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RUPRI Health Panel

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Medicare Advantage Plans in Rural America

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This document identifies key policy issues and questions concerning the impact of Medicare Advantage (MA) in rural areas. Recent data indicate a significant growth in MA and private fee-for-service plans (PFFS) and enrollment in both urban and rural areas. This expansion raises a number of key issues and questions for rural Medicare beneficiaries: (1) What are the trends, patterns, and impact of rural enrollment in MA and PFFS plans? (2) What effects have expanded plan availability and increased rural enrollment had on rural beneficiaries and providers? and (3) What effects have expanded plan availability and increased rural enrollment had on program costs?

History and Development of the Medicare Advantage Program

- At-risk and cost-based HMOs entered the Medicare program in the 1970s with payment set at 95% of adjusted average per capita cost (AAPCC), that is, 95% of the average Medicare expenses per person living in a given county.

- By 1995, the Medicare HMO plans were concentrated in high AAPCC counties, with a strong regional and urban bias: beneficiaries in those counties were able to purchase plans that provided extra benefits at little or no cost – raising equity questions across regions and between urban and rural.

- The 1997 Balanced Budget Act (BBA) legislated a rural floor payment of $415 per member per month (pmpm), raising county payments in some areas by more than $100 pmpm.

- The BBA also established new forms of Medicare managed care plans in the Medicare+Choice program: preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), medical savings accounts (MSAs), and PFFS plans.

- The Benefits Improvement and Protection Act of 2000 (BIPA) increased rural floor payments from $415 to $475 and created an urban floor payment at $525.

- The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) increased payments for all MA plans, and increased floor payments again – urban counties to $613 and *all others* to $555.

- The MMA established the MA program to replace M+C and created new types of plans: regional PPOs (offering a new plan anywhere in the region required offering the same plan everywhere in the region) and MA/Prescription Drug Plans.

- The MMA included a regional stabilization fund to begin in 2007 and a network adequacy fund for extra payment to essential hospitals.

- Although payment to Medicare managed care plans was originally based on 95% of traditional Medicare fee for service expenditures, this is no longer the case. The MMA sets a benchmark in each county to be the *higher of* what would have been paid to MA plans by a formula based on the most recent payment rate for each county, or the average plan bid (weighted by number of enrolled beneficiaries). If a plan bid falls above the benchmark, the beneficiary pays the difference as part of their premium. If the plan bid falls below the benchmark, it is "rebated" 75% of the difference, which must be used to provide additional benefits.

- The MMA established a new payment adjustment for risk by using risk corridors around the benchmark payment so that aggregate losses and gains are shared between the Medicare program and the plan.

Enrollment of Rural Beneficiaries in Medicare Advantage

- Prior to the BBA, enrollment was very modest and concentrated in the cost-based plans.

- Rural enrollment grew after the BBA was enacted (beginning in 1998) to a peak of just over 260,000 in 1999, then fell until 2002 as M+C plans withdrew from rural markets.

- By 2002, the benefits offered by plans that were still available in rural areas were not equitable with plans offered in urban areas – 1% of people in rural areas not adjacent to urban areas had access to a plan with zero premium as compared with 66% of those living in large urban areas.

- Rural enrollment grew following the MMA as MA plans expanded territory and offerings, to 845,000 in September 2007, a modest 12% of all rural beneficiaries.

- The MA growth in rural enrollment has been concentrated in PFFS plans, as has the growth in urban areas: in rural areas PFFS enrollment increased eightfold from 2005 to 2007 and in urban areas by 10 times, to total enrollment of 519,427 and over 1.1 million, respectively.

- By 2007, over 50% of enrollment in rural areas was in PFFS plans, and half of those enrollees were signed up in five MA contracts (Humana Insurance Co. enrolls over 22% of rural enrollees).

- Almost half of the rural MA enrollment is concentrated in a few states (leaders are PA, WI, MN, NC, and MI).

Effects on Beneficiaries

- The MA program and the previous iterations of managed care contracting in Medicare have been supported by some members of Congress based on the belief that beneficiaries will value having choices among plan options that include private plans and traditional Medicare.

- Legislative changes to the program have in part been designed to encourage the spread of managed care into places where beneficiaries had limited access to such plans, including rural counties and some regions of the country. Examples of such changes include creating floor payments in rural counties, non-HMO options for contracting, and regional PPOs.

- MA plans must return 75% of any payment above their initial bid to enrollees as additional benefits.

- MA plans must be actuarially equivalent to traditional Medicare, but that could mean higher beneficiary cost-sharing for some services, such as inpatient hospitalization, and lower cost-sharing for other benefits, such as vision services.

- To understand the financial value of MA plans from the perspective of beneficiaries, a fair comparison would be the total cost of MA plans vs. the cost of a benefit package from the combination of traditional Medicare and supplemental plans.

- All beneficiaries, including those enrolled in traditional Medicare Part B, pay premiums that are set to reflect 25% of the *total* costs of Part B services. Therefore when Part B costs increase because of higher expenditures attributed to MA plans, premiums also increase for those enrolled in traditional Part B, by $2 per month in 2006. This affects more than 85% of rural beneficiaries who are enrolled in traditional Part B.

<u>Questions about the effects on beneficiaries</u>

- If the goal is to expand the choices of benefit packages offered by Medicare, what is the best way to do so?

- How do MA plans compare to traditional Medicare plus Medigap coverage in terms of benefits and costs (i.e. are the beneficiaries better or worse off)?

    - What do the beneficiaries pay for additional benefits?
    - What is the value of the additional benefits to MA enrollees?
    - What is the value of multiple choices to beneficiaries?

- How do MA PFFS plans compare to other MA plans (i.e. HMOs and PPOs) in terms of benefits or programs designed to improve quality of care? Specifically, do they offer such services as active care management?

- Do rural beneficiaries have sufficient information to make informed choices and do they act based on that information? Do beneficiaries understand the relationship between the plans they enroll in and their out-of-pocket costs at point of service? Are rural beneficiaries' choices affected by difficulties delivering information to rural America (e.g., restricted access to the Internet)? If beneficiaries better understood the consequences of plan differences, would increased PFFS enrollment still occur?

- If enrollees with a pre-existing condition opt out of an MA plan (perhaps because they incur costs higher than they expected), Medigap plans are not required to enroll them, leaving them without supplemental coverage. Is this more likely to happen in rural areas?

- Are the reforms in the BBA and MMA achieving the goal of equitable access to benefits and plan choices that inspired these pieces of legislation?

- Will current increases in Part B premiums that are attributable to increased expenditures associated with MA plan payments continue?

Effects on Rural Providers

- MA plans that negotiate contracts with providers are not obligated to use the same payment methodologies as traditional Medicare, which could alter the timing and amount of payment to providers. Rural providers that receive cost-based payment from traditional Medicare are most likely to be affected because of a change from interim payments and cost settlement.

- MA PFFS plans that do not contract with providers are obligated to set total provider payments (the plan share and the beneficiary copayment) equivalent to what they would have received from Medicare. PFFS plans can vary benefit design which can result in higher beneficiary out-of-pocket charges, which then become the responsibility of the provider to collect.

- Providers can refuse to treat patients insured by MA plans, but if they accept patients in PFFS plans, they are "deemed" to be plan providers and thus must accept the plan's payment policies (such as how to determine cost-based payment amount and the timing of payment).

<u>Questions about the effects on providers</u>

- Are providers given full information about both the price structure proposed by MA plans and the rules governing payment (e.g., defining clean claims, prompt payment standards)?

- How are provider administrative costs affected by working with multiple MA plans (with different benefit designs and forms) as compared to a single intermediary in traditional Medicare?

- Are rural providers at risk for financial shortfalls when contracting with MA plans compared to receiving traditional Medicare payments? If so, what are the implications for access to services? How do the answers to these questions vary across types of providers?

- How are provider-patient relationships affected by changes in beneficiary financial liability for care received?

- Are rural providers refusing to participate in MA PFFS plans?

Program Costs

- The Medicare program spends 12% more for those enrolled in MA plans (and 19% more for the subset of beneficiaries enrolled in PFFS plans) than it would spend for the same beneficiaries if they were enrolled in traditional Medicare.

- The higher payment to MA plans (over and above traditional Medicare) results from a combination of factors, including higher floor payments, increases in legislated payments in the MMA, and payments above traditional Medicare for graduate medical education.

- Analysis of the payment above traditional Medicare shows the following sources of extra payment to MA plans (as of 2005):

Payment at the urban floor:	$1.9 billion
Inclusion of IME payment:	$0.6 billion
Risk adjustment payment:	$1.8 billion
Rural and other urban floor:	$0.357 billion

- When a plan's bid is below the benchmark, 75% of the difference between the bid and the benchmark payment is rebated to the plan to use for additional beneficiary benefits and 25% is retained by the government. Thus, much of the additional payment results in additional benefits for the beneficiary, including but not limited to reduced copayments and premiums and additional services beyond traditional Medicare (e.g., prescription drugs, vision and hearing benefits).

<u>Questions about program costs</u>

- Given that there are concerns about the future health of the Medicare trust funds and strain on the general fund due to increases in Medicare commitments, how long can the MA program continue to pay plans at rates that are significantly higher than traditional Medicare, while also sustaining the growth in other traditional Medicare payments?

- Will targeted payment programs, including cost-based payment and bonus payments intended to assure access, be at risk if MA payments increase Medicare expenditures?

- Is there adverse risk selection into the traditional Medicare program, increasing the costs of the traditional Medicare?

- Is the MA program the most cost-effective means of providing a more comprehensive package of benefits to Medicare beneficiaries?

Sources And Resources

Internet-based resources:

Henry Kaiser Family Foundation. Available at http://kff.org/
Kaiser Family Foundation State Health Facts: http://www.statehealthfacts.org/
Kaiser Family Foundation Health Plan Tracker: http://www.kff.org/medicare/healthplantracker/
Medicare Payment Advisory Commission. Available at http://medpac.gov/
RUPRI Center for Rural Health Policy Analysis. Available at http://www.unmc.edu/ruprihealth/

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