Medicare Advantage: What are We Trying to Achieve Anyway?

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We keep Reinventing Medicare Private Plans...

- Before Medicare Advantage... there was...
  - Medicare risk (1982)
  - Medicare+Choice (1997)

- Medicare+Choice was created in good part designed to deal with problems perceived with Medicare risk plans
Medicare Advantage: What are We Trying to Achieve Anyway?

The Congress identified two primary goals in adopting the Medicare+Choice program:

- to “…allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare,” and

- to “…enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options”

The Balanced Budget Act, and Confusing Goals …

- But a big part of the debate in 1997 was changing the payment to M+C plans, because recall:
  - the legislation was called the “Balanced Budget Act of 1997”, so the goal was to reduce the budget deficit
  - And the perception was that Medicare risk plans were “overpaid”
    - “self selection” into Medicare HMOs by younger healthier Medicare recipients, with arcane reliance on prior FFS Medicare payments

- But there was a huge lobbying campaign on behalf of rural interests to fix what they perceived to be an “equity” problem in Medicare’s risk program
  - Payment rates were higher in urban areas, leading to a more generous array of benefit packages
    - Policy prescription: create artificial “floor” payments not based on prior Medicare costs, and Byzantine payment structure
Could the payment system get more complicated?

Source: Centers for Medicare and Medicaid Services
If they raised the rates, did they come?

- The shocking (was it really?) response to the BBA:
  - Massive withdrawals of M+C plans
    - Both entire plans
    - And plans from geographic areas
  - Huge reductions in the benefits offered by M+C plans

- Shouldn’t we have been able to predict this?
  - Well, yes, in urban areas
  - But in rural, we raised the rates, and they did not come.
    - Why? It wasn’t just the rates, stupid!
So what was the response?

- The President and the Congress could not simply let private plans die, because after all, Speaker Newt Gingrich had said:
  - “Now let me talk a little bit about Medicare…We believe it’s going to wither on the vine because people are voluntarily going to leave it.”
  - [10/24/95]
If at first private plans don’t succeed, try try again ...

- So, several attempts were made to repair the M+C program and finally, in the MMA the program was renamed the **Medicare Advantage** program
  - payment rates were raised a lot (6% or more)
  - a new option (Local PPOs) was introduced
So where are we now with Medicare Advantage Enrollment, especially in Rural Areas?
Analysis of Medicare Advantage at RUPRI Center for Rural Health Policy Analysis

Analyses of:
- Enrollment in the Medicare Advantage program in rural and urban areas across U.S., with assessment of plan benefits

Data and Methods:
- Data: Center for Rural Health Policy Analysis has built and maintains large database of all Medicare Part D and Medicare Advantage plans in the U.S., with data on enrollment and plan characteristics in every county in the U.S.
- Methods: use various methods to analyze these data, including descriptive analysis as well as multivariate methods to explore factors associated with disparities in enrollment and plan benefits

Rural Enrollment in Medicare Advantage Is Concentrated in Private Fee-for-Service Plans

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The Medicare Advantage Roller Coaster…

Enrollment in MA Contracts, 1985-2008

Source: Health Care Financing Administration, Medicare Managed Care Contract Reports.
Includes enrollment in Medicare Advantage plans only, as of December on year shown.
More than one in five Medicare beneficiaries are in a Medicare Advantage Plan, April 2008

Total Medicare Beneficiaries = 44 million

Traditional Medicare
34.2 million (78.7%)

Medicare Advantage
9.3 million (21.3%)
Change in Medicare Advantage Enrollment, 2005-2008
Medicare Advantage Enrollment, in Urban and Rural Areas, April 2008

Urban MA enrollment is about 8 times as high as rural; Over one million rural persons now in MA plans, new milestone reached

SOURCE: RUPRI Center for Rural Health Policy Analysis
Medicare Advantage Enrollment in Urban and Rural areas, April 2008

Urban MA enrollment percentage twice as high as rural

Growth in Medicare Advantage Enrollment in Rural areas, 2005-2008

Almost all growth in Medicare Advantage has been in PFFS plans

The Dominance and Growth of Private Fee for Service Plans in Rural Areas
Enrollment in Medicare Advantage and other "Prepaid" Plans
April 2008, by Rural and Urban, and by Type of Plan

Rural PFFS enrollment is 57%; in urban areas HMO/POS plans are 65% of enrollment

Enrollment in Medicare Advantage and other "Prepaid" Plans  
2005-2008 in Rural areas, by Type of Plan

2005
- HMOs/POS: 51%
- Regional PPO: 0%
- PFFS: 18%
- Local PPO: 1%
- Other Prepaid: 30%

2006
- HMOs/POS: 33%
- Regional PPO: 2%
- PFFS: 44%
- Local PPO: 4%
- Other Prepaid: 17%

April 2008
- HMOs/POS: 24%
- Regional PPO: 6%
- PFFS: 57%
- Local PPO: 6%
- Other Prepaid: 7%

PFFS enrollment has grown from 18% to 57% from 2005 to 2007; HMO/POS enrollment dropped from 51% to 24%

Medicare Advantage PFFS Enrollment, by Payment Rate Category, September 2007

- About 23% of MA PFFS enrollees in counties with rate set by rural floor, 52% in counties with rate set by urban floor.
- About 81% of spending in counties with rate set above rural floor, 77% in counties with rate at or above urban floor.

**Distribution of Enrollment**

- Rural and Urban Above Urban Floor: 21%
- Rural at Rural Floor: 23%
- Rural Below Urban Floor: 4%
- Urban Floor: 52%

**Distribution of Spending**

- Rural and Urban Above Urban Floor: 23%
- Rural at Rural Floor: 19%
- Rural Below Urban Floor: 4%
- Urban Floor: 54%

Concentration of Medicare Advantage and PFFS Enrollment by Plan Organization
September 2007, in Rural Areas

- About 43% of rural MA enrollees in five contracts, 22% in one contract – Humana
- About 76% of rural MA PFFS enrollees are in five contracts, 40% in one contract – Humana

So are we achieving the goals Congress set for Private Medicare?
So where are we on Congress’ goals for private Medicare?

- Have we met the goal to contain costs?
  - Answer: No!
  - Payments to MA plans are 112% of FFS costs
On the face of it, yes, because … in 2003, most counties had 0-1 plans, now most have several plans.

Have we met the goal of increased choice?

But… it is more complicated than this!
Mega-Medicine Merger Corp.

Thank goodness health care isn't run by some big government bureaucracy.
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