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Rural Policy Brief

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June 2012: Rural MA Enrollment and Premium Update

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Key Data Findings[1]

- Rural Medicare Advantage (MA) enrollment grew to over 1.7 million in June 2012 (17% of eligible beneficiaries), while total MA enrollment grew to nearly 13.4 million (27% of eligible beneficiaries).
- Rural preferred provider organization (PPO) and health maintenance organization (HMO) enrollment grew to over 840 thousand (48% of the market) and 532 thousand (31% of the market), respectively, while private fee-for-service (PFFS) enrollment fell to 230 thousand in rural areas (13% of the market).
- Rural MA enrollment varies across the country with concentrations of enrollment on the West Coast, the Great Lakes, and the Northeast regions of the United States.
- The average monthly weighted premium for rural MA plans with prescription drugs fell in 2012 to $48 from $52 in 2011, but it remains significantly higher than the urban average which also fell during the same time from $38 to $34.
- Zero premium plans are available to 73% of rural MA beneficiaries and to 95% of urban beneficiaries;[2] however, only 48% of rural beneficiaries that have this option choose these plans compared to 63% of urban beneficiaries. The resulting average non-zero premium was $72 in rural areas in 2012, while the average non-zero premium in urban areas was $81.
- Roughly a third (35%) of rural MA beneficiaries receive their MA coverage including prescription drugs without having to pay a premium, however this is significantly lower than 60% of urban beneficiaries that do not have to pay a premium.

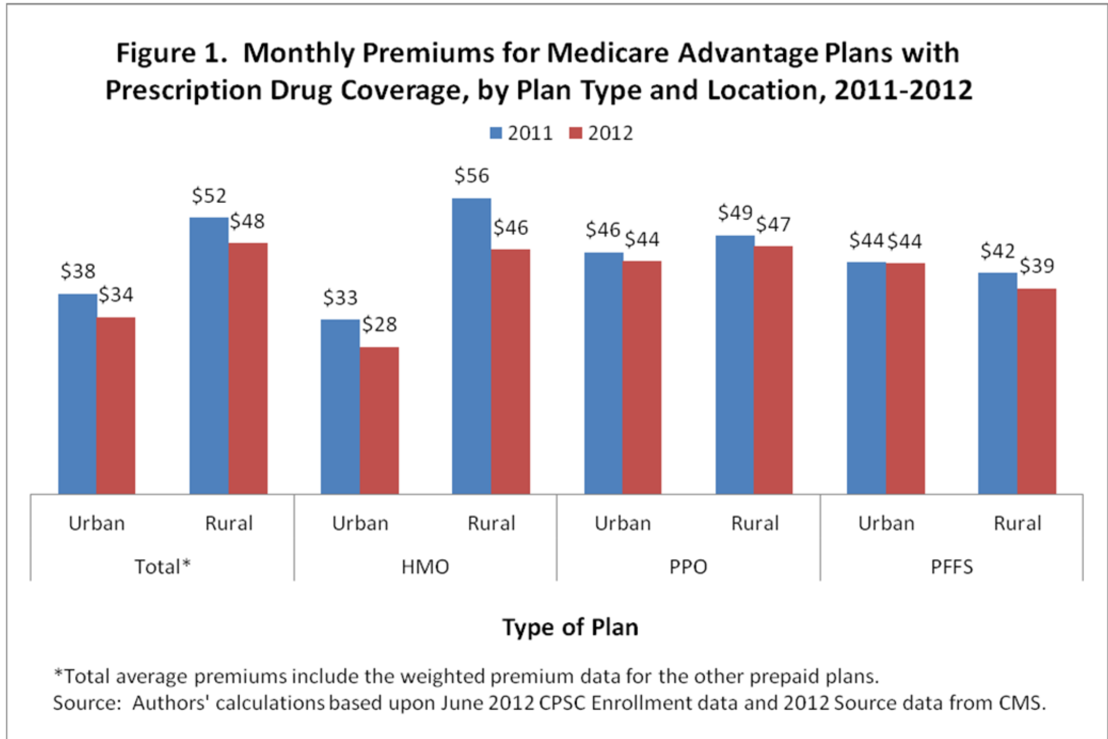
Enrollment Update

Rural[3] MA enrollment continues to grow in 2012 despite reductions in payment to the plans as mandated by the Patient Protection and Affordable Care Act of 2010 (ACA). Rural enrollment has grown to over 1.7 million enrollees in June 2012 from 1.5 million in June 2011, while national MA enrollment has grown to over 13.4 million Medicare beneficiaries from 12.1 million during that same time. Nationally, PPOs and HMOs are driving the growth in rural MA enrollment, while PFFS enrollment has fallen from June 2011. Rural MA enrollment varies significantly across the country: in thirteen states over 20% of rural beneficiaries are enrolled in an MA plan, while in six states fewer than 5% of rural beneficiaries are enrolled.

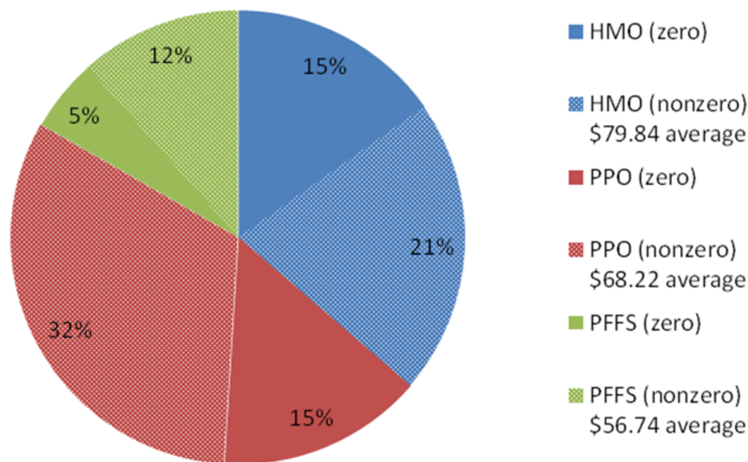
Determination of MA Premiums

MA premiums are a function of the payment mechanism in place for MA plans through the Centers for Medicare and Medicaid Services (CMS). CMS bases payment to the MA plans on the relationship between the bid submitted to CMS by the plan and the county-level benchmark. The benchmark is a “bidding target” set in place by CMS and is based on historical county-level MA payment rates. These historical payment rates were originally based on fee-for-service costs within the county, but adjustments over time in payment rates in many of these counties have caused the rates to rise above fee-for-service costs. Currently, plans submit bids for their MA plans annually and based on the relationship between the bid and the benchmark, the plans pass along the difference in the bid and benchmark to the beneficiary. If the plan’s estimated costs (or bid) are above the benchmark the plan charges the excess to the beneficiary as a premium. This premium is in addition to the Medicare Part B premium paid by the beneficiary (less any rebate in the premium by the MA plan). MA plans with costs (or bids) below the benchmark receive a rebate from Medicare of 75 percent of the difference between the plan’s bid and the benchmark. This rebate can be used by the plans to offer lower premiums to their beneficiaries or to provide additional services, such as prescription drug coverage. In many instances, the rebate that the MA plan receives allows the plan to offer MA coverage for no cost to the beneficiary, or for a zero premium. In this brief, in order to make direct comparisons, we analyze only premium data on those MA plans that do offer Part D prescription drug coverage. However, MA plans are available that do not provide prescription drug coverage but they have not been included in this analysis.

MA Premium Update
MA premiums fell in both rural and urban areas in 2012, falling from an average overall of $40 in 2011 to an average of $36 in 2012.[5] This decline in premiums happened despite the cuts in MA payment rates mandated by the ACA. As shown in Figure 1, rural MA enrollees face higher premiums than their urban counterparts, and the average premium for rural MA beneficiaries fell to $48 per month as compared to $52 per month in 2011. (Note that all of these figures are for the entire population of enrollees in MA plans, so standard errors are not shown.)

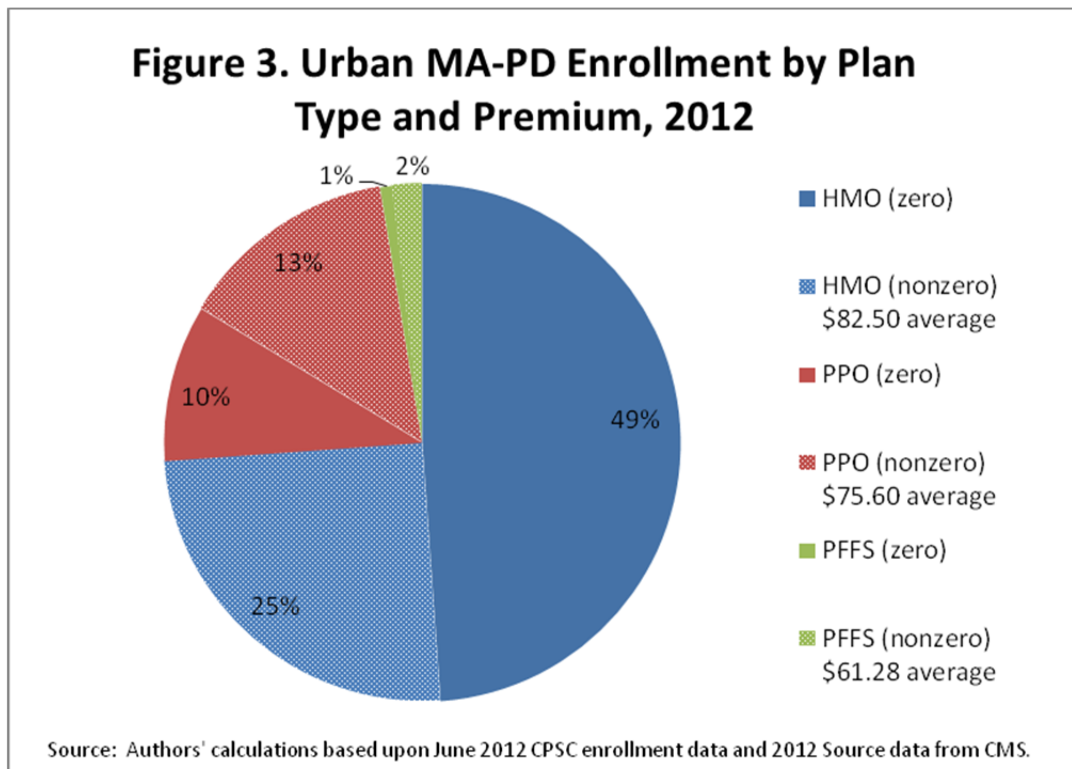


Rural HMO premiums fell by ten dollars to $46 in 2012, compared to 2011. Average rural PPO and PFFS plan premiums fell less dramatically in 2012. The premiums paid by urban beneficiaries in HMO and PPO plans also declined in 2012, while urban PFFS plan premiums were generally stable. There is however significant variation in premiums across plans in rural areas: monthly premiums range from the zero premium plans to premiums of $255/month for the MVP HealthCare Gold Anywhere Rx PPO plan.



Reporting averages of MA premiums masks one significant source of urban/rural difference: the number of people who are able to obtain coverage without paying a premium at all. Rural MA premiums are higher on average than

urban premiums when all individuals are included in the analysis. However, an analysis of the non-zero premiums paid by the MA population shows that, among urban enrollees that do pay a premium for their coverage, the premium is higher than for rural enrollees (Figures 2 & 3). These zero-premium plans are available in 53% of rural counties, representing 73% of the rural Medicare-eligible population, whereas zero premium MA plans are available in 83% of urban counties, which represents 95% of the eligible urban population. Actual enrollment data show that over 60% of urban beneficiaries enrolling in a MA plan obtain coverage through MA with a zero premium, while only 35% of rural beneficiaries select an MA plan with a zero premium. Notice that this means that 63% of urban persons who have a zero premium option choose it, whereas only 48% of rural persons with a zero premium option do so.[6] This suggests that availability is only one factor: we also need to understand why zero premium options are less attractive in rural areas. The availability measure, in practice, is capturing availability of a zero-premium HMO, since HMOs more commonly offer such an option across both county types. Rural people are in fact more likely to select a zero-premium PPO if it is available to them. It seems clear that other aspects of plan type are important considerations for rural enrollees.



It is possible that other aspects of cost sharing (e.g. copays and deductibles) may differ significantly across plans and the quality of MA plans may differ as well. Quality is communicated to enrollees through "star ratings" compiled and issued yearly by CMS. The weighted average star ratings for urban HMOs are 3.49 and 4.05 stars (out of a maximum of 5.0 stars) for zero premium and nonzero premium plans, respectively, while the analogous numbers for rural HMOs are 3.29 and 4.06 stars. Thus, a rural individual considering choosing a zero premium HMO is on average sacrificing a greater degree of quality than does an urban individual making the same decision. PPO quality differentials, on the other hand, are not statistically significantly different across urban and rural. This may be one explanation for why rural enrollees find such HMO plans less attractive but do select zero-premium PPOs at the same rate (65%) at which urban enrollees select zero-premium HMOs when available. Clearly, more research is needed to understand beneficiary enrollment decisions. For example, it would be helpful to know whether the lower quality in the case of rural zero-premium HMOs translates to any obvious shortcomings in coverage or care delivery from the view of the person enrolled. Firms whose benchmark payment from CMS exceeds their FFS costs can choose to offer a zero premium plan, or they can offer enhanced benefits and reduced cost-sharing, or they can combine these approaches. It is tautological – due to regulations – that the larger the "padding" conferred by the benchmark payment, the more of

The difference in premiums between rural MA enrollees and urban enrollees is due to both availability of zero-premium plans and the attractiveness of zero-premium plans to rural beneficiaries.

these additional features will be added. In urban environments, which are usually marked by a greater degree of competition, the option of a zero premium is very likely to be exercised. Many MA consumers shop by price, i.e. premium, without fully considering the expected value of other benefits[7] This gives the zero premium option some power as a marketing tool. In urban environments, there is a strong correlation between levels of competition, as measured by the Herfindahl index, and the percentage of people with a zero premium[8]. This relationship is more difficult to establish in rural areas, however, as the smaller amount of data makes it more difficult to detect a trend. In addition, historical circumstance likely plays a role. As Figures 2 and 3 show, HMOs are in general the most likely to be in a position to offer zero premiums, doubtless due to lower overall costs, and HMOs have historically been more heavily concentrated in urban areas and have not penetrated to rural areas.

Discussion

MA enrollment continues to grow and premiums continue to decline. Analysis of the zero premiums by plan in relationship to the plans charging a premium gives additional insights into the MA marketplace as faced by rural enrollees. Zero premium plans are less available in rural areas and are selected less often when they are available, a potential source of inequity between rural and urban areas. One complicating factor is that bonus payments to the plans, which have been implemented as a CMS demonstration beginning in 2012 and which reward plans for meeting certain quality thresholds, have helped to reduce the effects of the payment reductions and have allowed the plans to continue to offer attractive coverage options with limited premium costs to the beneficiaries. Although reductions in government premium payments have not had a dramatic effect on the MA market or actions of the beneficiaries in 2012, the ACA has mandated additional reductions in payment to the MA plans in the coming years. Whether the quality bonus payments that are concurrently mandated by the ACA will counterbalance the impact of these reductions on rural enrollment and plan availability within the MA program is a question that will need to be answered, as some quality improvements might only be cost-effective for plans with large enrollment and market presence. In addition, it will be important to monitor the impact of continued implementation of the ACA and new legislative proposals that might have any additional influence on MA program payment, especially since a growing percentage of the rural Medicare population is enrolling in and benefiting from the expanded benefits available through the MA program.

Endnotes

[1]Additional Medicare Advantage enrollment data available at http://www.public-health.uiowa.edu/rupri/maupdates/nstablesmaps.html.
[2]For a numerical breakdown of all plan availability by rural and urban status, including plans without prescription drugs and Cost plans, see Gold, M. et al, "Medicare Advantage 2012 Data Spotlight: Enrollment Market Update," Kaiser Family Foundation, June 2012.
[3]Rural counties are defined using the 2003 Urban Influence Codes which are developed by the United States Department of Agriculture's Economic Research Service. Codes 1 and 2 are considered urban areas and codes 3-12 are considered rural for the purposes of this paper.
[4]Medpac, "Medicare Advantage Program Payment System," Payment Basics, October 2008, accessed at http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_MA.pdf
[5]Premiums were expected to grow by one dollar when analyses were done using 2011 enrollment numbers to predict 2012 enrollment patterns in an analysis done by Kaiser Family Foundation, "Medicare Advantage 2012 Spotlight: Plan Availability and Premiums," November 2011. However, the analysis of the data using the 2012 plan enrollments has found that the premium fell by four dollars in 2012.
[6]This is because 60%/95% equals 63%, while 35%/73% equals 48%.
[7]Abaluck, Jason, and Jonathan Gruber. 2011. "Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program." *American Economic Review*, 101(4): 1180–1210.
[8]The Herfindahl Index, common in industrial organization literature in Economics, is a measure of the concentration of market power in an industry. In this analysis, it was constructed as the sum of the squares of the shares of enrollees covered by each firm in each county.

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