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?

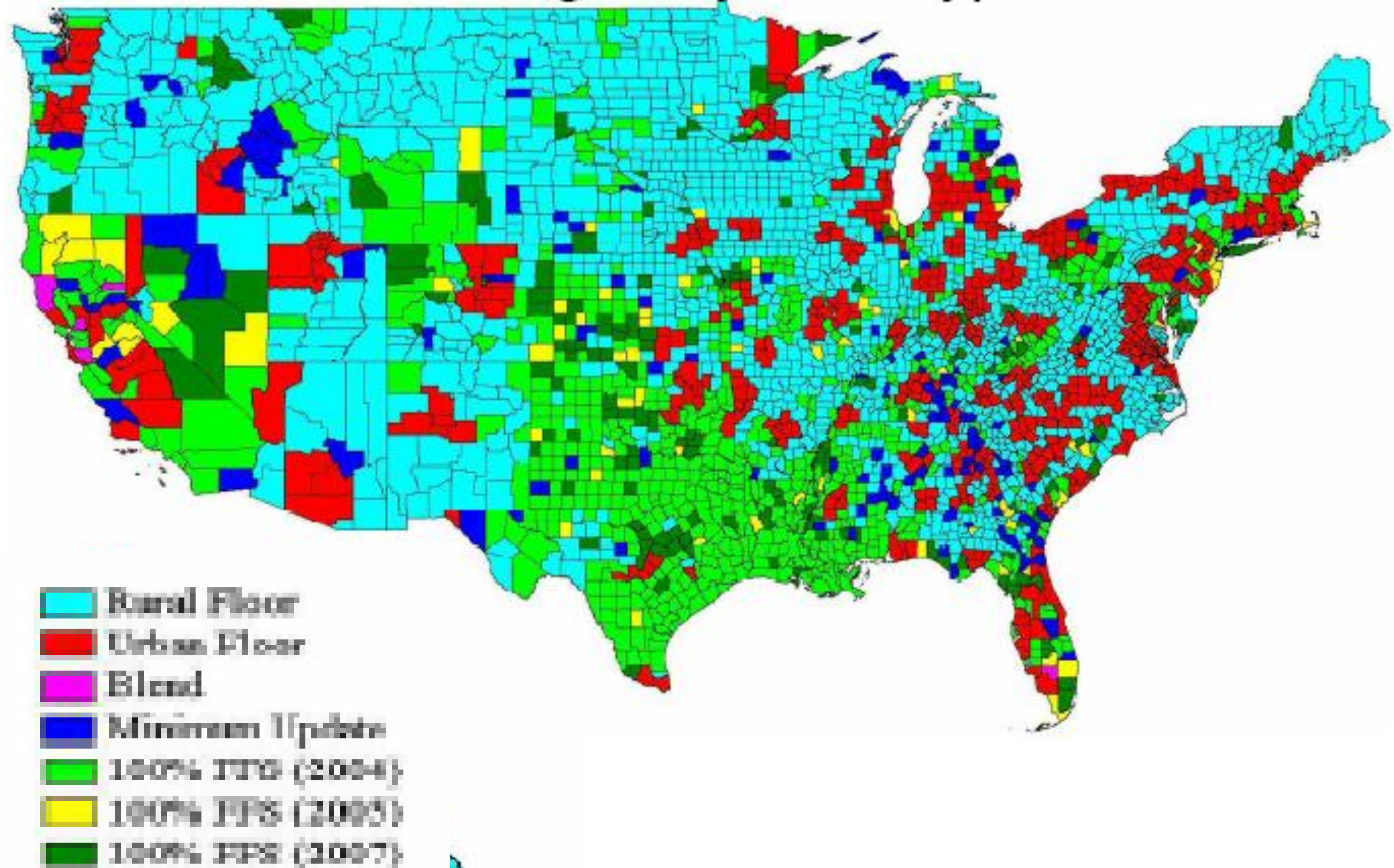
- The Congress identified two primary goals in adopting the Medicare+Choice program:
  - to "...allow beneficiaries to have access to a wide array of ***private health plan choices*** in addition to traditional fee-for-service Medicare," and
  - to "...enable the Medicare program to utilize innovations that have helped the private market ***contain costs*** and expand health care delivery options"

Source: U.S. Congress. Conference report on HR 2015, Balanced Budget Act of 1997, Congressional Record. July 29, 1997.

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]

"We welcome your review of the full text of Mr. Gingrich's speech because we are confident you will agree that it was indeed Medicare that Mr. Gingrich intended would 'wither'."

AFL-CIO Statement

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

Volume 12, Number 2 (PB2007-2)

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

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- 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 Policy Brief

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The Medicare Advantage Roller Coaster…

Enrollment in MA Contracts, 1985-2008

Year	Enrollment (Millions of Enrollees)	Contracts (Number of contracts)
1985	0.5	94
86	0.9	153
87	1.1	165
88	1.1	158
89	1.1	133
90	1.3	96
91	1.4	93
92	1.6	95
93	1.8	109
94	2.3	154
95	3.1	183
96	4.1	241
97	5.2	307
98	6.1	346
99	6.3	309
2000	6.3	266
2001	5.5	179
2002	4.9	155
2003	4.6	151
2004	4.8	160
2005	5.4	319
2006	6.6	377
2007	8.3	471
Apr-08	9.4	609

Millions of Enrollees (0.0–10.0) · Number of contracts (0–700) · Year

Legend: Enrollment · Contracts

Source: Health Care Financing Administration, Medicare Managed Care Contract Reports.
Includes enrollment in Medicare Advantage plans only, as of December on year shown.

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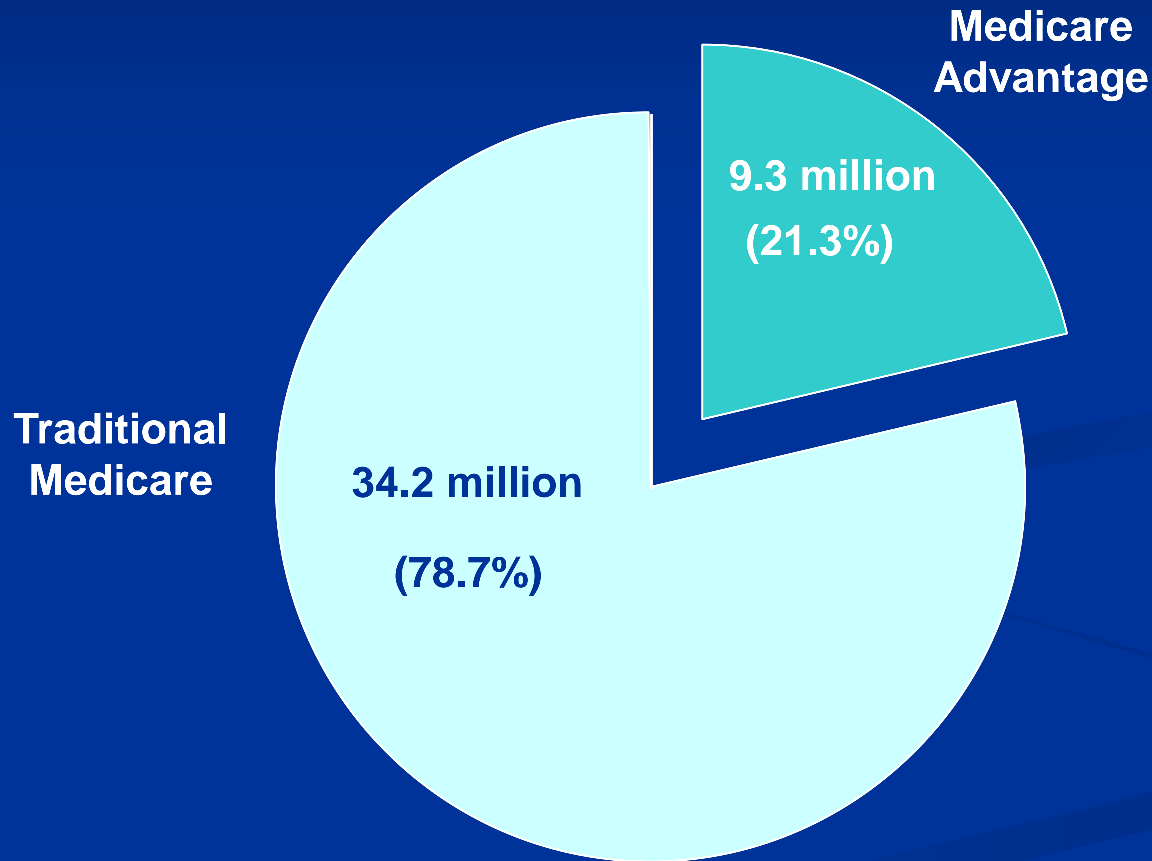
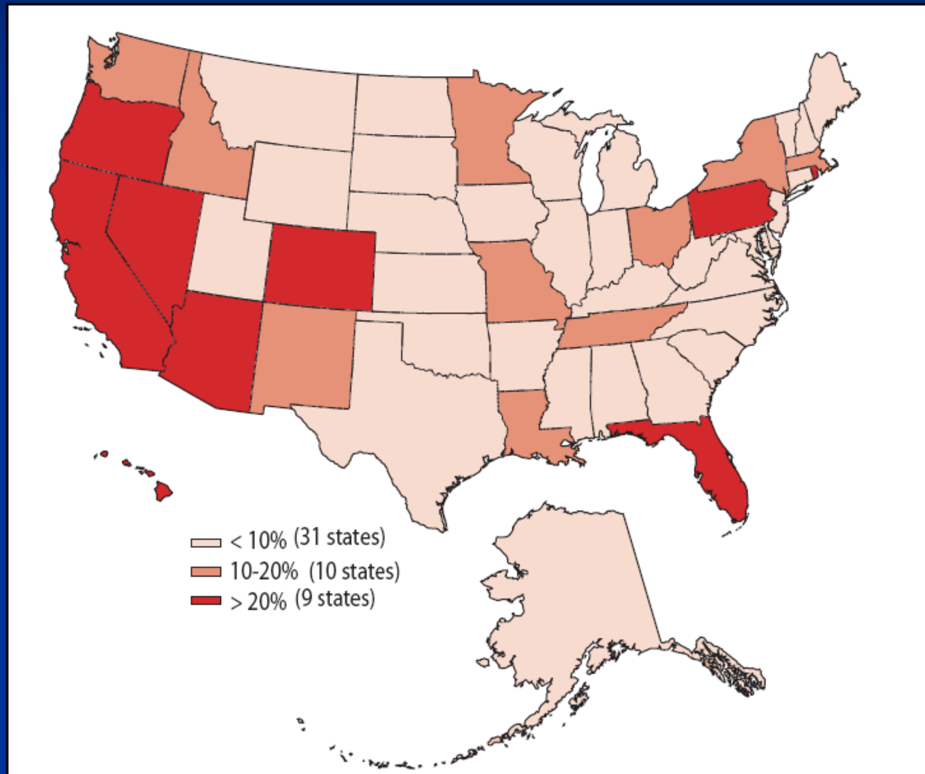
More than one in five Medicare beneficiaries are in a Medicare Advantage Plan, April 2008



Total Medicare Beneficiaries = 44 million

Change in Medicare Advantage Enrollment, 2005-2008



2005

2008

<10% (14 states)
10-20% (17 states)
>20% (19 states)

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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

	Urban	Rural
PFFS	1,448,173	639,259
PPOs and other	754,492	128,302
HMOs/POS	6,018,712	278,401
Total	8,221,377	1,045,962

SOURCE: RUPRI Center for Rural Health Policy Analysis

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Medicare Advantage Enrollment in Urban and Rural areas, April 2008

	HMOs/POS	PPOs and other	Private Fee-for-Service	Total
Urban	17.6%	2.2%	4.2%	24.0%
Rural	3.0%	1.4%	6.9%	11.3%

Urban MA enrollment percentage twice as high as rural

SOURCE: RUPRI Center for Rural Health Policy Analysis, http://www.unmc.edu/ruprihealth/

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

Almost all growth in Medicare Advantage has been in PFFS plans

	HMOs/POS	PPOs	PFFS	Total
2005	174,789	3,524	63,393	255,401
2006	203,391	40,896	276,210	538,552
April 2008	278,401	127,869	639,259	1,045,962

SOURCE: RUPRI Center for Rural Health Policy Analysis, http://www.unmc.edu/ruprihealth/

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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

Type of Plan	Share
HMOs/POS	24%
Local PPO	6%
PFFS	57%
Regional PPO	6%
Other Prepaid	7%

Urban

Type of Plan	Share
HMOs/POS	65%
Local PPO	6%
PFFS	22%
Regional PPO	3%
Other Prepaid	4%

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

SOURCE: RUPRI Center for Rural Health Policy Analysis, http://www.unmc.edu/ruprihealth/

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Enrollment in Medicare Advantage and other "Prepaid" Plans

2005-2008 in Rural areas, by Type of Plan

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

SOURCE: RUPRI Center for Rural Health Policy Analysis, http://www.unmc.edu/ruprihealth/

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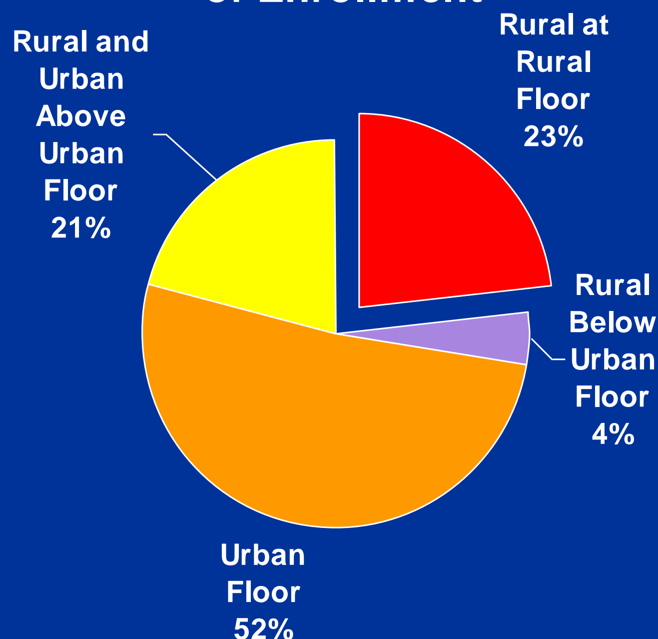
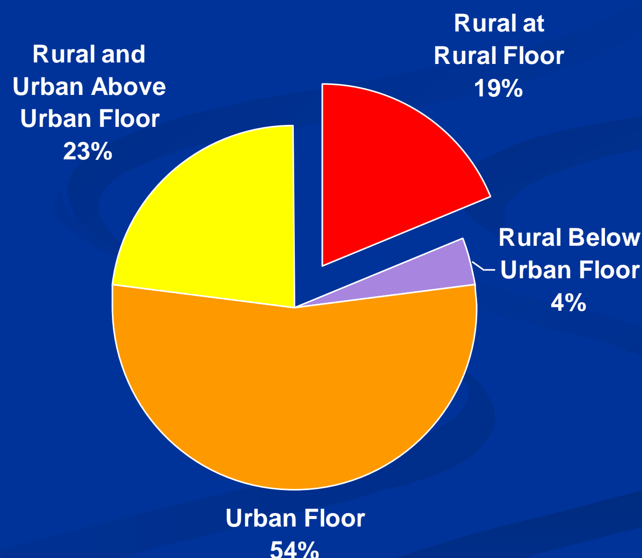
Medicare Advantage PFFS Enrollment, by Payment Rate Category, September 2007

- 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





SOURCE: RUPRI Center for Rural Health Policy Analysis, http://www.unmc.edu/ruprihealth/

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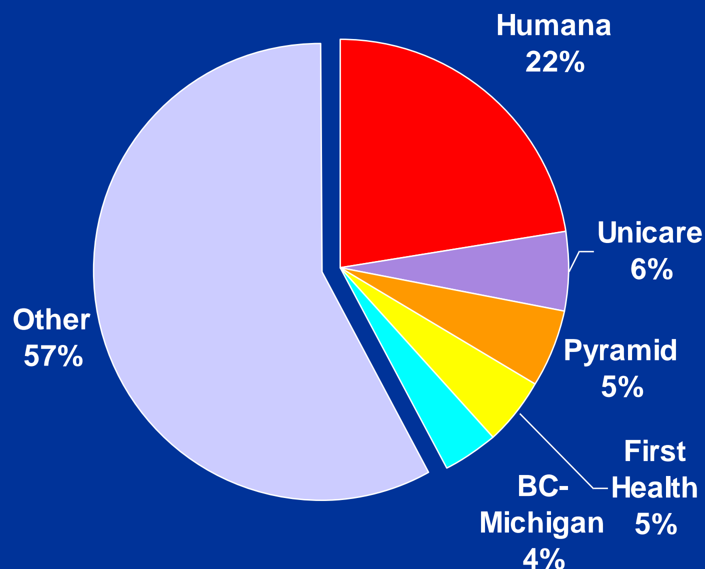
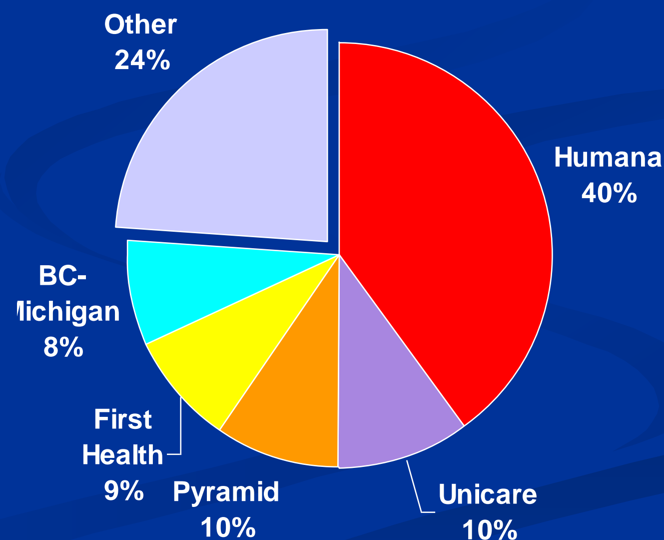
Concentration of Medicare Advantage and PFFS Enrollment by Plan Organization

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**





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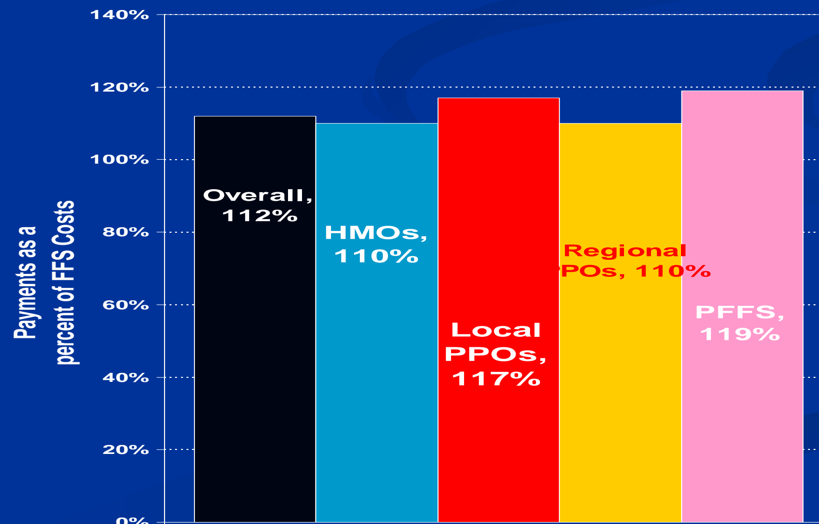
SOURCE: RUPRI Center for Rural Health Policy Analysis, http://www.unmc.edu/ruprihealth/

So are we achieving the goals Congress set for Private Medicare?

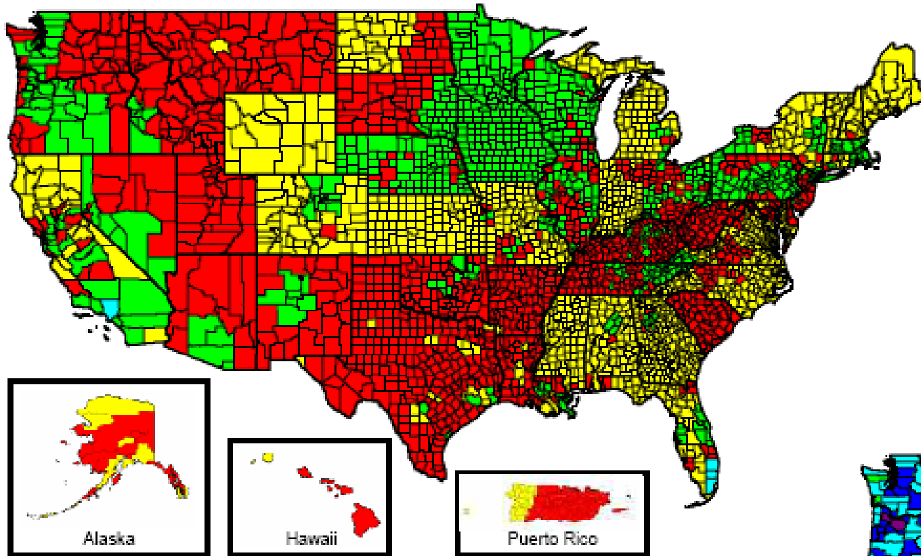
So where are we on Congress' goals for private Medicare?

- Have we met the goal to *contain costs?*
  - Answer: No!
    - Payments to MA plans are 112% of FFS costs



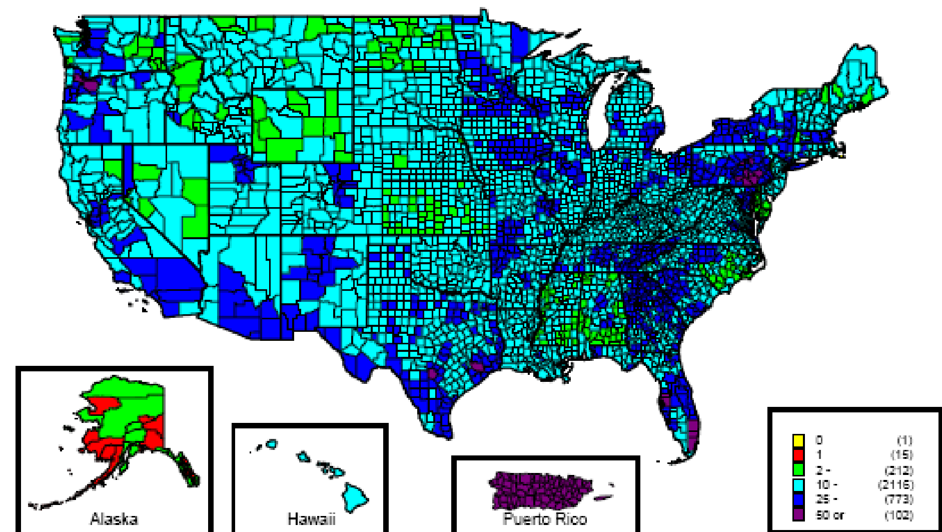
REPORT TO THE CONGRESS
Medicare Payment Policy
MEDPAC

Have we met the goal of increased choice?

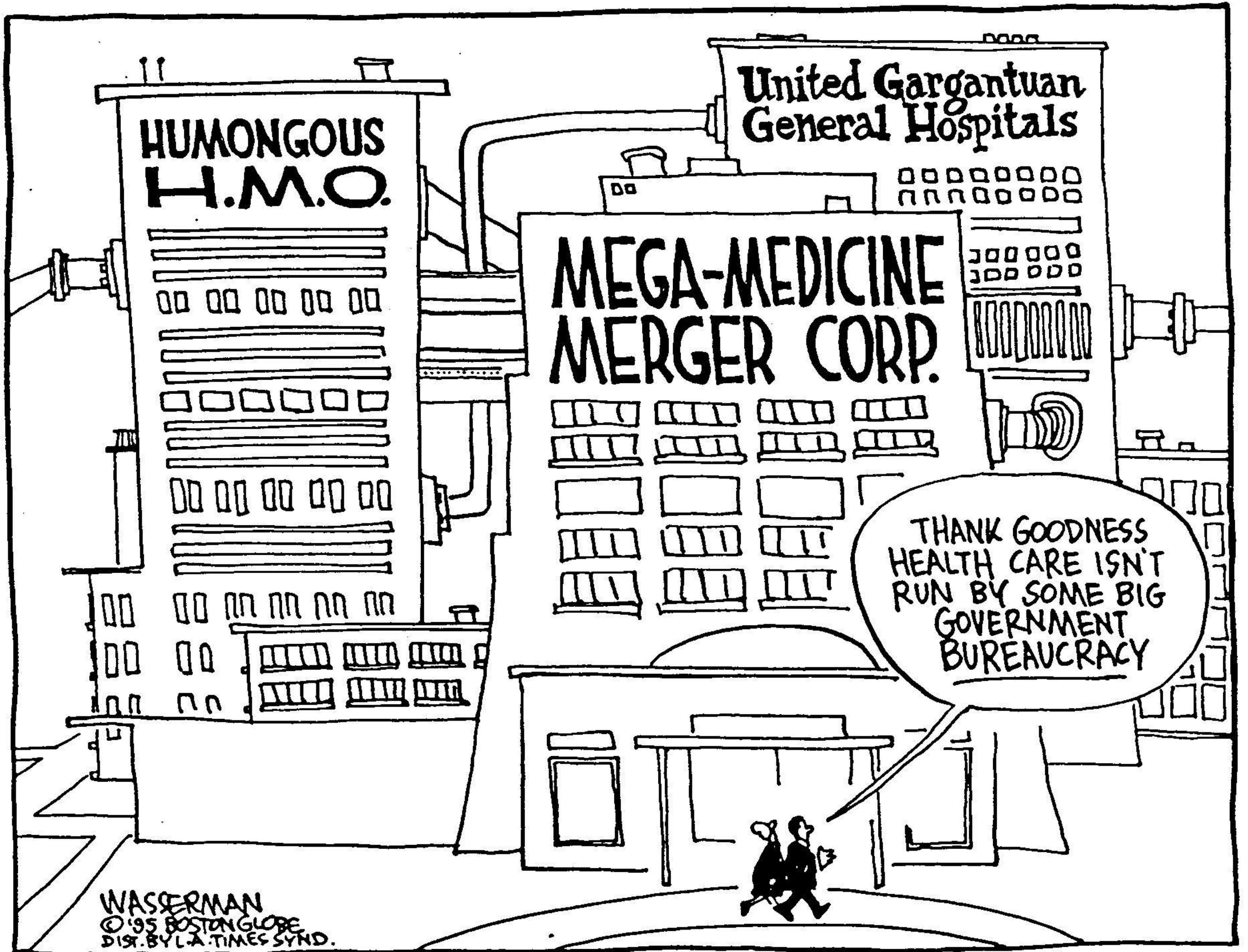


On the face of it, yes, because … in 2003, most counties had 0-1 plans, now most have several plans

- 0 plans
- 1 plan
- 2 - 9 plans
- 10 - 24 plans
- 25 - 49 plans
- 50 or more plans



But… it is more complicated than this!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