RUPRI Center for Rural Health Policy Analysis
*Rural Policy Brief*

Brief No. 2010-3 March 2010 www.unmc.edu/ruprihealth

# February 2010: A Dramatic Shift Away from Private Fee-for-Service Plans in Rural Medicare Advantage Enrollment

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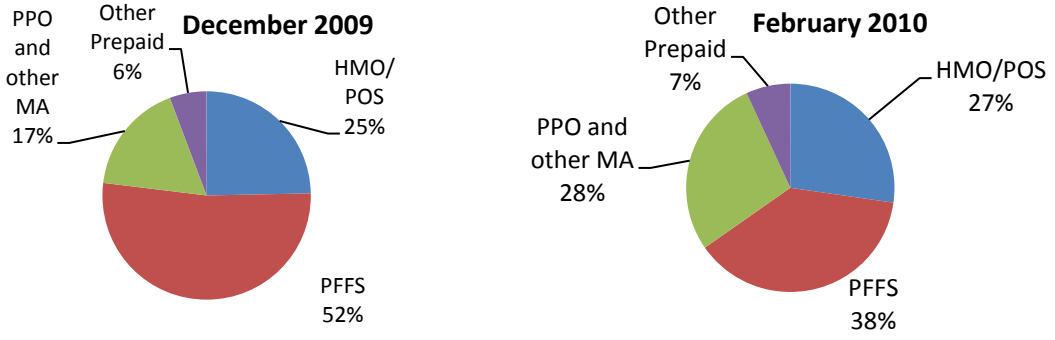
In a reversal of recent trends, private fee-for-service (PFFS) enrollment fell dramatically in rural areas in early 2010. As a result, Medicare Advantage (MA) enrollment in rural areas (excluding other prepaid plans) fell slightly in early 2010 for the first time in years. The dramatic drop in PFFS enrollment was offset by increases in enrollment in preferred provider organization (PPO) and health maintenance organization (HMO) plans. Although PFFS enrollment has driven the rapid growth of the MA program in recent years, particularly in rural areas, the MA market share held by PFFS plans in rural areas fell significantly from 52% in December 2009 to 38% in February 2010 (Figure 1). The decline was driven by some plans leaving the market and by underutilized and duplicative plans consolidating; factors contributing to this trend include slow growth in payment rates, legislative changes requiring PFFS plans to form provider networks by 2011, and significant increases in beneficiary premiums. Nationwide, enrollment in PPO and HMO plans grew, offsetting the decline in PFFS enrollment and contributing to a slight growth in total MA enrollment in 2010.

## Key Findings

*The market share held by PFFS plans in rural areas fell from 52% in December 2009 to 38% in February 2010.*

- Rural enrollment in MA plans fell by nearly 13,000 (1%) from December 2009 to February 2010 as Medicare beneficiaries chose their coverage options for 2010. National enrollment in MA plans grew only slightly, by 66,000 (<1%), during this time.
- Enrollment in PFFS plans fell dramatically, by 196,000 (27%), in rural areas and by over 750,000 (32%) nationally.
- Offsetting the trends in PFFS plans, enrollment in PPOs, HMOs, and other prepaid plans continued to grow in both urban and rural areas. Enrollment in PPO plans grew by over 600,000 (42%) nationally and by 147,000 (61%) in rural areas from December 2009 to February 2010.
- The growth in regional and local PPOs in rural areas was split evenly between growth in regional PPOs (77,000 new enrollees) and local PPOs (73,000).
- Total enrollment in MA plans fell in 12 states and the District of Columbia. Michigan experienced the most dramatic decline in enrollment, with over 167,000 (40%) Michigan Medicare beneficiaries leaving MA plans since December 2009, nearly 50,000 of these in rural areas (a loss of 57% of enrollment in rural areas).
- In contrast, rural MA enrollment grew by over 20,000 enrollees in both Ohio and Georgia (an increase in enrollment of 24% and 38% respectively), while rural MA enrollment fell in 16 states.

**Figure 1. Change in Market Share in Medicare Advantage in Rural Areas, December 2009 to February 2010**




Funded by the Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (Grant #1U1G RH07633)
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## Enrollment

In the past year, enrollment in MA plans grew by over 600,000 enrollees nationally and by over 90,000 enrollees in rural areas (Table 1). However, enrollment in PFFS plans dropped significantly in early 2010, as beneficiaries opted or were forced to leave their PFFS plans when the plans withdrew from the market. Some of these beneficiaries may have enrolled in a PPO or an HMO or returned to traditional fee-for-service Medicare. Employer-sponsored PFFS plans experienced an almost 50% loss in enrollment of approximately 350,000 beneficiaries.[1] The largest decreases in enrollment in PFFS plans were in Michigan with 220,000 enrollees (75% of enrollment) and Ohio with 130,000 enrollees (73% of enrollment).

- In Michigan, most of the drop in PFFS enrollment came from the loss of beneficiaries enrolled in a contract held by the Blue Cross Blue Shield of Michigan plans. Two of the plans were terminated, Medicare Plus Blue Options C and D, accounting for approximately 40,000 beneficiaries. An additional 170,000 beneficiaries who were enrolled in Medicare Plus Blue Employer CY and Medicare Plus Blue Employer Rx CY in December 2009 lost coverage when these plans were eliminated. Over 52,000 rural beneficiaries and over 145,000 urban beneficiaries lost coverage under this contract. In Michigan, there has not been an increase in enrollment in alternative types of MA plans to reflect the drop in enrollment in PFFS plans; therefore, it appears that these beneficiaries have returned to traditional FFS Medicare, possibly coupled with a MediGap plan.

- In Ohio, most of the drop in PFFS enrollment came from the loss of 120,000 beneficiaries from a contract held by the Aetna sponsored employer plan, Aetna Medicare Open Plan. Over 24,000 rural beneficiaries and over 71,000 urban beneficiaries chose not to re-enroll under this contract. Ohio has had a dramatic increase in PPO enrollment of over 200,000 beneficiaries, suggesting that many Medicare beneficiaries leaving PFFS plans may have chosen a PPO plan as an alternative.

Most of the remaining reductions in PFFS enrollment can be attributed to contracts terminated by Coventry, Wellcare, and HealthNet. These reductions were spread across the states, with some states experiencing higher reductions in enrollment—Pennsylvania and West Virginia lost over 45,000 and 35,000 beneficiaries, respectively. In some states it appears that beneficiaries leaving PFFS plans have moved to PPO or HMO plans, but in other states there has been no corresponding increase in enrollment in alternative MA plans. Regional and local PPOs added 77,000 and 73,000 enrollees, respectively; regional PPOs added over 68,000 beneficiaries to existing plans and nearly 10,000 to new plans, and local PPOs added over 61,000 beneficiaries to new plans and 12,000 to existing plans.

## Contributing Factors to the Drop in Enrollment in PFFS Plans

Several factors have contributed to the decline in PFFS enrollment. The number of MA plans offering coverage in 2010 declined by 18% from 2009. The number of PFFS plans available decreased by over 40% from 2009 to 2010, from 696 plans to 413. Individuals in rural areas had an average of 35 plans to choose from in 2009 but in 2010 have an average of only 24.[2] Factors affecting these reductions in plan options and enrollment include the following:

- Changes established by legislation—the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires PFFS plans to form provider networks by 2011 in most locations;[3]
- Consolidation and elimination of plans by CMS to reduce the number of “low enrollment and duplicative” plans available to beneficiaries;[1]
- Slow growth in payment rates (CMS increased reimbursements to MA plans by 0.8% in 2010 compared to 3.6% in 2009), leading plans to limit enrollment, raise premiums, or reduce benefits;[4] and
- Increased beneficiary premiums for MA plans (PFFS plan premiums increased by 78% from 2009 to 2010).[2]

The combined effect of these factors, among others, drove the drop in PFFS enrollment in 2010. Although it is not possible to determine precisely where individuals obtain coverage, it is possible to speculate that many former PFFS enrollees have enrolled in an alternative MA plan. However, the future impact of these changes in enrollment on beneficiaries should be followed.

## Policy Implications and the Future

The future of MA in rural areas and across the nation is uncertain. The recent decline in PFFS enrollment could be the start of a trend of reduced enrollment. The factors contributing to the drop in PFFS enrollment in rural areas could continue to have an impact in coming years, as the effects of MIPPA play out. In 2011, the number of PFFS plans available may fall even further as the MIPPA legislation goes into effect and plans are required to establish regional provider networks. It is unclear whether the insurance providers will set up new plans with regional networks or discontinue their plans, but the MIPPA legislation will lead to the end of the traditional PFFS contracts. Rural beneficiaries can expect to see more changes to their benefit choices as PFFS plans make changes to their benefit plans or terminate their coverage options.

In addition, the future of MA remains uncertain pending the outcome of health care reform. In 2009, MA plans were paid at rates 13% higher (on average) than traditional fee-for-service costs.[5] Congress has proposed significant changes to the payment rates to MA plans, perhaps implementing either a competitive bidding structure or reducing MA payment rates to the fee-for-service rates paid in the region in which an MA plan operates. This action could have a dramatic impact on the number of MA plans available and on enrollment, as insurance companies may choose to reduce or eliminate their MA offerings or significantly increase the costs passed on to beneficiaries.

**Table 1. 2009-2010 Change in Enrollment in Medicare Advantage Plans**

| | *February 2009* | | | *December 2009* | | | *February 2010* | | |
|---|---|---|---|---|---|---|---|---|---|
| | Rural | Urban | Total | Rural | Urban | Total | Rural | Urban | Total |
| Enrollment in Medicare Advantage Plans: | | | | | | | | | |
| HMO/POS | 320,021 | 6,386,083 | 6,706,104 | 342,726 | 6,619,172 | 6,961,898 | 379,829 | 6,806,878 | 7,186,707 |
| PFFS | 702,634 | 1,597,939 | 2,300,573 | 725,444 | 1,644,065 | 2,369,509 | 528,468 | 1,081,195 | 1,609,663 |
| PPOs and Other MA Plans | 200,361 | 1,043,751 | 1,244,112 | 240,610 | 1,201,480 | 1,442,090 | 387,653 | 1,656,424 | 2,044,077 |
| **Total MA Enrollment** | **1,223,016** | **9,027,773** | **10,250,789** | **1,308,780** | **9,464,717** | **10,773,497** | **1,295,950** | **9,544,497** | **10,840,447** |
| Prepaid Plans | 77,880 | 281,594 | 359,474 | 79,831 | 285,286 | 365,117 | 95,718 | 295,453 | 391,171 |
| **Total MA and Prepaid Enrollment** | **1,300,896** | **9,309,414** | **10,610,310** | **1,388,611** | **9,750,068** | **11,138,679** | **1,391,668** | **9,839,950** | **11,231,618** |
| Total Medicare Eligibles | 9,482,695 | 34,955,444 | 44,438,139 | 9,633,597 | 35,613,514 | 45,247,111 | 9,685,593 | 35,833,950 | 45,519,543 |
| Percent of Medicare Eligibles Enrolled: | | | | | | | | | |
| PFFS | 7.2% | 4.6% | 5.0% | 7.5% | 4.6% | 5.2% | 5.5% | 3.0% | 3.5% |
| HMO/POS | 3.4% | 18.3% | 15.1% | 3.6% | 18.6% | 15.4% | 3.9% | 19.0% | 15.8% |
| PPOs and other MA plans | 2.1% | 3.0% | 2.8% | 2.5% | 3.4% | 3.2% | 4.0% | 4.6% | 4.5% |
| **MA Plans** | **11.9%** | **25.8%** | **21.9%** | **13.6%** | **26.6%** | **23.8%** | **13.4%** | **26.6%** | **23.8%** |
| Prepaid Plans | 0.8% | 0.8% | 0.8% | 0.8% | 0.8% | 0.8% | 1.0% | 0.8% | 0.9% |
| **MA and Prepaid** | **12.7%** | **26.6%** | **22.7%** | **14.4%** | **27.4%** | **24.6%** | **14.4%** | **27.5%** | **24.7%** |

## References and Notes


1. See Centers for Medicare and Medicaid Services press release, "Robust Medicare Health and Drug Plans Coverage Continues in 2010; Beneficiary Protections Strengthened," October 1, 2009.
2. Gold, M, D Phelps, T Neuman, G Jacobson. "Medicare Advantage 2010 Data Spotlight." Kaiser Family Foundation, November 2009.
3. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), P.L.110-275.
4. See Centers for Medicare and Medicaid Services press release, "Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, "April 6, 2009.
5. Biles, B, J. Pozen, S. Guterman. "The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to 11.4 Billion in 2009. " The Commonwealth Fund. May 2009.


Additional data tables and maps available at *www.unmc.edu/ruprihealth*