional Medicare members, and savings generated by Medicare Advantage plans may be passed on to beneficiaries to lower their overall health care costs.[8] Other important distinctions between Medicare Advantage and traditional Medicare are that Medicare Advantage health plans encourage preventive care and wellness and closely coordinate patient care.[10]

Medicare Advantage Plans that also include Part D prescription drug benefits are known as a Medicare Advantage Prescription Drug plan or a MAPD.

Enrollment in Medicare Advantage plans grew from 5.4 million in 2005 to 8.2 million in 2007. Enrollment grew by an additional 800,000 during the first four months of 2008. This represents 19% of Medicare beneficiaries. A third of beneficiaries with Part D coverage are enrolled in a Medicare Advantage plan. Medicare Advantage enrollment is higher in urban areas; the enrollment rate in urban counties is twice that in rural counties (22% vs. 10%). Almost all Medicare beneficiaries have access to at least two Medicare Advantage plans; most have access to three or more. Because of the 2003 law's overpayments, the number of organizations offering Fee-for-Service plans has increased dramatically, from 11 in 2006 to almost 50 in 2008. Eight out of ten beneficiaries (82%) now have access to six or more Private Fee-for-Service plans.[11]

Each year many individuals disenroll from MA plans. A recent study noted that about 20 percent of enrollees report that 'their most important reason for leaving was due to problems getting care.'<"Problems encountered by Medicare beneficiaries in managed Care plans," Booske B, Frees D, etc., AcademyHealth, Abstr Academy Health Meet. 2005, 22: abstract no. 3625.> There is some evidence that disabled beneficiaries 'are more likely to experience multiple problems in managed care.'<"Voluntary disenrollment from Medicare managed care: market factors," Mobley L, et al., Health Care Financing Review, 2005 Spring; 26(3): 45-62.> Some studies have reported that the older, poorer, and sicker persons have been less satisfied with the care they have received in MA plans.<Hellinger FJ, "The effect of managed care on quality: a review of recent evidence," Archives Internal Medicine, 1998 Apr 27; 158(8): 833-41..>

Twenty percent of African-American and 32 percent of Hispanic Medicare Beneficiaries were enrolled in Medicare Advantage plans in 2006. Almost half (48%) of Medicare Advantage enrollees had incomes below $20,000, including 71% of minority enrollees.[12] Others have reported that minority enrollment is not particularly above average.<"Insurers Fight to Defend Lucrative Medicare Business," Wall Street Journal, April 30, 2007> Another study has raised questions about the quality of care received by minorities in MA plans.<Trivedi AN, et al., "Relationship between quality of care and racial disparities in Medicare...," JAMA, 2006 Oct 25; 296(16): 1998-2004.>

The Government Accountability Office reported that in 2006, the plans earned profits of 6.6 percent, had overhead (sales, etc.) of 10.1 percent, and provided 83.3 percent of the revenue dollar in medical benefits. These administrative costs are far higher than traditional fee-for-service Medicare.<GAO-09-132R, "Medicare Advantage Expenses">