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Impact of Increased Financial Incentives to Medicare Advantage Plans

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CONTENTS

EXECUTIVE SUMMARY	1
CHAPTER 1 INTRODUCTION AND BACKGROUND	7
1.1 Mandate for a Report to Congress	7
1.2 Organization of this Report.....	7
1.3 Medicare Risk Plan Payment History	8
1.3.1 Prior to the Balanced Budget Act of 1997	8
1.3.2 Balanced Budget Act (BBA) of 1997	8
1.3.3 Balanced Budget Reform Act (BBRA) of 1999	10
1.3.4 Benefits Improvement and Protection Act (BIPA) of 2000.....	10
1.3.5 Medicare Modernization Act (MMA) of 2003	11
1.3.6 Medicare Risk Program Legislative Change Summary.....	12
1.4 Impact of Legislative Changes on County Payment Rates	12
1.5 Plan-Reported Uses of BIPA and MMA Payment Increases.....	17
CHAPTER 2 METHODOLOGY	21
2.1 Overview.....	21
2.2 Qualitative Analyses—Telephone Discussions with Medicare Advantage Plans.....	21
2.3 Quantitative Analyses—Secondary Data.....	22
2.3.1 Framework for Quantitative Analyses.....	22
2.3.2 Data Sources	25
CHAPTER 3 PLAN AVAILABILITY	27
3.1 Introduction.....	27
3.2 Medicare Advantage Organization Perspectives	27
3.3 Secondary Data Analysis	29
3.3.1 Descriptive Analysis	29
3.3.2 Multivariate Analysis.....	41
CHAPTER 4 PREMIUMS, BENEFITS, COST SHARING, AND OUT-OF-POCKET COSTS	43
4.1 Introduction.....	43
4.2 Medicare Advantage Organization Perspectives	43
4.3 Secondary Data Analysis	45
4.3.1 Descriptive Analysis	45
4.3.2 Multivariate Analysis.....	63
CHAPTER 5 ENROLLMENT	65
5.1 Introduction.....	65
5.2 Medicare Advantage Organization Perspectives	65
5.3 Secondary Data Analysis	66

5.3.1	Descriptive Analysis	66
5.3.2	Multivariate Analysis.....	74
CHAPTER 6 SUMMARY AND CONCLUSIONS		77
6.1	Plan Availability	77
6.2	Plan Premiums, Benefits, and Cost Sharing	79
6.3	Enrollment.....	83
6.4	Conclusions on Impact of Additional Financing	85
GLOSSARY		87
REFERENCES		88

List of Tables

Table 1-1	Floor rates for aged beneficiaries 1998–2005.....	11
Table 1-2	Medicare risk program legislative change summary	13
Table 1-3	Number of counties by change in Medicare Advantage monthly county payment rate, 2000–2005.....	14
Table 1-4	Average actual and simulated BIPA and BBA Medicare Advantage monthly county payment rates by county urbanicity, 2000–2005, in dollars	16
Table 1-5	Average actual and simulated BIPA and BBA Medicare Advantage monthly county payment rates by census regions, 2000–2005, in dollars.....	18
Table 1-6	Reported uses of increased BIPA payments by Medicare Advantage plans, 2001 .	19
Table 1-7	Reported uses of increased MMA payments by Medicare advantage plans, 2004 .	20
Table 3-1	Number of Medicare contracts, by contract type.....	29
Table 3-2	Percent of counties with at least one Medicare contract, by contract type	31
Table 3-3	Number and percent of Medicare beneficiaries with access to a Medicare plan, by contract type.....	33
Table 3-4	Percent of counties with at least one contract, by contract type and urban designation	35
Table 3-5	Number of contracts by census region, and contract type	37
Table 3-6	Percent of counties with at least one contract, by census region, and contract type	38
Table 3-7	Change in the number of HMO ¹ contracts, by change in aged payment rate.....	39
Table 3-8	Change in the number of PPO ¹ contracts, by change in aged payment rate.....	40
Table 3-9	Change in the number of PFFS contracts, by change in aged payment rate.....	40
Table 3-10	Simulated impact of MMA payment rates on increased county access to MA HMOs Counties with no MA HMO plan in 2004 gaining at least one MA HMO plan in June 2005	42
Table 4-1	Monthly premiums in basic HMO plans, 2000–2005.....	46
Table 4-2	Mean monthly premiums in basic HMO plans by urbanicity, 2000 – 2005.....	48
Table 4-3	Mean monthly premiums in basic HMO plans by census region, 2000–2005	49
Table 4-4	Change in premiums of basic HMO plans by change in county payment rate, November 2000 to June 2001 (Pre/Post BIPA)	51
Table 4-5	Change in premiums of basic HMO plans by change in county payment rate, February to April 2004 (Pre/Post MMA)	52
Table 4-6	Prescription drug benefits in basic HMO plans, 2000–2005	53

Table 4-7	Additional benefits in basic HMO plans, 2000–2005.....	54
Table 4-8	Cost sharing for selected services in basic HMO plans, 2000–2005.....	55
Table 4-9	Change in estimated monthly out-of-pocket (OOP) costs of enrollees in basic HMO plans, February to April 2004 (Pre/Post MMA).....	57
Table 4-10	Change in estimated monthly out-of-pocket (OOP) costs of enrollees in basic HMO plans by enrollee health status, February to April 2004 (Pre/Post MMA).....	59
Table 4-11	Change in estimated monthly out-of-pocket (OOP) cost of enrollees in basic HMO plans by urbanicity, February to April 2004 (Pre/Post MMA).....	60
Table 4-12	Change in estimated monthly out-of-pocket (OOP) cost of enrollees in basic HMO plans by census region, February to April 2004 (Pre/Post MMA).....	61
Table 4-13	Change in estimated out-of-pocket (OOP) costs of enrollees in basic HMO plans by change in county payment rate, February to April 2004 (Pre/Post MMA).....	62
Table 5-1	Medicare Advantage enrollment analysis sample, 2000–2005 ¹	67
Table 5-2	Enrollment and disenrollment in Medicare Advantage, 2000–2005 ¹	68
Table 5-3	Enrollment in Medicare Advantage, by contract type, 2000–2005 ¹	69
Table 5-4	Enrollment in Medicare Advantage, by urbanicity, 2000–2005 ¹	71
Table 5-5	Enrollment in Medicare Advantage, by census region, 2000–2005 ¹	73
Table 5-6	Enrollment in Medicare Advantage, by beneficiary characteristics, 2000–2005 ¹ ...	75
Table 5-7	Estimated impact of MMA payment increase on change in Medicare Advantage HMO enrollment between 2004 and 2005.....	76

List of Figures

Figure 6-1	Percentage of beneficiaries with access to a Medicare Advantage plan, by contract type.....	78
Figure 6-2	Average monthly premiums in basic HMO plans, 2000–2005.....	80
Figure 6-3	Prescription drug benefits in basic HMO plans, 2000–2005.....	81
Figure 6-4	Estimated Medicare Advantage plan use of additional 2004 Medicare Modernization Act financing.....	83
Figure 6-5	Medicare Advantage enrollment trends.....	84
Figure 6-6	Reported Medicare Advantage plan use of additional 2004 Medicare Modernization Act financing.....	86

EXECUTIVE SUMMARY

For more than 20 years, Medicare has offered enrollment in a risk-based private health plan as an option to beneficiaries in areas where these plans were available. Private health care plans cover all the services of the traditional Medicare fee-for-service (FFS) program and often offer additional benefits to attract beneficiaries to enroll. Plans may charge their enrollees a monthly premium. A number of different options are available, including health maintenance organizations (HMOs), which typically provide coverage for services obtained from their “network” hospitals and doctors, and preferred provider organizations (PPOs), which include coverage for services provided “out of network,” generally for a higher copayment. The Medicare private health plan program is known as the “Medicare Advantage” (MA) program. Medicare pays MA plans a fixed, prospective amount per enrollee per month, independent of the actual medical services used by the enrollee. MA plans historically have participated unevenly around the country, with greater availability in large urban areas and limited presence in rural areas.

Legislated Changes to Medicare Advantage Payment

The last decade has been a period of significant policy change for the Medicare private health plan program, with many policy changes focused on how plans are paid. The first major legislative change was enacted as the Balanced Budget Act of 1997 (BBA), which established the Medicare+Choice (M+C) program and fundamentally changed payments to Medicare plans. Prior to BBA, per-enrollee payments were closely tied to estimated per capita costs in the traditional fee-for-service (FFS) program (with payments at 95 percent of projected FFS costs). BBA established a minimum “floor” for payment rates, introduced a blended national/local rate, and limited rate updates in higher-payment counties in an attempt to narrow payment differences across geographic areas. Following BBA, and prompted in part by the limited rate updates, large numbers of M+C plans withdrew from the Medicare program, constricted service areas, raised premiums, or reduced benefits.

Partly in response to this contraction of M+C plans following these changes, Congress enacted several laws to refine and modify payment provisions of the BBA. The Balanced Budget Refinement Act of 1999 (BBRA) offered bonuses to plans that entered or remained in otherwise unserved counties. The Benefits Improvement Protection Act of 2000 (BIPA) raised rates in lower payment areas by establishing an urban floor payment rate and raising the minimum floor rate. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) changed the name of the M+C program to the MA program and reintroduced FFS costs (at 100 percent of the FFS level) as a minimum payment in each county, which raised rates especially in large, high-cost urban areas. By 2005 these three post-BBA legislative Acts raised Medicare plan payment rates (across all counties) to 20 percent, or \$118 per enrollee per month, more on average than they would have been under the BBA.

Mandate for a Report to Congress on the Impact of Additional Medicare Advantage Financing

Under Section 211(g) of the MMA, Congress required that the Secretary of Health and Human Services “describe the impact of additional financing provided under this Act [i.e., the

MMA] and other Acts [BBRA and BIPA] on the availability of Medicare Advantage Plans in different areas and its impact on lowering premiums and increasing benefits under such plans.” The Department of Health and Human Services’ Centers for Medicare and Medicaid Services (CMS) contracted with RTI International to undertake this analysis. To do this, RTI held discussions with MA plan representatives and analyzed secondary data maintained by CMS. RTI’s findings for the period 2000 to 2005 are presented in this report.

Key Findings: Plan Availability

Medicare plan availability decreased substantially after the implementation of the BBA, and despite interim legislation (BBRA and BIPA) aimed at addressing some of the effects of the BBA, availability of plans did not improve until after the MMA.

In 2000, the year after full implementation of the BBA payment (including risk adjustment) provisions and passage of the BBRA, a Medicare HMO was available to 68.1 percent of Medicare beneficiaries. By April 2003, the percentage with access had fallen to 57.4 percent. Plan availability did not improve markedly until after the MMA in 2005; this was the first full year that MA organizations had the opportunity to re-contract while taking advantage of the substantial MMA March 2004 and 2005 payment increases, as well as the permanent increase in the minimum MA payment update factor. In response to these MMA factors, the percentage of beneficiaries with access to MA plans (HMOs, PPOs, private fee-for-service [PFFS]) rose sharply in 2005. Access to all types of MA plans increased, especially local PPOs and PFFS plans, whose availability more than doubled from 2004 to 2005. The PPO increase included a large number of new PPO non-demonstration contracts for the first time. In addition, the number of PFFS contracts and the number of counties with access to a PFFS plan increased significantly; 92.9 percent of counties and 73.2 percent of beneficiaries had access to a PFFS plan in June 2005, making PFFS options the most accessible MA option for Medicare beneficiaries. Medicare HMOs were available to 69.6 percent of Medicare beneficiaries, and Medicare PPOs were available to 55.5 percent in June 2005. By mid-2005, availability of MA plans was greater than at the beginning of our analysis period in 2000, with nearly all Medicare beneficiaries (96 percent) having access to at least one MA plan in 2005.

To affect plan availability, payment increases must be viewed as long term by MA organizations; short term or temporary payment improvements appear to have little effect.

In discussions with MA organizations, the most important factor in their decisions about where to make plans available was the long-term adequacy of Medicare payment rates in an area. The MMA provisions establishing local FFS costs as a minimum payment rate for each county, and establishing a minimum payment update percentage of the national Medicare spending growth rate, were seen as key in ensuring that Medicare payment rates are adequate now and in the future. In contrast, short-term bonus payments provided in BBRA and BIPA had little influence on MA organization decisions about where to offer plans. Even if a bonus payment made it temporarily financially viable to offer a plan in an area, once the bonus ended, the plan would again become unprofitable if long-run payment rates were not adequate. In the short run, bonus payments may not have fully offset the high fixed costs of establishing health plans in new service areas, including the costs of provider network development, marketing, and administration.

Managed care availability (HMO and PPO) outside of large and medium urban areas improved under the MMA, but remained relatively weak in these areas. However, access to PFFS plans increased considerably in all areas, especially rural areas.

Urban counties continued to enjoy the greatest access to Medicare Advantage options. The percentage of large urban counties with at least one Medicare HMO declined from 75.8 percent to a low of 52.4 percent in 2003, and in 2005 it rose to 63.3 percent, well below 2000 levels. The limited recovery in 2005 HMO levels may have been because PPOs were substituted for HMOs in large urban counties. The percentage of large urban counties with at least one Medicare PPO increased from 1.2 percent to 57.0 percent. The percentage of medium urban counties with an HMO rose from 49.1 percent in 2000 to 58.6 percent in 2005, due to a large increase from 2004 to 2005. Likewise, the availability of PPOs increased to 46.3 percent of medium urban counties in 2005. HMO access also increased substantially in 2005 (to 32.5 percent) in small urban counties, to a greater level than in 2000 (25.9 percent). The availability of PPO plans also increased. However, the availability of HMO and PPO plans remained limited in small urban counties, well below availability in larger urban counties.

The availability of HMO and PPO plans in rural counties varied by population and proximity to urban areas, but was low throughout the period for both categories of rural counties compared to all categories of urban counties. The availability of both HMO and PPO plans improved in 2005 to a level exceeding availability in 2000. In rural areas adjacent to an urban area, 25.1 percent of the counties had an HMO plan in 2005 and 15.1 percent had a PPO plan. For rural counties not adjacent to an urban area, only 7.4 percent had an HMO plan and 7.5 percent had a PPO plan. PFFS plans, which do not require a provider network, were an exception to the geographic patterns of the network-based HMO and PPO plans and were more widely available in rural areas than in urban areas. Over 95 percent of rural counties had access to a PFFS plan.

Key Findings: Plan Premiums, Benefits, and Cost Sharing

Plan premiums and cost sharing generally increased, and benefits decreased, in response to the BBA. These conditions improved after passage of the MMA, with many plans lowering premiums and cost sharing, and improving benefits, after the March 2004 MMA payment increases.

Medicare HMO plans became considerably less affordable between 2000 and 2003.¹ Average premiums rose sharply, nearly tripling over this period from \$12.95 to \$37.87. The proportion of enrollees in zero-premium plans was cut nearly in half. This was clearly a period of retrenchment as plans responded to the payment update changes of the BBA and rising medical cost inflation by attempting to raise revenue through higher premiums. The implementation of BIPA in March 2001 resulted in reductions in plan premiums compared to those in effect in January/February 2001. However, even after incorporating the effects of BIPA, average plan premiums nearly doubled from November 2000 to June 2001 (post-BIPA). This trend began to

¹ All premium, benefits, and cost sharing statistics refer to basic HMO plans, which are the lowest-premium plans offered in a county by an HMO contract. Enrollment is all enrollees in the contract offering the basic plan.

reverse after passage of the MMA. In March 2004, plans responded to the implementation of the MMA payment increases by reducing average premiums by \$10.49 or 31.5 percent. In 2005, a further four-dollar reduction in average premiums occurred as the MMA payment changes continued to take hold, and average premiums fell to about half their peak level in 2003. In addition, the proportion of enrollees in plans offering a zero-premium package increased to 57.7 percent in 2005.

To further examine the relationship between additional financing and changes in premiums, it is helpful to compare changes in premiums across geographic areas with differing levels of payment increases. If additional financing affected plan premiums, one would expect to observe larger changes in geographic areas where greater additional financing was provided. As expected, the amount of premium reductions is related to the amount of payment increase. Overall, the MMA increased Medicare payment per member per month by \$45.03 in 2004. In counties where average payment rose by less than \$25 per member per month, the average premium fell by \$5.37 or 14 percent. In counties where average payment rose by \$100 or more, the average premium fell by \$26.18 or 74 percent.

Coverage of prescription drugs—especially brand name drugs—is often one of the most valuable and attractive additional benefits offered by Medicare plans. In 2000, 78.4 percent of enrollees had some coverage for brand drugs. By early 2004, this number had sunk to only 27.3 percent. Over the same period, the proportion of enrollees without any drug benefit had nearly doubled from 16.8 to 31.4 percent. The implementation of BIPA in 2001 did not stem this tide of reduced drug coverage. With the implementation of the MMA in March 2004, drug coverage improved. The proportion of enrollees with brand coverage increased from 27.3 to 39.4 percent, and the proportion with no drug benefit declined from 31.4 percent in early 2004 to 24.8 percent in 2005. However, in 2005, drug coverage was much less generous than in 2000. Only 39.4 percent of enrollees versus 78.4 percent in 2000 had brand coverage, and 24.8 percent had no drug benefit in 2005 versus 16.8 percent in 2000. Additional non-drug benefits show a similar pattern of a significant decline in generosity early in the decade that was not reversed by BIPA, but a partial restoration of benefits post-MMA.

Cost sharing increased substantially in the early years of the decade, then declined or stabilized post-MMA. For example, less than one percent of enrollees were in plans with a primary care physician copayment greater than \$15 in 2000. This percentage rose to 23.9 percent by early 2004, then fell to 12.6 percent post-MMA. The percentage of enrollees with a specialist physician copayment greater than \$15 rose from 9.3 percent in 2000 to 71.4 percent in early 2004, then moderated to 60.2 percent in 2005.

In 2000, only 19.5 percent of enrollees in basic HMO plans were charged any cost sharing for acute hospital admissions. This percentage rose to 88.3 percent in early 2004 and remained near that level through 2005 despite the March 2004 MMA payment increases. In 2000, only 30 percent of enrollees were charged for use of hospital outpatient services. This percentage doubled and stabilized at about 60 percent from 2003 on. The percentage of enrollees paying cost sharing for X-ray and clinical laboratory services rose sharply through early 2004, and then leveled off, but did not decline, with the MMA payment increases in March 2004.

The result of changes in plan premiums, benefits, and cost-sharing can be summarized as changes in enrollee out-of-pocket costs. In 2004, MMA raised the average Medicare payment per member per month by \$45.03. About half of this amount—\$23.27—was used by plans to lower enrollee out-of-pocket costs for medical care. This reduction represents 5.9 percent of enrollee total out-of-pocket costs for medical care. Nearly half of the 2004 out-of-pocket cost reduction was due to lower premiums (\$10.62), about one-third to improved prescription drug benefits (\$7.52), and about one-fifth (\$5.10) to lower cost sharing or improved benefits for non-drug medical care. The relationship between increased plan payments and reduced enrollee out-of-pocket costs is especially evident when changes are compared across geographic areas with differing levels of payment increases. In counties where payment rose by \$100 or more per member per month in 2004, average out-of-pocket costs fell by \$64.55 or 16.2 percent, while in counties where payment increased less than \$25, average out-of-pocket costs fell by only \$11.49 or 2.8 percent. Reductions in HMO enrollee out-of-pocket costs occurred in all urban, rural, and regional areas, but were largest on average in large cities, in the South, and in counties with the largest payment increases. Even after the BBA, BBRA, BIPA, and MMA payment changes, substantial urban-rural and regional disparities in estimated MA plan enrollee out-of-pocket costs remained, with estimated enrollee costs highest in rural areas and in the Midwest.

Key Findings: Enrollment

Medicare Advantage plan enrollment decreased steadily through 2003, began to stabilize in 2004, and rebounded somewhat in 2005 after the passage and full implementation of the MMA.

Overall MA enrollment significantly declined between 2000 and 2003, falling from 6.2 million enrollees in 2000 to 5.6 million in 2001, 5.0 million in 2002, and finally 4.7 million in 2003. Enrollment began to stabilize in 2004, and rebounded in 2005 to 5.1 million. Thus, while the MMA appeared to have had a positive effect on Medicare Advantage enrollment, the number of beneficiaries enrolled in plans remained well below (by approximately 1.1 million) 2000 levels.

Although the number of new enrollees declined slightly over 2001–2003, the primary reason for the decline in enrollment was disenrollment due to reasons other than death. The decline in enrollment in the early part of this decade was likely in large part a response to the BBA payment changes coupled with rising medical cost inflation, which caused many plans to withdraw or contract service areas, creating “involuntary” disenrollment. In addition, BBA payment constraints combined with medical cost inflation caused many plans to raise premiums, and reduce benefits for enrollees, which also contributed to the decline in enrollment.

Enrollment in urban counties continued to dominate the Medicare Advantage program throughout this time period. Enrollment in rural counties improved slightly as of 2005, though overall rural enrollment remained small.

The legislative initiatives were focused, in part, on improving availability of Medicare plan options in underserved areas. Therefore, we examined trends in Medicare enrollment by urbanicity over 2000–2005. Urban enrollment consistently comprised the vast majority of total

enrollment, ranging from a high of 97.9 percent of total enrollment in 2001 to a low of 96.5 percent in 2005.

Somewhat different patterns characterized enrollment trends in rural versus urban counties. In 2001, there was a 29.4 percent decrease in rural enrollment, which might be surprising considering the BBA-mandated floor payment rate, and the BIPA-mandated increase in the floor payment rate, each of which was intended to stabilize, and even increase, rural enrollment. The decline in rural enrollment might reflect retraction of a prior overexpansion by plans in extending their service areas to rural areas when it was not a viable business proposition.

Unlike urban enrollment, over 2001–2003, rural enrollment experienced only a one-time substantial decrease, and then remained relatively stable until the MMA payment changes took effect. In 2005, there was a noticeable enrollment increase of rural beneficiaries. As a result, over the entire period from 2000 to 2005, enrollment remained stable in rural counties, but fell by 22.7 percent in urban counties.

CHAPTER 1 INTRODUCTION AND BACKGROUND

1.1 Mandate for a Report to Congress

Section 211 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 made immediate revisions to the monthly capitation rates paid to Medicare Advantage (MA) plans, which resulted in additional payments to MA plans. The purpose of these revisions was to increase the choice of plans available to beneficiaries by greater plan participation in the Medicare program.

As part of MMA, Section 211(g) required a Report to Congress (RTC) that analyzed the impact of various legislated payment system reforms on the Medicare managed care, or “risk” program, renamed the Medicare Advantage (MA) program. Specifically, the MMA required the Secretary of Health and Human Services (HHS) to report the following to Congress:

“describe the impact of additional financing provided under this Act (i.e., the MMA) and other Acts (BBRA and BIPA) on the availability of Medicare Advantage Plans in different areas and its impact on lowering premiums and increasing benefits under such plans.”

The Centers for Medicare & Medicaid Services (CMS) was tasked with responsibility for the preparation of this report. To support CMS, RTI International was awarded a contract to develop and implement a system to monitor and evaluate the impact on the Medicare risk program of various legislative payment methodology changes subsequent to the landmark Balanced Budget Act of 1997 (BBA). This analysis focused on key indicators of health plan performance to measure the impact of the legislative initiatives effective between 2000 and 2005, including the Balanced Budget Reform Act of 1999 (BBRA), the Benefits Improvement and Protection Act of 2000 (BIPA), and the initial effects of the MMA.

Underlying the RTC mandate, Congress is interested in understanding how the multiple changes in payment methodology for the Medicare risk program affected key policy outcomes: the number and type of health care organizations willing to participate in the Medicare program, the benefits and premiums they offer, and the number of beneficiaries they enrolled. The intent of the legislative changes in Medicare payments has been to expand the range of health plans available to beneficiaries, including those living in areas with few or no options, such as rural areas. Less clear is the extent to which these legislated payment changes were successful in meeting policy goals of expanded beneficiary health plan options.

1.2 Organization of this Report

Given the changing payment methods for the MA program, it is logical for policy makers to monitor how new MMA provisions are meeting the long-standing policy goals of increased beneficiary choice of health plan options and benefits for beneficiaries living in different geographic areas. Monitoring these and other program indicators, and disseminating results through this RTC, will provide Congress with a sense of the impact of legislative changes on the MA program. We focused on three primary areas of possible MA payment change impacts:

- MA plan availability
- Plan premiums, benefits and cost sharing
- MA enrollment and disenrollment.

We therefore organized the substantive chapters of this report (Chapters 3 through 5) by these three areas of potential payment system impact, combining findings from our discussions with health care organizations and secondary data analyses. Chapter 2 of this report provides a detailed summary of the methods and data used to conduct these analyses. Chapter 6 provides a summary of our findings.

We concluded this introductory chapter with a summary of the payment methodology history for Medicare risk plans focusing on the most relevant period to this report: 2000 through 2005. We also briefly described the impact of legislation on risk plan county payment rates from 2000 to 2005, and we reviewed previous analyses of plan-reported uses of legislated payment increases. These analyses provide useful background for the remainder of the report.

1.3 Medicare Risk Plan Payment History

1.3.1 Prior to the Balanced Budget Act of 1997

Prior to BBA, capitated payments to Medicare HMOs were based on a rate book that, for each county, was based on local fee-for-service (FFS) per capita costs. The costs were, however, adjusted so that the rate book amount represents the local fee-for-service costs for the national average beneficiary. This adjusted cost was called the “Adjusted Average Per Capita Cost” or AAPCC. The national average beneficiary was defined according to demographic risk factors assigned to each beneficiary (age, sex, institutional status, and welfare status).

Many criticisms have been made of the AAPCC payment system, including that the differences in payment levels across counties were too extreme, that payment levels in many communities were either too low or too high, that year to year changes in payment levels were too unpredictable, and that the payment system led to favorable selection in Medicare HMO enrollment. Favorable selection meant that HMOs enrolled healthy beneficiaries whose medical costs were lower than predicted by the payment formula, resulting in overpayments to HMOs by the Medicare program.

1.3.2 Balanced Budget Act (BBA) of 1997

BBA established the Medicare+Choice (M+C) program to increase types of plans available to Medicare beneficiaries such as preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. BBA also attempted to decrease the variation in payment rates throughout the country, expand the availability of health plans in markets where access to Medicare plans was limited or non-existent, and implement a health status risk adjustment of plan per capita payments to control for differences in beneficiary health status and expected cost. In pursuit of these goals, the BBA established the M+C program and made a number of complex changes to the Medicare capitated payment methodology. The BBA

eliminated the direct link between Medicare plan payment rates and FFS expenditures and began the process of risk adjusting the plan payment rates to account for beneficiary health status.

Beginning in 1998, the payment rates (in most cases, based on the county²) were updated annually from the 1997 Average Adjusted Per Capita Cost (AAPCC), where as they had previously been recalculated annually based on actual FFS expenditures. Once the area rate was calculated, it was used to calculate a blended local/national rate. Plans were then paid the maximum of the blended rate³, a minimum floor rate, or a 2 percent increase over the prior year's rate. We describe each of these three rates and the risk adjustment methodology in more detail below.

Blended Rate: The blended rate was a weighted mix of the area rate and the national rate. Its purpose was to reduce the range in plan payment rates between the counties with the highest and the lowest payment rates. The blended rate was phased in between 1998 and 2003, where the area rate was the 1997 AAPCC rate updated by the national growth percentage. However, while the 1997 AAPCC included payments for Graduate Medical Education (GME), beginning in 1998, these payments were phased out. Under the BBA changes, both direct and indirect medical education payments were carved out of the AAPCC and a separate payment stream was established to pay teaching hospitals for indirect medical education for M+C enrollees. The blend was also subject to a budget neutrality constraint, such that total M+C payments could not exceed the amount that would have been spent if payments were entirely based on county rates. Consequently, the only year the blended rate was actually implemented was 2000; the rate resulted in payments higher than the other two payment possibilities under the BBA “greater of methodology.”

Floor Rate: The BBA implemented a minimum or “floor” payment rate for M+C plans. The intent of the floor was to increase rates in historically lower-rate counties and thereby encourage plans to enter these counties. The floor rate in 1998 was \$367 in the 50 states and the District of Columbia⁴, more than a 50 percent increase over the lowest payment rate of \$221 in 1997. In 1998, more than one-third of U.S. counties and independent cities received the floor rate.⁵ The BBA required that the floor rate increase annually by the national growth percentage, calculated as the expected per capita increase in total Medicare (both FFS and M+C) expenditures minus a specific reduction set in law. While many counties did receive the floor rate, as it turned out, most of them did not have any M+C plans.

Minimum Increase: Each county received at least the minimum percentage increase over the previous year's rate. The BBA set the minimum increase at 2 percent; from 1998 to March

² End Stage Renal Disease (ESRD) rates were set at the state level.

³ The blended rate is subject to budget neutrality.

⁴ The maximum floor rate in the territories was 150 percent of the 1997 payment rate.

⁵ This amounted to 1100, of 3146, counties and independent cities, excluding Guam, Puerto Rico, and the Virgin Islands.

2001 the minimum increase remained at 2 percent. During this time, the majority of counties with M+C plans received only the 2 percent increase in payment rates.

Health Status Risk Adjustment: The BBA also mandated that beginning in 2000, plan per capita payment rates must be risk adjusted to account for differences in beneficiary health status. Prior to 2000, plan payment rates were only adjusted for specific demographic factors: beneficiary age, sex, working status, Medicaid coverage, disabled status, and institutional (mostly nursing home) status. Beginning in 2000, 10 percent of the plan payment rate was risk adjusted using the Principal Inpatient Diagnostic Cost Group (PIP-DCG), with the remaining 90 percent demographically adjusted as under the old system.

1.3.3 Balanced Budget Reform Act (BBRA) of 1999

The BBRA of 1999 attempted to address the plan withdrawals that occurred after the payment changes enacted in the BBA. To induce M+C plans to enter areas without plans, BBRA established bonus payments and made it easier for a plan to reenter a market by reducing the minimum period from five years to two years for plans that terminate their contracts and exit the market to re-enter.⁶ The bonus increased plan payments by an additional 5 percent for the first 12 months the plan was offered and an additional 3 percent in the second 12 months. Plans could qualify for the bonus if they entered a market where an M+C plan had not been offered since 1997, or for which all plans had announced they would exit by October 13, 1999 and no longer provide services as of January 1, 2000. However, these payments were offered only to the first plan approved in any given area unless more than one plan was approved on the same date during the two-year period beginning January 1, 2000.

BBRA also affected future payments to M+C plans by slowing the PIP-DCG risk adjustment phase-in. As a result, the PIP-DCG risk adjustment remained at 10 percent from 2001 thru 2003⁷.

1.3.4 Benefits Improvement and Protection Act (BIPA) of 2000

BIPA modified the local area rate in several ways. It temporarily raised the minimum increase from 2 percent to 3 percent for March 2001 through December 2001. Concurrently, BIPA reset the floor rate beginning in March 2001 and created a second higher urban floor for counties within Metropolitan Statistical Areas (MSAs) with at least 250,000 people. BIPA's higher urban floor payment had a major impact on the program. By 2002, about one-third of M+C enrollees were in Metropolitan Statistical Area (MSA) urban floor counties. *Table 1-1* summarizes the floor rates for aged⁸ beneficiaries between 1998 and 2005.

⁶ Even prior to BBRA, the waiting period for plan reentry was applied at the discretion of the Secretary of HHS and was not necessarily enforced.

⁷ CMS-HCC risk adjustment, which takes into account both inpatient and ambulatory conditions, superseded the PIP-DCG model in 2004. In 2004, 30 percent of plan per capita rates were risk adjusted using the CMS-HCC model.

⁸ CMS uses different rates for disabled and ESRD beneficiaries.

Table 1-1
Floor rates for aged beneficiaries 1998–2005

Year	Floor	Urban Floor*
1998	\$367	-
1999	\$380	-
2000	\$402	-
2001 (January-February)	\$415	-
2001 (March-December)	\$475	\$525
2002	\$500	\$553
2003	\$495	\$548
2004 (January-February)	\$535	\$592
2004 (March-December)	\$555	\$613
2005 ⁹	\$592	\$654

* Counties located in metropolitan areas with more than 250,000 people.

BIPA also implemented a new method of risk adjustment, the CMS version of the Hierarchical Condition Category model (CMS-HCC), which includes diagnoses from both hospital and ambulatory conditions. In addition, BIPA required that the CMS-HCC risk adjustment method be phased-in to adjust 30 percent of the plan per capita payment rate in 2004, 50 percent in 2005, 75 percent in 2006, and 100 percent in 2007.

BIPA also expanded the application of bonus payments for M+C plans to include areas for which notification had been provided by October 2000 that no plans would be available on January 2001.¹⁰ Another change with BIPA was that it permitted M+C plans to use their “savings” under the Adjusted Community Rate (ACR) to reduce Part B premiums; previously, plans could only offer additional benefits or put the savings into a stabilization fund.

1.3.5 Medicare Modernization Act (MMA) of 2003

Under the MMA, the M+C program was renamed Medicare Advantage (MA). The revised MA plan payment provisions under section 211 of MMA took effect in March 2004. This report analyzes the impact of the MMA payment provisions effective in 2004 and 2005.

The MMA enacted the following changes to MA plan payment, effective March 2004:

- A minimum county payment rate of 100 percent of local Medicare FFS per capita costs excluding direct GME was added.

⁹ Technically, not floor rates but increase of preceding year's rate by the MMA-specified update factor (discussed in the next section). Could be superseded by other rate minimums specified in the MMA, such as 100 percent of FFS costs.

¹⁰ It took until 2003, however, for any plans to qualify for the bonus, when six M+C plans and the Sterling Private Fee for Service (PFFS) qualified.

- The minimum annual MA payment update was changed to the greater of 2 percent or the national per capita MA growth percentage.
- The floor payment rate for aged beneficiaries was updated to \$613 for urban counties and \$555 for all other counties.
- The blended national/local rate was not subject to budget neutrality in 2004 only.

While the initial statutory minimum MA payment increase for 2004 was set at 2 percent over 2003 county rates, to compensate MA plans for additional benefits resulting from MMA adjustments to Medicare coverage, the minimum increase was raised by 0.2 percent to 2.2 percent. Thus, counties receiving the minimum update received a 2.2 percent update over their 2003 rates for January–February 2004. But the 2004 national Medicare growth percentage for aged beneficiaries was 6.3 percent, so all counties received at least a 6.3 percent update over their 2003 rates for March through December 2004 as a result of the MMA’s modification of the minimum payment update for MA plans. As will be discussed below, some counties received a much higher update as of March 2004 based on the MMA’s new 100 percent of FFS minimum rate. For 2005, the national Medicare growth percentage for aged beneficiaries was 6.6 percent, which was the minimum MA payment update for 2005.

Also for 2004 payments, CMS issued new health-risk-adjusted rates, accounting for 30 percent of MA plan payment. CMS decided to implement the risk adjusted rates on a budget neutral basis (meaning that risk adjustment would not decrease aggregate plan payments if MA enrollee risk scores were less on average than FFS beneficiaries’ risk scores) for 2004 and future years.

1.3.6 Medicare Risk Program Legislative Change Summary

Table 1-2 summarizes the legislative history of payment changes for the Medicare risk program.

1.4 Impact of Legislative Changes on County Payment Rates

From the previous section summarizing the multiple, complex, and interacting legislated payment rate changes implemented from 2000 to 2005, it might have been difficult to understand the net effects on actual county payment rates for M+C and MA health care organizations over this time period. Therefore, we analyzed the dollar and percent change impact on county rates from 2000 through 2005. Results are shown in *Table 1-3*. Dollar and percent changes listed here were relative to the prior year (or other time period as noted, since some of the legislated payment changes were not enacted as part of annual January updates).

**Table 1-2
Medicare risk program legislative change summary**

Year	Legislation	Rates	Risk Adjustment	Bonus
Pre-1997		Per capita rates set annually at 95 percent of AAPCC, 95 percent of expected FFS expenditures for the area/county.	The following are demographic adjustors only: age, sex, Medicaid status, working status, disabled status, and institutional (nursing home) status.	
1997-1998	BBA passed	The rate is the maximum of the following: 1) Blended rate: a weighted average of the local area rate and the national rate. 2) Floor rate: \$367 (updated annually). 3) Two percent increase over previous year's rate. * Base area rate 1997 AAPCC, updated by national growth factor. * Weight of national rate to be phased in until 2003. * GME payments to be phased out by 2002. * Blended rate subject to budget neutrality. Floor and minimum 2 percent increase are not subject to budget neutrality.		
1999	BBRA passed		Slowed down phase-in of PIP-DCG health status risk adjustment. PIP-DCG remained constant at 10 percent rather than having it increase to 55 percent by 2002 and 100 percent by 2004.	Bonus payments to enter areas with no plans or exit of all plans announced as of October 1999. * Plans get a 5 percent increase in rates the first year and 3 percent increase in rates the second year.
2000	BIPA passed		PIP-DCG 10 percent of per capita payment rate, remaining 90% demographic adjustors. (BBA) * PIP-DCG based on prior year's inpatient hospital admissions	Bonus payments extended to include areas where no plans available as of January 2001.
2001		1) Temporary increase in minimum update from 2 percent to 3 percent: March 2001 through December 2001. 2) Floor reset and new urban floor created for counties in metropolitan areas with at least 250,000 people: base: \$475, urban: \$525. * If floor had not been reset, the floor would have been \$515. ¹	PIP-DCG remains at 10% of per capita rate (compared to original planned increase to 30%).	
2002		Minimum increase returns to 2 percent.	PIP-DCG remains at 10% of per capita rate (compared to original planned increase to 55%). PIP-DCG remains at 10% of per capita rate (compared to original planned increase to 80%). PIP-DCG at 0% of per capita rate (compared to original planned increase to 100%). * CMS-HCC risk adjustment at 30% of per capita rate. * CMS-HCC based on inpatient admissions and outpatient ambulatory groups (BIPA).	
2003	MMA passed			
2004		1) Minimum increase changed to the maximum of 2 percent or national per capita growth rate. 2) 100 percent of per capita FFS expenditures added as new minimum county rate. 3) Blended rate no longer subject to budget neutrality (2004 only). 4) Floor rate reset again March 2004: base: \$555, urban: \$613 (An increase from base: \$535, urban: \$592.) ²		

NOTES: Legislation in parenthesis is used to note which piece of legislation implemented the change.

¹ Medicare+Choice Organizations and Other Interested Parties, Subject: Announcement of Calendar Year (CY) 2001 Medicare+Choice Payment Rates, March 1, 2000. Found at <http://www.cms.hhs.gov/healthplans/rates/2001/cover-00.asp>

² Medicare+Choice Organizations and Other Interested Parties, Subject: Announcement of Calendar Year (CY) 2004 Medicare+Choice Payment Rates, May 12, 2003. Found at <http://www.cms.hhs.gov/healthplans/rates/2004/cover.asp>.

Table 1-3
Number of counties by change in Medicare Advantage monthly county payment rate, 2000–2005

	BIPA				MMA			
Date of rate change:	1/2001	3/2001	1/2002	1/2003	1/2004	3/2004	1/2005	
Total counties	3,121	3,121	3,121	3,121	3,121	3,121	3,121	
<u>Dollar change</u>								
<\$25	3,120	1,239	858	3,116	633	2,064	0	
\$25–49.99	1	538	2,263	5	2,488	378	2,827	
\$50–74.99	0	1,185	0	0	0	211	284	
\$75–99.99	0	84	0	0	0	267	9	
\$100+	0	75	0	0	0	201	1	
<u>Percent change</u>								
<2%	0	942	0	0	0	0	0	
2–4.9%	3,120	253	840	3,116	646	2,168	0	
5–9.9%	1	447	2,281	5	2,475	333	3,091	
10–14.9%	0	1,298	0	0	0	337	30	
15–19.9%	0	68	0	0	0	133	0	
20% +	0	113	0	0	0	150	0	

NOTE: Based on aged A + B demographic rate only. Excludes Puerto Rico, the Virgin Islands, and Guam.

SOURCE: RTI analysis of CMS county Medicare Advantage payment rate files.

During two distinct periods between 2000 and 2005, a substantial number of counties received very significant payment increases; these were due to the implementation of BIPA in March 2001 and the implementation of MMA in March 2004. On March 1, 2001, approximately 1,500 county payment rates—nearly half of all county rates—rose more than \$50 or by more than 10 percent. These increases resulted from BIPA’s \$60 increase in the minimum floor and its establishment of the urban floor rate. (See *Table 1-1*). While on March 1, 2004, more than 600 counties—about one-fifth of counties—received payment updates of more than \$50 or more than 10 percent. These large increases resulted from the MMA’s new minimum payment rate of county FFS costs and its increase in the minimum update percentage. For other time periods, the payment updates were comparatively modest. But substantial numbers of counties received moderate payment increases of \$25 to \$50 , or 5 to 9.9 percent in 2002 and in early 2004 because of increases in floor payment rates in those years, and in 2005 because of the 6.6 national growth percentage minimum payment update from 2004 to 2005.

Table 1-3 shows that BIPA and MMA had substantial effects on MA payment rates. But the analysis also indicated that their effects on payment rates varied greatly across counties and that many counties received only modest initial updates from BIPA and MMA. For example, in

March 2001, BIPA raised payment rates in 75 counties more than \$100 per member per month above January 2001 levels. But in 1,239 counties, the increase was less than \$25. Similarly, in 150 counties post-MMA March 2004 rates were more than 20 percent greater than pre-MMA January 2004 rates. But in 2,168 counties, rates rose by no more than 4.9 percent.

Table 1-4 shows the result of the payment changes in *Table 1-3* for counties classified by their urbanicity. For each period, we presented both average actual MA payment rates and average simulated BBA and BIPA rates that would have been effective had the provisions of those Acts not been modified by subsequent legislation. By 2005, across all counties, average actual payment rates were \$118 (\$694 minus \$576), or 20 percent, higher than they would have been if BBA provisions had continued to determine rates. BIPA raised average payment rates by 5 to 8 percent relative to BBA from 2001 to early 2004, and MMA raised average rates by another 7 to 9 percent relative to BIPA in later 2004 through 2005.

BIPA and MMA raised average payment rates for all types of urban and rural counties. But there were some differences in their effects by urbanicity. BIPA raised rates the most for medium urban counties (9 percent), and the least for large urban counties (3 percent). By 2003, actual rates are 12 and 10 percent greater than simulated BBA rates in medium urban and rural non-adjacent counties, respectively, versus only 3 percent greater in large urban counties. This difference is the result of BIPA's urban floor, which especially benefited mid-sized urban areas. Rural counties also benefited proportionately more than large urban counties because BIPA raised minimum floor rates. MMA, on the other hand, had a greater proportional impact on large urban counties. In 2005, actual rates were 12 percent greater than simulated BIPA rates in large urban counties versus only 7 to 8 percent greater in other counties. MMA's 100 percent of FFS minimum rate was especially generous to large urban counties with their high FFS costs.

The cumulative effect of BIPA and MMA on actual 2005 rates relative to simulated BBA rates was fairly similar across the various urban and rural county categories. Medium urban counties benefited more from the two Acts than other types of counties, and large urban counties benefited slightly less. Continuing the trend begun by BBA, BIPA and MMA resulted in a narrowing of the percentage difference between average payment rates across urban and rural counties. In 2000, actual urban rates were 20 percent greater than rates in rural counties (\$533 versus \$443). By 2005, both rates were much higher, but this gap had narrowed to 15 percent (\$714 versus \$621).

Table 1-5 shows the same information as *Table 1-4*, but with counties classified by the four Census regions (Northeast, Midwest, South, and West) rather than urbanicity. The relatively low-cost, rural, and low payment Midwest benefited the most from BIPA's increase in the minimum floor rate and the establishment of the urban floor rate, which raised payments to low-payment areas. The relatively high-cost, highly-urbanized, and high-payment Northeast benefited the least from BIPA. Conversely, the high-cost Northeast benefited the most from MMA's 100 percent of FFS minimum rate, and the low-cost Midwest the least. The cumulative effect of BIPA and MMA was to raise actual 2005 rates relative to simulated BBA rates slightly more in the South and the Northeast, and slightly less in the West, with the Midwest at the national average. BIPA and MMA slightly narrowed regional percentage differences in payment: actual average Northeast rates were 16 percent greater than average Midwest rates in 2000 (\$558 versus \$481) as compared to 14 percent greater in 2005 (\$751 versus \$656).

Table 1-4
Average actual and simulated BIPA and BBA Medicare Advantage monthly county
payment rates by county urbanicity, 2000–2005, in dollars

County Urbanicity	Payment Rate	Pre-BIPA		Post-BIPA			Pre-MMA		Post-MMA
		Jan-00	Jan-01	Mar-01	2002	2003	Jan-04	Mar-04	2005
Total (3,120 counties)	Actual	513	524	551	571	582	604	649	694
	BIPA	.	.	551	571	582	604	604	634
	BBA	513	524	524	537	547	560	560	576
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.07	1.09
	<i>Actual/BBA</i>	1	1	1.05	1.06	1.06	1.08	1.16	1.20
Urban (1,089 counties)	Actual	533	543	568	587	599	620	668	714
	BIPA	.	.	568	587	599	620	620	649
	BBA	533	543	543	555	566	578	578	592
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.08	1.10
	<i>Actual/BBA</i>	1	1	1.05	1.06	1.06	1.07	1.16	1.21
Large Urban (414 counties)	Actual	572	583	598	615	627	646	699	749
	BIPA	.	.	598	615	627	646	646	671
	BBA	572	583	583	594	606	618	618	630
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.08	1.12
	<i>Actual/BBA</i>	1	1	1.03	1.04	1.03	1.05	1.13	1.19
Medium Urban (324 counties)	Actual	477	486	532	555	567	593	630	673
	BIPA	.	.	532	555	567	593	593	629
	BBA	477	486	486	498	508	520	520	538
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.06	1.07
	<i>Actual/BBA</i>	1	1	1.09	1.11	1.12	1.14	1.21	1.25
Small Urban (351 counties)	Actual	461	471	503	523	534	556	597	637
	BIPA	.	.	503	523	534	556	556	588
	BBA	461	471	471	484	494	507	507	526
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.07	1.08
	<i>Actual/BBA</i>	1	1	1.07	1.08	1.08	1.10	1.18	1.21
Rural (2,031 counties)	Actual	443	453	489	511	522	545	581	621
	BIPA	.	.	489	511	522	545	545	578
	BBA	432	443	443	460	469	484	484	508
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.07	1.07
	<i>Actual/BBA</i>	1	1	1.08	1.09	1.08	1.11	1.18	1.21

Continued

Table 1-4 (continued)
Average actual and simulated BIPA and BBA Medicare Advantage monthly county payment rates by county urbanicity, 2000–2005, in dollars

County Urbanicity	Payment Rate	Pre-BIPA		Post-BIPA			Pre-MMA		Post-MMA
		Jan-00	Jan-01	Mar-01	2002	2003	Jan-04	Mar-04	2005
Rural MSA Adjacent (1,061 counties)	Actual	449	459	493	515	525	548	585	625
	BIPA	.	.	493	515	525	548	548	581
	BBA	449	459	459	474	483	497	497	518
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.07	1.08
	<i>Actual/BBA</i>	1	1	1.07	1.09	1.09	1.10	1.18	1.21
Rural non-Adjacent (970 counties)	Actual	432	443	482	505	515	539	574	613
	BIPA	.	.	482	505	515	539	539	573
	BBA	432	443	443	460	469	484	484	508
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.06	1.07
	<i>Actual/BBA</i>	1	1	1.09	1.10	1.10	1.11	1.19	1.21

NOTE: Based on aged A + B demographic rate only. Excludes Puerto Rico, the Virgin Islands, and Guam. Rates are weighted by the number of Medicare beneficiaries residing in each county. BIPA and BBA rates assume that no counties would have received the blended rate because of budget neutrality.

SOURCE: RTI analysis of CMS county Medicare Advantage payment rate files.

1.5 Plan-Reported Uses of BIPA and MMA Payment Increases

The remainder of this report analyzes the impacts on plan participation, premiums and benefits, and enrollment that resulted from BIPA and MMA changes in payment rates. Before beginning the presentation of the analyses, however, it is informative to consider the uses to which plans have *reported* they applied the extra payments.

As a condition of participation in the MA program, plans must file an Adjusted Community Rate Proposal, or ACRP, with CMS each year. In the years BIPA and MMA were implemented, 2001 and 2004 respectively, CMS required plans to file an amended ACRP detailing how they planned to use the extra payments resulting from the two Acts. CMS required that plans use the extra funds to do the following: 1) reduce enrollee premiums or cost sharing; 2) improve enrollee benefits; 3) improve access to providers, for example by raising payments to providers; or 4) contribute to a stabilization fund to offset future premium increases or benefit cuts. These plan-reported uses of extra payments have been analyzed by the United States Government Accountability Office (formerly named the General Accounting Office) for BIPA (GAO, 2001) and by CMS for MMA (CMS, 2004).

Tables 1-6 and 1-7 presents the key findings from GAO’s and CMS’ analyses of plan-reported uses of extra BIPA and MMA payments, respectively. The most important use of BIPA funds was “increasing access to providers.” For MMA, it was to improve the benefit package (included reducing enrollee premiums) with “increasing access to providers” second.

Table 1-5
Average actual and simulated BIPA and BBA Medicare Advantage monthly county
payment rates by census regions, 2000–2005, in dollars

Census region	Payment Rate	Post-BIPA					Pre-MMA	Post-MMA	2005
		Jan-00	Jan-01	Mar-01	2002	2003	Jan-04	Mar-04	
Total (3,120 counties)	Actual	513	524	551	571	582	604	649	694
	BIPA	.	.	551	571	582	604	604	634
	BBA	513	524	524	537	547	560	560	576
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.07	1.09
	<i>Actual/BBA</i>	1	1	1.05	1.06	1.06	1.08	1.16	1.2
North East (217 counties)	Actual	558	569	590	607	619	639	701	751
	BIPA	.	.	590	607	619	639	639	665
	BBA	558	569	569	581	592	605	605	620
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.10	1.13
	<i>Actual/BBA</i>	1	1	1.04	1.04	1.05	1.06	1.16	1.21
Mid West (1,056 counties)	Actual	481	492	528	550	561	585	615	656
	BIPA	.	.	528	550	561	585	585	617
	BBA	481	492	492	506	516	529	529	548
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.05	1.06
	<i>Actual/BBA</i>	1	1	1.07	1.09	1.09	1.11	1.16	1.20
South (1,425 counties)	Actual	505	516	542	562	573	595	646	691
	BIPA	.	.	542	562	573	595	595	626
	BBA	505	516	516	528	538	550	550	566
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.09	1.10
	<i>Actual/BBA</i>	1	1	1.05	1.06	1.07	1.08	1.17	1.22
West (422 counties)	Actual	521	531	557	575	587	608	644	689
	BIPA	.	.	557	575	587	608	608	637
	BBA	521	531	531	543	554	566	566	582
	<i>Actual/BIPA</i>	-	-	1	1	1	1	1.06	1.08
	<i>Actual/BBA</i>	1	1	1.05	1.06	1.06	1.07	1.14	1.18

NOTE: Based on aged A + B demographic rate only. Excludes Puerto Rico, the Virgin Islands, and Guam. Rates are weighted by the number of Medicare beneficiaries residing in each county. Counterfactual rates assume that no counties would have received the blended rate because of budget neutrality.

SOURCE: RTI analysis of CMS county Medicare Advantage payment rate files.

Table 1-6
Reported uses of increased BIPA payments by Medicare Advantage plans, 2001

Use	Percent of plans		
	Total ¹	Sole use	One use ²
Increase access to providers ³	82.6	62.7	19.9
Improve benefit package ⁴	28.7	12.4	16.3
Contribute to stabilization fund ⁵	12.2	1.8	10.4

NOTE: BIPA is the Benefits Improvement and Protection Act of 2000.

¹ Percentage uses sum to more than 100 percent because plans may report more than one use.

² One use among multiple uses of extra payments reported.

³ Includes:
 1) increasing payment rates to providers
 2) contracting with additional providers
 3) offsetting projected medical cost increases.

⁴ Includes:
 1) reducing premiums
 2) reducing cost sharing
 3) adding benefits
 4) enhancing existing benefits.

⁵ Setting aside money for future years in a benefit stabilization fund.

SOURCE: United States General Accounting Office (2001) analysis of plan Adjusted Community Rate Proposals.

Table 1-7
Reported uses of increased MMA payments by Medicare advantage plans, 2004

Use	Percentage of payments
Total	100%
Increase access to providers	42
Reduce enrollee premiums	31
Enhance existing benefits	17
Reduce cost sharing	5
Contribute to stabilization fund	5

NOTE: MMA is Medicare Modernization Act of 2003.

SOURCE: CMS (2004) analysis of plan Adjusted Community Rate Proposals.

CHAPTER 2 METHODOLOGY

2.1 Overview

In this chapter, we describe our methodological approach for assessing the impact of providing increased financial incentives to Medicare Advantage plans. We used a combination of qualitative and quantitative methods to obtain the most complete picture of the impacts of legislated payment changes between 2000 through 2005. Additional methodological detail specific to certain analyses is presented in subsequent chapters of this report.

A note on terminology is important. The term “Medicare Advantage organization” (the predecessor Medicare+Choice organization) or “MA organization” refers to a contract between an insurer and CMS to enroll Medicare beneficiaries and provide them with medical services in a defined geographic area. CMS identifies MA organizations, and the contracts that establish them, by “H-numbers” (e.g., H4403). In contexts where it is important to distinguish MA organizations and specific benefit packages, the term “plan” refers to a specific benefit package and premium offered by an MA organization in specific counties. Several “plans” may be offered by the same MA organization in the same county—for example, a “high option” plan including a drug benefit and a “low option” plan without a drug benefit.¹¹

2.2 Qualitative Analyses—Telephone Discussions with Medicare Advantage Plans

We completed a series of telephone discussions with staff of 12 MA organizations representing financial, marketing and government relations functions within each plan. The purpose of these discussions was to gain organizations’ perspectives on the impact of the various legislated payment changes on their business decisions to either participate in or withdraw from the MA program. We were also interested in understanding their view of the effect each round of legislation had on premiums, cost sharing, and benefit offerings (particularly related to prescription drugs), service area decisions, the service delivery model (PPO, POS, etc.) offered, relationships with providers, the ability to build and retain physician networks, enrollment, and other issues.

Some of the interviewed organizations were national or regional providers, while others operated primarily in a single state. Most of the organizations were major, established Medicare plans. Also, we spoke with an insurer who at that time had no Medicare MA contracts in an effort to understand why—even with the additional incentives offered under these legislative initiatives—it did not participate in the MA program. We conducted all of our interviews by telephone; each interview generally lasted about one hour. We developed and used a detailed protocol to guide these discussions. We do not present findings from individual organizations in this report. Rather, in each subsequent chapter, we summarize the comments without attribution.

¹¹ Benefits—such as a drug benefit—may be available as optional supplemental “riders” to a plan that beneficiaries can purchase for an additional premium.

2.3 Quantitative Analyses—Secondary Data

The majority of our quantitative analyses were performed on CMS administrative data. We describe here some of the primary methodological definitions, approaches, and data sources used in those analyses.

2.3.1 Framework for Quantitative Analyses

Conceptual Framework. The MMA directs the DHHS to describe the impact of additional financing under various legislative Acts on the availability, premiums, and benefits of MA plans. In our descriptive analyses, we use two approaches to identify impacts. Our primary method is pre/post-legislation trend analysis. We present statistics on plan availability, premiums, and benefits at multiple time intervals from 2000 to 2005, including periods before and after the implementation of BBRA, BIPA, and MMA. It is reasonable to infer that changes in availability, premiums, and benefits before and after implementation of these Acts are related to the additional financing provided under the Acts. This is especially true if the observed changes are in geographic areas where Medicare payment was increased significantly by an Act. For example, if an Act raised floor payments substantially, and greater plan availability in rural areas was observed subsequent to the Act’s implementation, it is reasonable to infer a relationship. The length of time to detect a change post-legislative-implementation varies across our analyses. For example, MA organizations may adjust plan premiums very rapidly in response to higher payments, but it may take them longer to expand the availability of plans, and even longer for enrollment to increase in response to greater availability and lower premiums.

Our second descriptive method, used in some analyses in conjunction with the first, is to compare changes in availability, premiums, and benefits among areas with differing levels of payment increases due to an Act. If the additional financing provided by the Act is affecting availability, premiums, and benefits, we would expect to observe larger changes in areas where greater additional financing has been provided.

In addition to descriptive analyses, we conducted multivariate analyses. A limitation of our descriptive analysis is that changes from implementation of a legislative Act may have been affected by factors other than the Act alone. For example, availability of plans may be affected by trends in medical care costs and developments in the commercial insurance market. Multivariate analyses allow us to “hold constant” the influence of other measurable factors to isolate the effect of additional legislative financing. Multivariate analyses provide a concise means of estimating the impact of payment changes across the entire 2000 to 2005 period while simultaneously accounting for the influences of relevant factors other than legislative changes. Estimated impacts derived from multivariate analyses incorporate both of our descriptive methods of evaluating the Acts: pre/post-legislative changes, and differences in impacts across areas with different payment increases.

Geographic Areas. The MMA asks for analysis of the impact of legislated changes in financing “in different areas.” Because it is the geographic unit for which payment rates are defined, the county is the basic building block for our area definitions. In our analysis of plan availability, number and percentage of counties is a key measure of the availability of types of plans. We have full data on 3,120 counties throughout our time period (2000–2005). There are

two exceptions in which counties may be included or excluded depending on data availability for a particular analysis.¹² The first exception is Broomfield County, Colorado, which was created in 2003. The other exception involves counties in Alaska that were not coded consistently across different data sources. To address the latter, we created a single aggregate “county” for “rest of Alaska,” which comprises Alaska excluding Anchorage, Juneau, and Fairbanks. In general, we also excluded U.S. territories (Puerto Rico, the Virgin Islands, and Guam) from our analyses.

In addition to national and county-level analyses, we grouped counties by urbanicity and region to examine aggregated impacts by type and location of county. Evaluating impacts by urbanicity is particularly important since several of the legislative Acts provided additional financing to areas based on urban designation, namely floor and urban floor counties. We defined five categories of urbanicity based on the “Beale” codes created by the U.S. Department of Agriculture for the year 2003 based on the 2000 Census. The categories included the following:

- Large urban: counties in metropolitan areas of 1 million or more;
- Medium urban: counties in metropolitan areas of 250,000 to 1 million;
- Small urban: counties in metropolitan areas of less than 250,000;
- Rural, urban-adjacent: non-metropolitan counties adjacent to at least one metropolitan county; and
- Rural, non-adjacent: non-metropolitan counties not adjacent to any metropolitan counties.

Our regional definition was the four US Census regions:

- Northeast;
- Midwest;
- South; and
- West.

We also in some cases grouped counties by their level of payment increase due to a legislative Act, to examine differences in the impact of the Act by payment change.

Types of Plans Analyzed. As required by the MMA, our analysis focuses on Medicare Advantage plans. There are three main types of MA plans, which we often distinguish because of their different provider access and other characteristics. The three types of plans include the following:

¹² The maximum number of counties for any of our analyses is 3,122 and the minimum is 3,120.

- Health Maintenance Organizations (HMOs), including HMO-Point of Service (POS) plans;
- Preferred Provider Organizations (PPOs), including PPO Demonstration and non-Demonstration plans; and
- Private Fee for Service (PFFS) plans.

HMOs and PPOs have provider networks and, together with the rare Provider-Sponsored Organizations (PSO), comprise “coordinated care plans.” HMOs generally cover only in-network care, although HMOs with a POS option offer some out-of-network care at a higher cost to the enrollee. PPOs provide coverage for all care out of network, but at higher enrollee cost sharing levels than in-network. PFFS plans are not required to have a provider network and enrollees may obtain care from any provider who accepts their plan’s terms.

Unless otherwise noted, we did not include demonstration plans (with the exception of Medicare PPO demonstration plans¹³), cost reimbursement plans, Part A or Part B only plans, and employer based plans¹⁴ in our analyses because these either have unique payment arrangements, enrollment limitations, or benefit design features not found in Medicare Advantage plans. The Special Needs Plans (SNPs) established by the MMA—for either dual Medicare and Medicaid eligibles or for beneficiaries with specific chronic diseases—are included in our analyses unless otherwise noted. Many of the special needs plans are offered as a different benefit package under an MA contract rather than a separate contract. Because MA organizations may offer more than one plan in a county and only total contract enrollment for each county is available throughout the time period, SNPs have been included in the analyses.

HMO Basic Plans. To examine the impact of additional financing on plan premiums and benefits, we wanted to measure premiums and benefits for a consistent type of plan over time. Since HMOs were the dominant MA plan type throughout our period, we conducted the premiums/benefit analysis for only HMO plans. Because MA organizations may offer more than one plan in a county and only total contract enrollment for each county is available throughout the time period and the premium and benefits results are enrollment weighted, we chose a single basic plan per contract in a county for our analysis. Basic plans were defined as the lowest-premium plan offered by an MA organization in a county. If more than one plan had the same lowest premium, the basic plan was the plan with defined as the one with the most generous drug benefit. Basic plans were the most affordable option available to beneficiaries and tended to have the largest enrollments. Beneficiaries enrolled in higher-option plans within a contract effectively purchased the basic plan and paid more for the extra benefits in the high-option plan.

¹³ Although they operated under slightly different payment and other rules from 2003 to 2005, we included PPO Demonstration plans with non-Demonstration PPO plans because in 2006 Demonstration plans will transition to local PPOs operating under the same rules as other local PPOs.

¹⁴ We excluded contracts that offered only employer-based plans. For contracts that offered a mix of employer-only and open-enrollment plans, we excluded counties where only employer-only plans were offered. It was not possible to exclude employer-only plans in counties where the same contract also offered open-enrollment plans.

The algorithm we used to define a basic plan within a contract/county was as follows. If only one plan remained at any step of this algorithm, that plan was chosen and the further factors were not considered:¹⁵

1. The plan with the lowest premium.¹⁶
2. The plan with an outpatient prescription drug benefit.
3. The plan with a drug benefit covering at least some brand-name drugs.
4. The plan with the lowest Plan ID number.

The plan with the lowest Plan ID number was chosen at the final step because these plans tend to be the longest-established plans that are likely to have the largest enrollments.

Time Periods for Analysis. Because much of our analysis involved pre/post-legislative comparisons, an important issue was the time periods of the data we used. Our primary data source for plan availability, premium, and benefit analyses was the CMS Health Plan Management System (or HPMS, described in more detail below). The HPMS system is the most complete source of information regarding the number, type, and benefit plans offered under Medicare. However, HPMS data were not available prior to 2000, which limited the starting point of our analyses to 2000. Also, since MA organization contracts and benefits sometimes change during the contract calendar year, HPMS data are updated and changed on a monthly basis. Therefore, there are 12 separate monthly files—not a single final annual file—for each calendar year. Because of this, we selected one or more specific months for our analysis of 2000 through 2005.

We initially attempted to choose a consistent month (April) for each year and also wanted data for February in 2001 and in 2004 as “pre” months before the implementation of BIPA in March 2001 and MMA in March 2004. But HPMS data were not available for these months. November 2000 was the only data available for 2000, so by necessity chose it. 2001 HPMS data prior to June were not available, so we measured the effect of BIPA by the change from November 2000 to June 2001. For 2002 and 2003, we analyzed data from the April monthly files. In 2004, HPMS data for both February and April were available, allowing us to conduct a pre/post-legislation analysis of the implementation of MMA in March 2004. For 2005, we analyzed the June 2005 file as these were the most recent data we could include.

2.3.2 Data Sources

CMS Health Plan Management System (HPMS). The primary data source used in our analyses was CMS’s Health Plan Management System (HPMS), which collected service area, premium, and benefit information for MA and certain other plans. This information was

¹⁵ We specified that Special Needs Plans could not be chosen as the basic plan unless they were the only plan offered by a contract in a county.

¹⁶ Plans reducing beneficiaries’ Part B premiums were treated as zero premium plans.

submitted by plans annually, or more frequently if data changed. The HPMS Plan Benefit Package (PBP) datasets were available from 2000. The PBP data contained information describing the benefit package provided by each plan, including information on premiums, copayments, coinsurance and deductible amounts, and drug and other benefit descriptions.

Out-of-pocket costs. CMS and its contractor Fu Associates generated out-of-pocket payment estimates for beneficiaries enrolled in MA plans. CMS combined 1999 and 2000 Medicare Current Beneficiary Survey (MCBS) data to create utilization information for a nationally representative cohort of 14,774 beneficiaries (Fu Associates, 2004) for 2004.¹⁷ Beneficiaries who did not have both Part A and Part B coverage or who were in a long-term care facility for any part of the year were excluded. Each health plan's benefit structure, as reported in the HPMS/PBP, was applied to the utilization for these beneficiaries to estimate out-of-pocket costs. These out-of-pocket costs were then averaged across beneficiaries for each health plan. The out-of-pocket cost data contains information on average costs for each health plan for five self-reported health status categories and six age categories. We aggregated out-of-pocket (OOP) costs across these categories to a single composite based on weights provided by CMS/Fu.

County payment rates. Medicare county payment rates were obtained from the CMS web site. We used the sum of the demographic aged A and B rates to measure monthly per capita payments to MA plans. This constituted most of the payments (70 percent or more) for most enrollees (approximately 88 percent of enrollees are aged) throughout our time period. But it does not incorporate risk-adjusted payments, or payment rates for disabled or End-Stage Renal Disease beneficiaries. Using the county rate files and our review of legislative provisions, we simulated BBA and BIPA payment rates that would have remained in effect had these Acts not been superseded by later legislation modifying payment rules.

Other data. RTI employed several other data sources. The Medicare Enrollment Database (EDB) was used to obtain enrollment by contract, county, and time period. The Area Resource File provided county information that was used in the multivariate analyses. RTI used 100 percent Medicare Provider Analysis and Review claims and American Hospital Association data on hospital affiliation to construct an index of hospital competition for each county. FFS per capita costs were obtained from the CMS web site.

¹⁷ For 2005, the MCBS utilization profile was regenerated based on 2000 and 2001 MCBS data, making it incomparable to the 2004 data. We used only the 2004 data for this report.

CHAPTER 3 PLAN AVAILABILITY

3.1 Introduction

One of the primary goals of the legislative initiatives from the BBA through the MMA was to expand the number and type of Medicare health plans available to Medicare beneficiaries, particularly in geographic areas (such as rural counties) that have traditionally been underserved by managed care. Therefore, in this chapter, we described changes in plan availability between 2000 (after the BBA and BBRA were implemented) and 2005 (one year after initial MMA provisions were implemented). We examined changes in the number and types of health plan options available to Medicare beneficiaries, as well as changes in the service areas of Medicare participating plans. We began this chapter with the feedback we gathered from Medicare Advantage organizations (MA organizations) that participated in our discussions, and then presented our empirical analysis.

3.2 Medicare Advantage Organization Perspectives

In discussions held with a range of MA organizations, we asked representatives of the Medicare participating and non-participating organizations how recent legislative initiatives (from the BBA through initial provisions of the MMA) impacted the number, types and service areas of plans they offered to Medicare beneficiaries. The following are a summary of these discussions on each of the legislative initiatives.

BBA

- These MA organizations tended to have Medicare membership concentrated in urban areas, so almost all of their plans were affected by the 2 percent minimum rate increase provision in the BBA. The “meager” 2 percent annual payment rate increase (despite net increases over what rates would have been under the former AAPCC methodology) was viewed as “not enough to keep up with medical inflation costs” that were higher than 2 percent during the post-BBA period. As a result, these organizations reported that they had to pull out of some markets. A few MA organizations exited a majority of their Medicare service areas, greatly reducing their Medicare plan offerings.
- Regarding the expansion of new plan types, such as PPOs authorized under the BBA, the organizations commented almost universally that the slow growth rates in M+C payment rates made it difficult for them to sustain a Medicare base product, never mind a new premium product like PPOs in their competitive market.
- Interviewed MA organizations noted that the continued difficulty in expanding plans to rural areas is primarily related to provider networks. Even though the establishment of a minimum floor payment was viewed as a positive impact, these payments were initially insufficient to overcome this problem. It allowed some of the MA organizations to remain in their primarily rural markets. However, none of them entered new floor counties as a result of the new floor payment.

- Risk adjustment received mixed reviews from the MA organizations. For a number of the organizations who viewed their Medicare beneficiaries as sicker than average, risk adjustment provided additional funding – particularly coupled with the minimum floors. Others were more critical of the implementation of risk adjustment and viewed this BBA provision as a negative. However, because of the phase in, MA organizations did not view risk adjustment nearly as negatively as the changes in the rate book payment methodology. A few MA organizations admitted that they were very concerned with the potential negative impacts of risk adjustment, but found the actual impacts were not as “bad as they expected.”

BBRA and BIPA

- The short-term bonus provisions of the BBRA and BIPA, intended to induce plans to enter areas without plans, were not considered particularly helpful or significant by insurers. The bonus provisions caused more confusion and uncertainty for the long range predictability of Medicare payments. Additionally, few of the MA organizations took advantage of the payments because either they were not even remotely considering expansions in any counties, or because any counties that were considered viable for their organizations were not eligible for bonus payments. Some of the counties that turned out to be ineligible were due to the presence of a single PFFS plan. Even if a bonus payment made it temporarily financially viable to offer a plan in an area, once the bonus ended the plan would again become unprofitable if long-run payment rates were not adequate. Even in the short run, bonus payments may not fully offset the high fixed costs of establishing health care plans in new service areas, including the costs of provider network development, marketing, and administration.
- BIPA payment increases were cited as more significant because the increases were viewed as more “long term.” The MA organizations reported that the additional payments received under BIPA were used either to improve or stabilize payments to their provider networks or to stabilize benefits and premiums for Medicare beneficiaries, which otherwise would have declined more severely as health care costs continued to rise rapidly.
- The organizations conceded, however, that BBRA and BIPA additional payments were not substantial enough to restore benefits or service areas to pre-BBA levels.

MMA

- The MA organizations emphasized that the most important factor in their decisions about where to make plans available is the long-term adequacy of Medicare payment rates in an area. The MMA provisions establishing local FFS costs as a minimum payment rate for each county, and a minimum payment update percentage of the national Medicare spending growth rate, are seen as the keys in ensuring that Medicare payment rates are adequate now and in the future. As a result, a number of MA organizations reported service area expansions in 2004 and 2005. Service area expansions for 2004 tended to be modest; however, a larger number of the MA organizations reported service area expansions in 2005.

- Under the MMA, more MA organizations were willing to consider additional plan types such as PPOs. A number of MA organizations were in the process of applying for Medicare PPOs, though more as a defense against the 2006 moratorium on local PPOs.

3.3 Secondary Data Analysis

3.3.1 Descriptive Analysis

In addition to discussing Medicare plan participation with MA organizations, we analyzed Medicare administrative data to document the trends in plan availability during the period 2000 through 2005.

Number of Contracts. First, we looked at the number of Medicare contracts, in total and by contract type, by year. Findings are presented in *Table 3-1*. In this analysis, we counted the number of contracts, not individual plans offered under these contracts.¹⁸

Table 3-1
Number of Medicare contracts, by contract type

	Nov-00	Jun-01	Apr-02	Apr-03	Feb-04	Jun-05
Total contracts	302	211	176	210	210	311
Total MA contracts	264	179	154	178	178	289
Total coordinated care contracts	263	178	152	175	175	275
HMO ¹	259	173	147	137	132	176
PPO ²	1	2	3	35	40	93
PSO ³	3	3	2	3	3	6
PFFS	1	1	2	3	3	14
Total non-MA contracts	38	32	22	32	32	22
COST	14	13	8	12	15	14
OTHER ³	24	19	14	20	17	8

¹ HMO includes HMO and HMO POS.

² PPO includes PPO Demo and PPO non-demo.

³ Other includes all other plans including all demonstrations except for the PPO demonstration.

SOURCE: RTI analysis of CMS Health Plan Management System data.

Consistent with feedback from the MA organizations, the post-BBA implementation period shows a marked decrease in the number of Medicare contracts. In 2000, the year marking

¹⁸ A contract is an agreement between an MA organization and CMS to offer Medicare health plans in an area. A plan is a specific benefit package offered by the MA organization. One or more plans may be offered under a single contract.

full implementation of the BBA payment (including risk adjustment) provisions and after passage of the BBRA, there were a total of 302 Medicare contracts. By 2001, after passage of the BIPA, this number declined by nearly one-third to 211, despite the fact that BIPA temporarily increased rates by 3 percent rather than 2 percent, and increased the minimum floor rate and established an urban floor rate, in March 2001. In 2002, when minimum increases returned to 2 percent, contracts declined yet again to the lowest point in our analysis, at 176 contracts nationally. It is possible that a small proportion of this decline in contracts was due to a consolidation of multiple contracts under a new single number; however, this contributing factor would be small.

In 2003, HMO contracts continued to decline (from 147 to 137), but at a slower rate than in 2001 or 2002. Total contracts, however, rose in 2003 because of the implementation of Medicare's PPO Demonstration with over 30 new contracts. Total contracts were stable in early 2004 prior to implementation of MMA payment increases in March 2004, as a slight increase in PPO contracts offset a continued slight decline in HMO contracts.

The following year, 2005, was the first full year that MA organizations had the opportunity to take into account the substantial MMA March 2004 and 2005 payment increases and permanent increase in the minimum MA payment update factor. In addition, the MMA created two other special factors in 2005. First, it temporarily prohibited new local PPO contracts in 2006 and 2007 to promote the new regional PPO option. Hence, MA organizations interested in new local PPO contracts had to enter in 2005 or wait until 2008. Second, the MMA established a new Medicare drug benefit beginning in 2006, which may be offered by either MA plans or standalone drug plans. The new drug benefit creates an opportunity for MA organizations to gain substantial new enrollment in 2006 and after, and some MA organizations may have signed contracts early, in 2005, in preparation for 2006.¹⁹

In response to these factors, the total number of contracts rose sharply—by about 50 percent—in 2005. All types of MA contracts increased, especially local PPOs, which more than doubled from 40 to 93. The PPO increase included a large number of new PPO non-demonstration contracts. By June 2005, the total number of contracts, and the number of MA contracts, exceeded the number of contracts at the beginning of our analysis period, 2000. MA organizations we interviewed generally attributed the 2005 increase in contracts primarily to the MMA payment increases, while acknowledging a lesser influence of the 2006-2007 local PPO moratorium and the implementation of the new drug benefit in 2006.

From 2000 to 2005, Health Maintenance Organization (HMOs) remained the dominant plan type of MA contract, but alternative types—especially PPOs—are growing in importance. In 2000, 259 of the 264 MA contracts, or 98 percent, were HMOs. In 2005, HMOs were 176 of 289 MA contracts, or 61 percent. PPOs grew from 1 to 93 contracts from 2000 to 2005, and comprised 32 percent of MA contracts in 2005. Provider-sponsored organizations (PSOs) and private fee-for-service plans accounted for only a small number of contracts throughout the

¹⁹ Typically most contracts are effective at the beginning of a calendar year. But in 2005, a significant number of new contracts continued to become effective well into the year. We counted contracts in June 2005, when many, but not all, new contracts effective in 2005 had been implemented. The continued entry of MA organizations throughout 2005 may be in part due to their desire to become operational prior to 2006.

period, but have also increased, especially in 2005. PFFS contracts tend to cover very large service areas relative to other plan types.

Percent of Counties with at least one Medicare contract. Because one of the goals of the recent legislative changes was to improve Medicare beneficiary access to Medicare health care plans, we also analyzed for each year between 2000 and 2005 the percent of counties in which at least one Medicare contract was available. Our findings are shown in *Table 3-2*.

Table 3-2
Percent of counties with at least one Medicare contract, by contract type

	Nov-00	Jun-01	Apr-02	Apr-03	Feb-04	Jun-05
MA Contracts						
Coordinated Care Plans						
HMO ¹	25.9%	20.3%	19.1%	17.8%	18.5%	29.0%
PPO ²	0.2	0.2	0.4	6.3	7.6	22.7
PSO	0.5	0.7	0.4	0.4	0.4	0.5
Non-coordinated care plans						
PFFS	52.7	52.7	51.6	54.9	40.6	92.9
Non MA Contracts						
COST	6.9	6.8	7.6	8.0	9.7	7.2
OTHER ³	5.4	3.7	2.1	2.8	2.6	1.0

¹ HMO includes HMO and HMO POS.

² PPO includes PPO Demo and PPO non-demo.

³ Other includes all other plans including all demonstrations except for the PPO demonstration.

SOURCE: RTI analysis of CMS Health Plan Management System data.

In 2000, almost 26 percent of counties had at least one Medicare HMO contract. By 2001, that figure had declined sharply to 20.3 percent, and fell gradually to 17.8 percent by 2003.

While the number of Medicare HMO contracts continued to decrease in 2004, the percent of counties with access to an HMO, rose slightly to 18.5 percent suggesting that in 2004, MCOs remaining in the Medicare Advantage program expanded service areas within existing HMO contracts. This may have been in response to BIPA-mandated increases in urban and rural floor payment rates in early 2004, or in anticipation of MMA payment increases implemented in March 2004. In 2005, there was a sizeable increase in the percent of counties (to 29 percent) with at least one HMO contract, corresponding to the increase in number of HMO contracts. In 2005, an HMO contract was available in a higher percentage of counties than in 2000.

The number of PPO contracts remained low until 2003, and increased from that point. Corresponding trends are seen in the percent of counties with access to a PPO. In 2003, 6.3 percent of counties had access to a Medicare PPO, increasing from less than one percent the year before. As noted above, this increase can be explained by the implementation of the Medicare PPO demonstration and the special payment methodology for these plans. Under the demonstration, the PPO demonstration plans were paid the higher of the county prevailing Medicare+Choice (M+C) payment rate or 99 percent of the FFS payment rate. For 2003, in most cases, the prevailing M+C rates represented the greater base payment. In addition, all but five PPOs negotiated various risk sharing arrangements based on preset medical loss ratios (MLRs). In most cases, CMS and the demonstration PPOs shared (generally at a rate of 50/50) losses and savings when and if the MCO's medical costs exceeded (or fell short of) the target MLRs. Each PPO that had a risk sharing arrangement with CMS, assumed full risk around the first 2 percent corridor of the MLR. Counties with access to a PPO increased sharply in 2005, corresponding to the large increase in PPO contracts apparently in anticipation of the moratorium on local PPOs in 2006; 22.7 percent of counties had access to a PPO in 2005, the first year in which the number of counties with a PPO approached the number of counties with an HMO.

The number of counties with access to a PFFS plan is quite large, particularly considering the relatively small number of PFFS contracts. In 2000, though there was only one PFFS contract, 52.7 percent of counties had access to a PFFS plan. The structure of the PFFS option appeared to favor large service areas under a single contract umbrella, possibly because of the much less demanding provider contracting structure. Though the number of PFFS contracts had increased to three by 2004, the number of counties with access to a PFFS plan actually decreased that year to 40.6 percent, suggesting that PFFS plans had contracted their service areas. However, by 2005, both the number of PFFS contracts and the number of counties with access to a PFFS plan increased significantly; 92.9 percent of counties had access to a PFFS plan, making PFFS options the most accessible MA option for Medicare beneficiaries.

Number and percent of beneficiaries with access to a Medicare plan. In addition to the percent of counties with access to a Medicare plan, we considered the number and percent of Medicare beneficiaries with access to a plan. This was an important distinction because Medicare beneficiaries are not equally distributed among counties. A large proportion of beneficiaries resided in a small proportion of heavily populated urban counties. *Table 3-3* displays our findings.

Though the number of Medicare contracts declined sharply between 2000 and 2004, the decrease in the percent of Medicare beneficiaries with access to at least one Medicare plan was less drastic. In 2000, 68.1 percent of Medicare beneficiaries had access to at least one Medicare HMO. This figure declined to a low of 57.4 percent in 2003; by 2003, the number of HMO contracts had declined by almost half. This suggests that HMOs were withdrawing from less populous counties, or that the number of HMO options in populous counties was dropping, but not to zero. The percent of Medicare beneficiaries with access to an HMO then climbed to just

Table 3-3
Number and percent of Medicare beneficiaries with access to a Medicare plan, by contract type

I. Number						
Plan Type	November-00	June-01	April-02	April-03	February-04	June-05
MA Plans	33,300,258	32,958,996	32,305,226	32,841,281	31,774,507	41,446,979
HMO¹	27,233,843	25,646,057	24,754,752	24,042,140	25,160,074	29,910,526
PPO²	598,318	864,952	1,693,642	9,625,333	10,660,896	23,881,603
PSO	513,200	575,404	538,567	2,161,369	2,197,186	3,336,570
PFFS	15,223,535	15,443,348	14,862,682	15,490,096	13,037,695	31,493,687
Non-MA Plans	10,755,703	9,353,162	7,880,791	10,205,817	10,573,385	6,938,781
COST	3,155,277	2,146,117	2,195,622	2,842,875	3,944,054	3,320,084
OTHER³	7,919,529	7,521,355	6,278,561	8,079,870	7,904,190	3,660,058

II. Percent						
Plan Type	November-00	June-01	April-02	April-03	February-04	June-05
MA Plans	83.3%	80.9%	78.3%	78.5%	74.8%	96.4%
HMO¹	68.1%	62.9%	60.0%	57.4%	59.2%	69.6%
PPO²	1.5%	2.1%	4.1%	23.0%	25.1%	55.5%
PSO	1.3%	1.4%	1.3%	5.2%	5.2%	7.8%
PFFS	38.1%	37.9%	36.0%	37.0%	30.7%	73.2%
Non-MA Plans	26.9%	23.0%	19.1%	24.4%	24.9%	16.1%
COST	7.9%	5.3%	5.3%	6.8%	9.3%	7.7%
OTHER³	19.8%	18.5%	15.2%	19.3%	18.6%	8.5%

¹ HMO includes HMO and HMO POS.

² PPO includes PPO Demo and PPO non-demo.

³ Other includes all other plans including all demonstrations except for the PPO demonstration.

SOURCE: RTI analysis of CMS Health Plan Management System data.

under 60 percent in 2004, and increased to 69.6 percent in 2005 – above the 2000 levels. The number of HMO contracts in 2005 was still well below 2000 levels, suggesting that the number of HMO options in less densely populated counties was lower in 2005.

Trends in Medicare beneficiary access to PPOs are also noteworthy. Consistent with the limited number of PPO contracts prior to 2003, few Medicare beneficiaries had access to a PPO. However, in 2003 and 2004, more than 20 percent of Medicare beneficiaries had access to a PPO (generally through the Medicare PPO demonstration). Because of the relatively few counties (less than 8 percent) with access to a PPO, the much larger percent of Medicare beneficiaries with access to a PPO suggests that PPO service areas tended to be concentrated in more densely populated counties. By June 2005, over one-half of all Medicare beneficiaries had access to a PPO, approaching the percent with access to an HMO.

Access of Medicare beneficiaries to a PFFS plan declined somewhat between 2000 (in which 38.1 percent of beneficiaries had access) and 2004 (30.7 percent of beneficiaries with

PFFS access), despite the fact that the number of PFFS contracts grew. But the percent of beneficiaries with access to a PFFS plan more than doubled to 73.2 percent in 2005. PFFS plans are the MA option that the most Medicare beneficiaries had access to in 2005. Also, converse to the pattern we observe in PPOs, while a very large percent of counties (92.9 percent) had at least one PFFS plan, a smaller percentage of Medicare beneficiaries had access to a PFFS plan (73.2 percent). This pattern suggests that PFFS plans are more likely to be offered in less populated counties.

Considering all types of MA plans together, more than three-quarters of beneficiaries had access to at least one MA plan throughout the 2000-2005 period, but the percentage with access declined from 2000 to 2004. In 2005, the pattern of declining access reversed dramatically, and virtually all beneficiaries (96 percent) had access to at least one MA plan.

Plan participation by urban designation. To further analyze how the legislated payment changes impacted access to Medicare plans, we analyzed plan participation by urban designation. We looked at the percent of counties with at least one HMO, PPO or PFFS contract by a range of urban/rural categories, from 2000 to 2005. Our results are shown in *Table 3-4*. We focus the discussion on HMO contracts because, during this period, these were the prevalent contract type.

From this analysis, a number of interesting trends emerge. A larger proportion of large urban counties had at least one HMO every year between 2000 and 2005 compared to any other county type. However, between 2000 and 2005, the percentage of large urban counties with at least one Medicare HMO declined from 75.8 percent to 63.3 percent. Some of the decline may arise from a substitution of PPO offerings for HMOs in large urban counties. Conversely, the percentage of medium urban counties with an HMO rose from 2000 to 2005, due to a large increase from 2004 to 2005. By June 2005, close to the same percentage of medium as large urban counties had access to an HMO. HMO access also rose sharply in 2005 in small urban counties, to a greater level than in 2000. But HMO availability in small urban counties remained poor, well below availability in larger urban counties.

It does not appear from these data that BIPA's creation of the urban floor (implemented in 2001 and applied to urban counties with population of at least 250,000) had much of an impact in its initial years in improving the portion of Medicare beneficiaries in these counties with access to at least one HMO. In urban counties with between 250,000 and one million population, the portion of Medicare beneficiaries with access to an HMO continued to decline even after the designation of the urban floor rate in 2001, increasing only in 2005 after the passage of the MMA. However, payment rates did increase most rapidly in mid-sized urban areas from 2000 to 2005 (*Table 1-4*), so perhaps when MA organizations were looking for areas to enter in 2005, mid-sized urban areas were especially attractive.

Table 3-4
Percent of counties with at least one contract, by contract type and urban designation

Urban Designation	Number of Counties	Nov-00	Jun-01	Apr-02	Apr-03	Feb-04	Jun-05
TOTAL							
HMO ¹	3,120	25.9%	20.3%	19.1%	17.7%	18.5%	29.0%
PPO ²		0.2	0.2	0.4	6.3	7.6	22.7
PFFS		52.7	52.7	51.6	54.9	40.6	92.9
Urban							
HMO ¹	1,089	51.8%	44.1%	39.5%	36.4%	38.1%	52.0%
PPO ²		0.5	0.6	1.0	14.6	17.4	43.5
PFFS		42.9	42.9	41.3	43.4	34.9	88.0
Large Urban							
HMO ¹	414	75.8%	64.3%	58.5%	52.4%	55.3%	63.3%
PPO ²		1.2	1.7	2.4	22.7	27.3	57.0
PFFS		33.6	33.6	31.6	29.7	25.8	81.2
Medium Urban							
HMO ¹	324	49.1%	44.4%	37.7%	37.0%	39.5%	58.6%
PPO ²		0.0	0.0	0.3	13.9	16.4	46.3
PFFS		50.3	50.3	48.5	51.5	41.7	92.0
Small Urban							
HMO ¹	351	25.9%	19.9%	18.8%	16.8%	16.5%	32.5%
PPO ²		0.0	0.0	0.0	5.7	6.6	25.1
PFFS		47.0	47.0	46.2	52.1	39.3	92.3
Rural							
HMO ¹	2,031	12.0%	7.5%	8.2%	7.7%	8.0%	16.6%
PPO ²		0.0	0.0	0.0	1.9	2.3	11.5
PFFS		57.9	57.9	57.1	61.1	43.7	95.5
Rural—Urban Adjacent							
HMO ¹	1,061	18.9%	12.0%	11.0%	12.1%	12.6%	25.1%
PPO ²		0.0	0.0	0.0	3.6	4.3	15.1
PFFS		57.0	57.0	55.8	61.1	44.3	94.9
Rural—Not Urban Adjacent							
HMO ¹	970	4.3%	2.7%	5.1%	3.0%	2.9%	7.4%
PPO ²		0.0	0.0	0.0	0.1	0.1	7.5
PFFS		58.9	58.9	58.6	61.0	43.1	96.1

¹ HMO includes HMO and HMO POS.

² PPO includes PPO demo and PPO non-Demo.

SOURCE: RTI analysis of CMS Health Plan Management System data.

Availability of HMOs in rural counties varied by population and proximity to urban areas, but remained poor for all categories of rural counties throughout the period. Rural availability did improve substantially in 2005 to a level exceeding availability in 2000. Increases in 2005 may be attributable to the increased floor rates that were part of the MMA provisions, and the minimum payment update percentage of the national Medicare spending growth rate. There was also a temporary increase in HMO availability observed in 2002 in rural counties. This temporary increase may correspond to floor rates reaching a high in 2002 of \$500 per member per month before falling again in 2003 to \$495 per member per month (because of the minimum 2 percent update, counties at the floor rate were actually paid \$510 in 2003).

PPOs were rarely offered anywhere before the inception of the PPO demonstration in 2003. The demonstration made PPOs available in a significant number of urban counties, but still a small proportion of the total. The availability of PPOs increased substantially in all areas in 2005. By 2005, PPOs were accessible in about half of large and medium urban counties, levels approaching the availability of HMOs. Like HMOs, PPOs were considerably less accessible in small urban and rural areas, but had established a limited presence in these areas by 2005.

In contrast to HMOs and PPOs, PFFS plans were available in a smaller portion of large urban than other counties throughout the period. Before 2005, PFFS plans were offered in roughly one-third of large urban counties and half of other counties. By 2005, they were available in 81 percent of large urban counties and over 90 percent of other counties.

Plan Participation by Census Region. To understand plan participation trends in different areas of the country, we analyzed plan participation by census regions. *Table 3-5* shows the number of different contract types in the Northeast, Midwest, South and West.

The number of HMO contracts participating in Medicare fell in all 4 regions between 2000 and 2004. The largest drop in contracts was observed in the South, where the number of HMO contracts fell by almost two-thirds (from 93 contracts in 2000 to 36 in 2004). HMO Contracts in the Midwest declined by more than half (from 58 to 25). Contracts also fell in the

Northeast and West, though at a more moderate rate. None of the census regions returned to their 2000 number of contracts, even after the MMA in 2005. Compared to HMOs, the number of PPO and PFFS contracts, though small, generally increased in 2005, likely as a result of the impending moratorium on local PPOs effective in 2006, and sharply increased payment rates effective beginning in March 2004.

Some of these findings appear contrary to the net payment rate changes affected by legislative changes after the BBA, as shown in *Table 1-5*. The South, with the largest number of initial contracts and the most significant decline through 2004, exhibited the lowest average county payment rates in 2000 and yet the sharpest increase in payments through 2004. One factor in explaining this finding may be that the South's average payment rate increase, with many rural counties, may have been driven up by the implementation of the floor payment rate, which we have found did little to encourage managed care penetration. Therefore, the exit of HMO contracts in the South may actually have been a result of the imposition of the 2 percent payment rate increase for most urban counties with the bulk of managed care contracts. Most MA

organizations we spoke with were clear that these minimum updates were insufficient; they may have been particularly problematic in the south, which historically had the lowest county rates.

Table 3-5
Number of contracts by census region, and contract type

Census region	Number of counties	Nov-00	Jun-01	Apr-02	Apr-03	Feb-04	Jun-05
Northeast	217						
HMO*		54	41	38	38	38	45
PPO**		1	1	1	11	13	20
PFFS		1	1	1	1	1	3
Midwest	1056						
HMO		58	42	33	26	25	33
PPO		0	1	1	9	11	23
PFFS		1	1	2	3	3	9
South	1425						
HMO		93	49	41	39	36	55
PPO		0	0	1	12	12	31
PFFS		1	1	1	2	2	6
West	423						
HMO		59	43	36	35	34	45
PPO		0	0	0	4	5	23
PFFS		4	4	5	7	7	22

* Includes HMO and HMO POS.

** PPO includes PPO demo and PPO non-Demo.

SOURCE: RTI analysis of CMS Health Plan Management System data.

We examine this issue further in *Table 3-6*, which shows the percent of counties with at least one Medicare managed care contract.

Table 3-6
Percent of counties with at least one contract, by census region, and contract type

Census Region	Number of Counties	Nov-00	Jun-01	Apr-02	Apr-03	Feb-04	Jun-05
Northeast	217						
HMO*		69.1%	60.4%	58.1%	57.1%	58.1%	63.1%
PPO**		2.3	2.3	2.3	32.7	34.1	56.7
PFFS		30.9	30.9	30.9	30.9	30.9	46.1
Midwest	1,056						
HMO		17.4	16.0	16.6	14.4	14.9	27.8
PPO		0.0	0.2	0.4	3.7	5.1	13.1
PFFS		49.3	49.3	49.3	57.8	48.9	100.0
South	1,425						
HMO		24.8	16.4	13.2	11.6	12.9	23.4
PPO		0.0	0.0	0.1	4.6	6.0	21.0
PFFS		58.9	58.9	52.7	53.7	33.4	98.2
West	423						
HMO		28.1	23.4	25.3	26.4	26.2	33.3
PPO		0.0	0.0	0.0	5.2	5.2	34.9
PFFS		51.3	51.3	64.3	64.2	49.3	80.7

* Includes HMO and HMO POS.

** PPO includes PPO demo and PPO non-Demo.

SOURCE: RTI analysis of CMS Health Plan Management System data.

While *Table 3-5* shows large decreases in the number of contracts between 2000 and 2004, negative impacts of pre-MMA legislative initiatives on the availability of at least one HMO or PPOs were more moderate. In the Northeast, availability of either an HMO or PPO remained the highest of the regions, likely related to its urbanized character and the historically high county payment rates found in this group of counties. However, the percentage of counties with at least one HMO did decrease slightly in the Northeast between June 2001 (post BIPA) and April 2003 (pre-MMA), then increasing again in 2004 and 2005.

In the Midwest, South, and West, availability of at least one HMO decreased somewhat in the post-BIPA and pre-MMA period. The percent of counties with at least one HMO in these three regions did improve substantially in 2005, with the implementation of the MMA. Even so, only a third or fewer counties in the Midwest, South or West offered access to at least one HMO.

Availability of PPOs in these regions was even lower. However, PFFS plans were far more prevalent outside of the Northeast. By 2005, the vast majority of beneficiaries living in Midwest, Southern or Western regions had access to a PFFS plan.

Plan Participation by Change in County Payment Rate. In our discussions with MCOs, we heard many comments that suggested that contract withdrawal or service area reduction decisions were often driven by the convergence of county payment rates that increased slowly and some dramatic increases in health care costs (particularly unanticipated increases in costs for prescription drugs and in some areas increased pressure from providers for higher payments from managed care organizations). *Tables 3-7* through *3-9* show the change in the number of contracts by the change in county aged payment rates.

Table 3-7 shows results for HMO contracts. Numbers in parentheses show contract withdrawals within categories of county monthly payment rate increases. Numbers without parentheses show the number of contract increases within each category of county monthly payment rate increases.²⁰ Figures are shown for important time periods in our analysis. In general, given comments from MA organizations, we might expect to see the majority of contract withdrawals clustered in counties with the lowest monthly payment rate increases.

Table 3-7
Change in the number of HMO¹ contracts, by change in aged payment rate

Date range	< \$25	\$25 - \$50	\$50 - \$75	\$75 - \$100	>\$100
November 2000 to June 2001	(66)	(27)	(27)	(15)	(8)
June 2001 to April 2002	(18)	(12)	.	.	.
April 2002 to April 2003	(1)	0	.	.	.
April 2003 to February 2004	(4)	5	.	.	.
February 2004 to June 2005	.	.	36	20	31

¹ HMO includes HMO and HMO POS.

SOURCE: RTI analysis of CMS Health Plan Management System data.

In fact, we observed that the majority of contract withdrawals in each year (indicated by figures in parentheses) were grouped in the counties with the lowest (less than \$25 change per member per month) payment category. In 2000, when post BBRA payment changes appeared to correspond with a large number of contract withdrawals, 66 of the 143 withdrawals that year are in the smallest payment rate increase category. The number of contract withdrawals then declined as the change in payment rate increases. This makes intuitive sense because the lowest-payment-increase counties were the highest paid counties. In the following years, corresponding to post BIPA payment rate changes, there were fewer withdrawals, but these continued to cluster in the counties with the smallest change in monthly payment rates. Interestingly, under the MMA

²⁰ A contract is considered present in a county payment change category if it is present in at least one county in this category in the relevant time period.

when payment rates generally increased, we saw contract additions in the counties with the higher payment rate changes, though the distribution is more mixed.

We observed somewhat different trends for changes in PPO contracts, as shown in **Table 3-8**. Because there were so few PPO contracts prior to the PPO demonstration (implemented in January 2003), there was very little change prior to 2003. However, when the demonstration was implemented, we observe all contracts clustered in the lowest payment increase category. This may be a function of the alternative payment rates available to demonstration plans, making the payment rate increase relative to the prior year a much less important factor for these demonstration contracts. During the initial post-MMA implementation period, we see a large increase in the number of PPOs joining the MA program, likely influenced by the impending moratorium in 2006 on local PPOs. For these PPO contracts, contract additions were clustered among the higher monthly payment rate counties.

Table 3-8
Change in the number of PPO¹ contracts, by change in aged payment rate

Date range	< \$25	\$25 - \$50	\$50 - \$75	\$75 - \$100	>\$100
November 2000 to June 2001	1	0	.	.	.
June 2001 to April 2002	2	0	.	.	.
April 2002 to April 2003	32	0	.	.	.
April 2003 to February 2004	2	7	.	.	.
February 2004 to June 2005	.	.	51	32	31

¹ PPO includes PPO demo and PPO non-demo.

SOURCE: RTI analysis of CMS Health Plan Management System data.

Finally, we analyzed changes in the number of PFFS contracts (**Table 3-9**). Very few changes in the number of contracts were observed prior to the MMA. After the MMA, as with changes in contracts for HMOs and PPOs, additional PFFS contracts were clustered in counties with higher increases in payment rates.

Table 3-9
Change in the number of PFFS contracts, by change in aged payment rate

Date range	< \$25	\$25 - \$50	\$50 - \$75	\$75 - \$100	>\$100
November 2000 to June 2001	0	0	0	0	0
June 2001 to April 2002	0	1	.	.	.
April 2002 to April 2003	1	0	.	.	.
April 2003 to February 2004	0	0	.	.	.
February 2004 to June 2005	.	.	10	6	8

SOURCE: RTI analysis of CMS Health Plan Management System data.

3.3.2 Multivariate Analysis

In this section, we focused on the impact of the additional MMA payments on plan entry and availability in 2005. We expected many factors affect plan availability, including the Medicare payment rate, the cost of providing care, geographic location (urban designation, Census region), physician bargaining power, hospital bargaining power, and population demographics. During our plan interviews, the health plans confirmed that these factors are important determinants that the plan would enter and offer an MA HMO plan or exit a particular county. Many of these factors are interrelated. Therefore, we conducted a multivariate analysis to determine the impact of legislated payment changes on plans' participation decision in the MA program adjusting for these other influences.

Simulation of MMA payment rate impact: We simulated the impact of the MMA payment rate on increased access to MA HMO plans in 2005. If the higher MMA payment rates increased access, then a larger number of counties with no Medicare HMO plans in 2004 would have at least one MA HMO plan in June 2005. Because some counties may have gained access to an MA HMO for reasons independent of the MMA payment changes, we measured the net impact of the MMA as the difference between the number of counties that we predicted to gain access to at least one MA HMO plan in 2005 under the MMA rates and the number of counties that we predicted would have gained access to at least one MA HMO plan in 2005 if rates remained at BIPA levels. In other words, the MMA's impact was the incremental number of counties gaining HMO access as a result of the higher MMA payment rates.

This simulation required two steps. In the first step, we estimated an entry model for MA HMOs into counties with no MA HMOs in February 2004 using the probit statistical technique. We estimated the model separately by urban designation: (1) urban counties, (2) rural counties adjacent to urban counties, and (3) rural non-adjacent counties using county level data for 2005. In the second step, we used the coefficients from the model to simulate the effect of the MMA payment rate on 2005 MA HMO plan entry.

The impact of the change in the MA payment rate on access was reflected in the increased number of counties predicted to gain access to at least one plan because of the MMA payment increases. *Table 3-10* shows the results of the simulation by urban designation. Because the number of counties without 2004 access predicted to gain 2005 access was very similar to the actual number gaining access, in Table 3-10 we estimate the MMA effect as the difference between the actual number gaining access and the number predicted to gain access without the MMA payment increases.

Analysis. The simulation estimates that an additional 4.5 percent of counties without an HMO in 2004 gained access to at least one MA HMO in June 2005 because of the MMA increases in plan payment rates. As a result, 115 more counties had an MA HMO plan in June 2005.

The simulated impact of the MMA payment rate on plan availability varied by urban designation. Urban counties gained the most from the MMA payment rate changes and an additional 9.8 percent of urban counties without an HMO in 2004 had an MA HMO in June 2005 because of the MMA payment changes. The MMA payment rate changes had a smaller impact

on rural counties, with less than 5 percent of rural counties without an HMO in 2004 gaining one by June 2005 due to the MMA changes. However, an estimated 31 additional rural, urban-adjacent counties, and 19 additional rural, non-urban-adjacent counties had access to an MA HMO in 2005 as a result of the MMA payment rate changes.

Table 3-10
Simulated impact of MMA payment rates on increased county access to MA HMOs
Counties with no MA HMO plan in 2004 gaining at least one MA HMO plan in June 2005

	Urban Counties	Rural, Urban- Adjacent Counties	Rural, Non- Adjacent Counties	All Counties
Number of counties without access to an MA HMO in 2004	674	927	942	2543
Actual Number of Counties gaining access to an MA HMO in 2005	150	132	44	326
Estimated Number of Counties gaining access in 2005 <i>without</i> the MMA payment rate	84	101	26	211
Estimated Change in the number of counties gaining access in 2005 because of the MMA payment rate	66	31	19	115
Estimated Percentage of counties without 2004 access gaining 2005 access because of the MMA payment rate increases	9.8%	3.3%	2.0%	4.5%

SOURCE: RTI analysis of CMS Health Plan Management System data.

The 100 percent of FFS MMA minimum benefited large urban counties and the urban floor benefiting counties in metropolitan areas with at least 250,000 in population was raised by the MMA. Many urban counties may already have had the infrastructure (physicians, hospitals, commercial HMO networks) to ease entry into the MA program. Rural counties adjacent to urban areas are not eligible for the urban floor and most already had payment rates above the rural floor even after the MMA increased the rural floor. As a result, MMA payment increases in these counties were limited. The MMA increased payments in rural, non-adjacent counties, but few unserved rural counties gained plans. The network requirements for MA HMOs might only have been feasible in urban counties or rural counties with some proximity to an urban area.

A caveat to our simulation results was the unusual nature of 2005 as the year prior to the implementation of the Medicare Part D prescription drug benefit and regional PPOs in 2006. Entry of plans in 2005 may have been driven by factors other than MMA payment increases, for example as plans positioned themselves as MA-prescription drug plans for the advent of the Part D drug benefit in 2006. Because plans may have wanted to be in place before 2006, there was considerable entry throughout the first nine months of 2005, so our results would have varied if we had chosen either an earlier month or a later month in 2005 to measure plan availability.

CHAPTER 4 PREMIUMS, BENEFITS, COST SHARING, AND OUT-OF-POCKET COSTS

4.1 Introduction

Medicare Advantage plans may be an important source of medical benefits and insurance protection for beneficiaries. MA plans may cover extra services, such as prescription drugs, that were not historically covered by the traditional Medicare fee-for-service program and may reduce or eliminate cost sharing (deductibles, coinsurance) that the traditional program includes for some services. Together, MA plans' premiums and benefits determine their enrollees' out-of-pocket costs. The attractiveness to Medicare beneficiaries of enrolling in MA plans will be closely related to their expected out-of-pocket costs in these plans.

The expected out-of-pocket costs for beneficiaries are anticipated to be related to the level of Medicare payments to the MA plans. As described in Chapter 1, the BBA, BBRA, BIPA, and MMA legislation modified Medicare payments to MA plans several times in the last decade. This chapter examines the effect of these legislative Acts on MA plan premiums and benefits over the period 2000 to 2005. We begin by summarizing MA organization perspectives on this linkage, derived from our discussions with MA organizations. Then, we analyze secondary data on plan premiums, benefits, cost sharing, and estimated beneficiary out-of-pocket costs.

4.2 Medicare Advantage Organization Perspectives

All MA organizations we interviewed modified benefit offerings in response to legislative changes to payment rates imposed from the 1997 BBA to the 2003 MMA. The degree of benefit changes varied among the MA plans, but, by and large, the payment rate reductions of the BBA prompted significant reductions. During the post-BBA period of the late 1990s, MA organizations raised premiums and cost-sharing requirements (e.g., copayments, coinsurance), reduced or eliminated prescription drug coverage, eliminated or raised out-of-pocket maximums, and scaled back on other benefits and services such as dental coverage. The payment increases of the 2000 BIPA did help stop the benefit reductions in some areas, but it was not until the 2003 MMA that the MA organizations we interviewed began to restore and enhance benefits that beneficiaries experienced before the BBA payment changes prompted reductions.

Premiums. Almost all of the organizations we interviewed implemented new premium requirements or increased premiums in the years immediately following the BBA. Some of the MA organizations, particularly smaller local plans, offered zero premium products prior to the BBA. All but one of these local plans formerly offering zero premium plans charged a premium to offset the change in payment rates. Many national and regional MA organizations significantly increased premiums in the years following the BBA. In some cases, premiums doubled over a few short years during the late 1990s and early 2000s.

These organizations took different approaches to offset payment rate changes from the BBA, but premium increases were one of the predominant forms of generating revenue for plans during a period of rising annual medical costs. In other cases, large premium increases were necessary for plans to remain viable or intact in service areas that were affected by the BBA's 2

percent minimum rate increase provision. One MA organization referred to their method for offsetting payment reductions with sharp medical cost increases as “payment differentials,” and stated that one-third of the payment differentials came out of premium increases, and the remaining two-thirds came out of additional cost-sharing requirements and service area reductions.

The 2000 BIPA did stop, to some degree, the level of premium increases for many of the MA organizations. However, the impact of this legislative initiative on restoring payment rates was small and did not address the large differentials between payment floors and high medical cost increases. The 2003 MMA, viewed by one MA organization as the “turnaround legislation,” has enabled plans to stabilize premiums beginning in 2004 and in some cases reduce premiums, although most MA organizations we interviewed maintained premium levels and made other benefits enhancements with the payment increases (e.g., restoring prescription drug benefits or reducing cost-sharing requirements).

Cost-sharing requirements. Similar to premiums, most MA organizations we interviewed increased cost-sharing requirements in the years following the BBA. The large, national plans made larger cost-sharing increases compared to regional and local plans. One local plan, whose service area was not impacted by the 2 percent minimum payment increase provision of the BBA, kept cost-sharing amounts stable over the study period. In contrast, one national plan raised copayments and coinsurance amounts across the board for an array of services, including office visits, inpatient hospitalizations, ambulatory care, and other services.

Raising copayments for primary and specialty office visits was a common benefit change made among most MA organizations following the payment cuts imposed from the BBA. Several MA organizations imposed an inpatient hospital stay copayment that did not exist prior to the BBA payment rate changes. Other plans that already had a modest inpatient hospital copayment increased the amount, albeit reluctantly. One national MA organization imposed copayments for the first time in the range of \$5–\$10 for primary care office visits. Another large MA organization imposed 20 percent coinsurance requirements to more closely match Medicare FFS cost sharing requirements for certain services.

Similar to premiums, the BIPA slowed the pace and in some cases stopped the trend to raise cost-sharing requirements as a means to offset low payment rates. In the case of most MA organizations we interviewed, copayments and coinsurance requirements have stabilized over the past two years because of MMA. One large plan concentrated most of their benefit improvements from the increased payments under the MMA towards reducing copayments for office visits and hospital stays and reducing the out-of-pocket maximum.

Drug Benefit. MA organizations we interviewed took different approaches to modifying their prescription drug benefit in response to legislative initiatives modifying payment methodology. For the companies that offered what they considered to be a “rich” drug benefit prior to the BBA payment changes, the drug benefit was scaled back. For one particular MA organization, the drug benefit after the BBA became an “empty benefit that was in essence no drug benefit at all.” Several of these plans had offered a limited brand name drug benefit in addition to an unlimited generic drug benefit offering, but some MA organizations dropped a brand name drug benefit entirely and others limited or capped the drug benefit contribution (e.g.,

\$500 or \$1,000 annual cap). A few of the smaller, local plans had not offered a drug benefit prior to the BBA, and they could not consider adding this benefit as an option until the enactment of the Part D program.

MMA payment increases led almost all the MA organizations interviewed to enhance their drug benefit. Plans that dropped brand name drug coverage entirely after the BBA have reinstated this benefit to varying degrees, including limited brand name drug coverage, an unlimited or more generous generic drug benefit, and more generous brand and generic drug coverage with higher caps. Other plans have expanded their drug formulary lists to include newer medications or lowered their tiered copayment requirements for formulary-approved or generic drugs.

4.3 Secondary Data Analysis

4.3.1 Descriptive Analysis

We analyzed trends in HMO plan premiums, benefits, and cost sharing from 2000 to 2005. We also analyzed changes in HMO enrollee out-of-pocket costs in 2004 resulting from the implementation of the MMA payment changes. We focused on HMOs because they represented more than 90 percent of Medicare Advantage enrollment throughout our analysis period. All of our analyses are for basic plans in HMO contracts, and are weighted by total contract enrollment (see Chapter 2). Analysis of basic plans measures trends in a consistent type of plan, the most affordable HMO option available to beneficiaries.

Premiums

National Trends. Premiums, together with cost sharing, determine the affordability of MA plans for Medicare beneficiaries. *Table 4-1* shows trends in monthly premiums for basic HMO plans. We examine trends in “net” premiums. Starting in 2003, plans were allowed to reduce the Medicare Part B premium as an added benefit to their enrollees. Enrollees in Part B premium reduction plans pay no plan premium, and a lower Medicare Part B premium than they would pay if they stayed in the traditional Medicare FFS program.²¹

Medicare HMO plans became considerably less affordable from 2000 to 2003. Average premiums rose sharply, nearly tripling over this period from \$12.95 to \$37.87. The proportion of enrollees in zero premium plans was cut nearly in half. This was clearly a period of retrenchment, as plans responded to the payment update restrictions of the BBA and cost pressures by attempting to raise revenue through higher premiums. The implementation of BIPA in March 2001 did result in reductions in plan premiums compared to those in effect in January/February 2001 (GAO, 2001). However, even after incorporating the effects of BIPA, average plan premiums nearly doubled from November 2000 to June 2001 (post-BIPA).

²¹ Part B premium reduction plans may increase cost sharing or reduce benefits as compared to non-premium reduction plans.

Table 4-1
Monthly premiums in basic HMO plans, 2000–2005

	<u>Pre-BIPA</u>	<u>Post-BIPA</u>	4/2002	4/2003	<u>Pre-MMA</u>	<u>Post-MMA</u>	
	11/2000	6/2001			2/2004	4/2004	6/2005
Enrollment-weighted mean premium	\$12.95	22.55	32.22	37.87	33.32	22.83	18.71
% of enrollment by premium range	100.0	100.0	100.0	100.0	100.0	100.0	100.0
\$0 with Part B premium reduction	N/A	N/A	N/A	0.1	1.0	7.3	5.6
0	64.0	45.8	39.8	37.1	45.8	46.4	57.7
1–24.99	12.4	12.7	6.8	5.4	4.8	10.7	7.5
25–49.99	14.0	23.3	21.1	22.0	15.3	10.8	8.0
50–74.99	6.6	11.5	17.7	11.8	12.8	14.7	12.7
75–99.99	2.9	5.9	12.3	19.1	15.0	7.6	6.3
100+	0.2	0.7	2.3	4.5	5.2	2.5	2.2

NOTES: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract’s lowest-premium plan in a service area county. N/A is “not applicable.” Mean premiums are weighted by contract/county enrollment.

SOURCE: RTI analysis of CMS Health Plan Management System and Enrollment Database data.

From 2003 to early 2004, prior to implementation of the MMA, average premiums fell by 12 percent. The reasons for this drop are not clear. Increases in floor payment rates scheduled under BIPA may have lowered premiums in these counties. Withdrawals or enrollment losses of higher-premium plans may have contributed. Plans may have felt they “overshot” in their earlier premium increases and reduced premiums to stem further enrollment losses, possibly emphasizing cost sharing increases instead. Anticipation of the MMA may have been a factor.

In March 2004, plans responded to the implementation of the MMA payment increases by reducing average premiums by \$10.49 or 31 percent. The percentage of enrollees in contracts with “Medicare Part B premium reduction” basic plans that reduce enrollees’ Part B premium rose from 1 to 7 percent, and the percentage in contracts with high-premium basic plans charging \$75 or more fell from 20 percent to 10 percent.

In 2005, a further \$4.12 reduction in average premiums occurred as the MMA payment changes continued to take hold.²² The percentage of enrollees in contracts with basic plans offsetting part of their Part B premium fell slightly, but the percentage in contracts with other zero premium plans rose sharply. By 2005, about the same proportion of beneficiaries was in contracts with zero premium basic plans as in 2000 (including Part B reduction plans with other zero premium plans in 2005). However, average premiums were higher in 2005 than in 2000, \$18.71 versus \$12.95.²³ A larger portion of enrollees were in contracts with higher premium basic plans in 2005 than 2000: 21 percent in contracts with basic plans with a premium of \$50 or more compared to only 10 percent in 2000. By 2005, average premiums had fallen to about half their peak level in 2003.

Overall, then, the premium affordability of basic HMO plans declined sharply from 2000 to 2003, but has improved significantly thereafter. By 2005, average premiums were higher than in 2000 because of a larger proportion of enrollees in contracts with higher-premium basic plans. But about the same proportion were in contracts with no premium basic plans, and a small portion of these beneficiaries in 2005 were in contracts with basic plans that reduced Medicare Part B premiums. .

Trends by Urbanicity. MA plan premiums varied in different areas. We examined trends in average premiums of basic HMO plans by urbanicity and region. Results by urbanicity are shown in *Table 4-2*. Throughout this period, premiums were lower in large urban areas, and highest in small urban areas and rural areas not adjacent to urban areas. Higher premiums may indicate the difficulty and higher costs of establishing plans in less urbanized areas reported by many MA organizations, and may deter greater beneficiary enrollment. Few beneficiaries have chosen to enroll and pay the higher premiums in less urbanized areas.²⁴ About three-quarters of total MA enrollment was in large urban areas, and more than 90 percent in large and medium urban areas combined throughout this period. Only 5 to 7 percent of MA enrollees were in small urban and rural areas (see Chapter 5).

Premiums in all areas showed the same overall trend of a sharp increase through the middle of the analysis period, then declined thereafter. But there were differences by area. Although dollar premium increases from 2000 to June 2001 were similar across areas, proportional increases were greatest in large urban areas, where average premiums more than doubled from \$9.28 to \$19.41. BIPA's increase in the minimum payment floor, and implementation of an urban floor may have limited premium increases in rural and mid-sized urban areas compared to large urban areas. However, despite these rate increases in rural areas, premiums in rural non-adjacent counties increased by the greatest net dollar amount during this

²² In 2005, plans had to use up all their contributions to the stabilization fund that was one allowed use of the 2004 MMA payment increases. Lowering 2005 premiums was one way to use the stabilization fund.

²³ Inflation as measured by the U.S. city average, all urban consumers, was only 11.7% between November 2001 and June 2005, so average premiums in 2005 were considerably higher than in 2000 even adjusting for economy-wide inflation (the average 2000 premium in 2005 dollars is \$14.47).

²⁴ Rural areas tend to be lower-income areas, and also areas in which there are fewer beneficiaries with employer-sponsored retiree health benefits that could be the source of MA enrollment.

time period; increases hovered around \$20 in premiums per month. Conversely, proportional decreases in premiums post-MMA were greatest in large urban areas, where premiums were cut in half from February 2004 to 2005. MMA's 100 percent of FFS costs minimum county payment rate was especially generous to large urban areas. In large and medium urban areas, average premiums peaked in 2003. In small urban and rural areas, premiums continued rising into early 2004, and fell proportionally less post-MMA.

Table 4-2
Mean monthly premiums in basic HMO plans by urbanicity,
2000 – 2005

	<u>Pre-BIPA</u>	<u>Post-BIPA</u>		<u>Pre-MMA</u>		<u>Post-MMA</u>	
	11/2000	6/2001	4/2002	4/2003	02/2004	04/2004	6/2005
Total	\$12.95	22.55	32.22	37.87	33.32	22.83	18.71
<u>Urban</u>	12.60	22.33	31.99	37.66	32.86	22.35	18.23
Large Urban	9.28	19.41	29.01	34.29	28.86	17.78	14.35
Medium Urban	23.68	32.91	43.63	50.64	46.47	39.34	30.82
Small Urban	34.07	42.90	52.48	60.78	67.95	53.83	51.22
<u>Rural</u>	25.92	33.11	41.81	46.12	50.15	39.70	34.20
Rural Urban-Adjacent	24.67	30.81	39.99	44.33	48.12	36.94	30.93
Rural Non-Adjacent	43.78	60.25	61.35	64.86	71.12	68.15	68.99

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest-premium plan in a service area county. Premiums are weighted by contract/county enrollment.

SOURCE: RTI analysis of CMS Health Plan Management System and Enrollment Database data.

Premiums were higher in every area in 2005 than in 2000, with the rate of growth lowest in medium urban and urban-adjacent rural areas. Despite policy interest in reducing disparities in the affordability of MA plans across areas, from 2000 to 2005 premium disparities between urban and rural areas were only slightly reduced. The rural-urban difference in premium declined from 106 percent higher in rural areas in 2000 (\$25.92 versus \$12.60) to 88 percent higher in rural areas in 2005 (\$34.20 versus \$18.23).

Trends by Region. *Table 4-3* shows trends in average premiums from 2000 to 2005 for the four Census regions. The Northeast, Midwest, and West showed the same pattern as the national average premiums. The average premiums rose to a peak in 2003, then declined through

2005 to levels that still exceed premiums in 2000. Premiums in the Northeast were only 14 percent higher in 2005 than in 2000, while they were 64 percent higher in the Midwest, and 90 percent higher in the West. Consequently, while in 2000 average premiums in the Northeast were the highest in the country, by 2005, they were lower than average premiums in the West and Midwest. These shifts appear to be related to relatively generous MMA payment increases in the Northeast versus the Midwest and the West (see *Table 1-5*). Premiums in the Northeast were still the highest in the country in early 2004, but fell more rapidly with the implementation of the MMA in March 2004.

Table 4-3
Mean monthly premiums in basic HMO plans by census region, 2000–2005

	Pre-BIPA	Post-BIPA		Pre-MMA		Post-MMA	
	11/2000	6/2001	4/2002	4/2003	02/2004	04/2004	6/2005
Total	\$12.95	22.55	32.22	37.87	33.32	22.83	18.71
<u>Region</u>							
Northeast	16.98	31.66	39.21	50.44	43.53	27.74	19.36
Midwest	13.30	17.18	25.48	29.14	26.74	24.37	21.85
South	7.66	14.18	12.16	9.99	8.64	2.95	3.15
West	13.47	22.90	39.47	44.94	39.86	28.61	25.58

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest-premium plan in a service area county. Premiums are weighted by contract/county enrollment.

SOURCE: RTI analysis of CMS Health Plan Management System and Enrollment Database data.

Premiums in the West nearly doubled from 2000 to 2005, the highest rate of increase of any region. This is consistent with the fact that the West benefited the least cumulatively over this period from the BIPA and MMA payment increases (see *Table 1-5*). The Midwest benefited the most from the BIPA payment increases (*Table 1-5*), and shows the slowest rate of average premium increase from November 2000 to June 2001 (BIPA was implemented in March 2001). However, the Midwest did not fare as well under MMA, therefore premiums declined relatively slowly after early 2004.

Average premiums in the South show a distinctly different trend from the other regions over this period. Southern premiums peaked in 2001, two years before those in other regions. They then declined through 2004, but unlike other regions, rose slightly in 2005. Premiums in the South were the lowest in the country throughout this period. In 2000, they were about half those in other regions. By 2005, they had declined to approximately one-seventh of the premiums in other regions. The South was the only region in which premiums were lower in 2005 than in 2000. The behavior of Southern premiums was hard to fully explain by payment

changes. But cumulatively from 2000 to 2005, the South benefited more than any other region from the BIPA and MMA payment increases (*Table 1-5*).

Relationship of Premium Changes to County Payment Rate Changes. In addition to examining overall trends in premiums, we analyzed the change in premiums by the change in the county payment rate for selected time periods. As we discussed in Section 1, the legislative Acts changed payment rates differentially across counties. If the payment changes are affecting plan premiums, we would expect to see larger premium reductions among plans offered in counties where payment rates rose the most.

We investigated the relationship between payment increases and premium reductions over the period November 2000 to June 2001, which straddled the implementation of the BIPA payment changes in March 2001. *Table 4-4* shows changes in premiums of basic HMO plans post-BIPA by the amount of the increase in the county payment rate. Over this period premiums were rising rapidly, by 66 percent overall. But we observe an inverse relationship between payment increases and premium changes. The average premium rose the most in the counties with the lowest payment increases while the premium rose the least or even fell in counties with the largest payment increases. For example, in counties where payment grew by less than \$25, the average premium rose by \$10.15, or 118 percent, while in counties where payment rose by \$100 or more, the average premium fell by \$2.98, or -6 percent.

We also investigated payment and premium changes from February to April 2004, before and after the MMA payment increases in March 2004. *Table 4-5* shows the results. Overall, premiums fell by 32 percent post-MMA. But the amount of the premium reduction varies with the amount of payment increase. For example, in counties where payment rose by less than \$25, the average premium fell by \$5.37 or 14 percent. In counties where average payment rose by \$100 or more, the average premium fell by \$26.18 or 74 percent. The relationship between larger payment increases and greater premium reductions is consistent across the range of payment increases. This relationship is strong evidence that it is the legislated payment changes that are causing the premium reductions observed from February to April 2004, and not other factors that may affect premium trends over time.

National Trends in Benefits and Cost Sharing, 2000 to 2005

We examined national trends in selected MA plan supplemental benefits and cost sharing over our analysis period, 2000 to 2005. We begin with a discussion of trends in prescription drug benefits, then consider trends in selected other supplemental benefits and in cost sharing.

Prescription Drug Benefits. Coverage of prescription drugs—especially brand name drugs—is one of the most valuable and attractive additional benefits offered by MA plans. *Table 4-6* shows trends 2000 to 2005 in coverage of prescription drugs in basic HMO plans. In 2000, 78 percent of enrollees were in contracts with basic plans that had some coverage for brand drugs. By early 2004, this number had sunk to only 27 percent. Over the same period, the proportion of enrollees in contracts with basic plans without any drug benefit had nearly doubled from 17 to 31 percent. The implementation of BIPA in 2001 did not stem this tide of reduced drug coverage. With the implementation of the MMA in March 2004, drug coverage did improve. The proportion of enrollees in contracts with basic plans with brand coverage increased

Table 4-4
Change in premiums of basic HMO plans by change in county payment rate, November 2000 to June 2001
(Pre/Post BIPA)

Change in county payment rate	Number of counties	11/00 % HMO enrollment	Average payment rate				Average premium			
			11/00	6/01	Change	% Change	11/00	6/01	Change	% Change
All counties	3,121	100.0%	\$564.43	\$597.83	\$33.40	5.9	\$12.95	\$21.53	\$8.58	66.2
<u>Change</u>										
<\$25	1,060	78.6	592.73	617.10	24.37	4.1	8.57	18.72	10.15	118.3
\$25–49.99	518	8.5	484.36	522.24	37.88	7.8	16.61	20.44	3.83	23.0
\$50–74.99	1,359	6.6	455.30	520.43	65.13	14.3	37.15	42.92	5.77	15.5
\$75–99.99	86	4.7	439.58	525.00	85.42	19.4	34.58	36.72	2.14	6.2
\$100+	98	1.6	412.16	525.00	112.84	27.4	46.27	43.29	-2.98	-6.4
<u>% Change</u>										
2%–4.9%	1,014	78.0	593.75	617.60	23.85	4.0	8.30	18.55	10.25	123.6
5%–9.9%	432	8.5	484.79	521.48	36.69	7.6	18.12	22.20	4.08	22.5
10%–14.9%	440	5.2	463.99	522.84	58.85	12.7	33.10	38.84	5.74	17.3
15%–19.9%	1,089	5.2	440.69	520.79	80.10	18.2	38.29	40.31	2.02	5.3
20.0%+	146	3.1	422.14	525.00	102.86	24.4	39.47	38.32	-1.15	-2.9

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Payment rates are aged A+B demographic rates. Payment rates and premiums are weighted by contract/county enrollment. Benefits Improvement and Protection Act payment increases took effect in March 2001.

SOURCE: RTI analysis of CMS Health Plan Management System and Enrollment Database data.

Table 4-5
Change in premiums of basic HMO plans by change in county payment rate, February to April 2004
(Pre/Post MMA)

Change in county payment rate	Number of counties	2/04 % HMO enrollment	Average payment rate				Average premium ¹			
			2/04	4/04	Change	% Change	2/04	4/04	Change	% Change
All counties	3,121	100.0%	\$649.08	\$694.11	\$45.03	6.9	\$33.32	\$22.83	-\$10.49	-31.5
<u>Change</u>										
<\$25	2,064	33.7	591.36	613.19	21.83	3.7	37.66	32.29	-5.37	-14.3
\$25–49.99	378	38.2	712.44	747.99	35.55	5.0	23.59	16.42	-7.17	-30.4
\$50–74.99	211	9.9	617.27	676.92	59.65	9.7	58.39	39.15	-19.24	-32.9
\$75–99.99	267	13.3	637.33	724.29	86.96	13.6	30.86	10.14	-20.72	-67.1
\$100+	201	5.0	647.41	781.74	134.33	20.7	35.57	9.39	-26.18	-73.6
<u>% Change</u>										
2%–4.9%	2,168	55.9	654.86	679.84	24.98	3.8	26.12	21.21	-4.91	-18.8
5%–9.9%	333	21.5	651.35	697.60	46.25	7.1	48.08	35.85	-12.23	-25.4
10%–14.9%	337	13.8	637.47	715.37	77.90	12.2	34.99	15.11	-19.88	-56.8
15%–19.9%	133	5.7	607.42	706.77	99.35	16.4	49.09	16.58	-32.51	-66.2
20.0%+	150	3.1	657.62	806.43	148.81	22.6	24.44	7.79	-16.65	-68.1

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Payment rates are aged A+B demographic rates. Payment rates and premiums are weighted by contract/county enrollment. Medicare Modernization Act payment increases took effect in March 2004.

SOURCE: RTI analysis of CMS Health Plan Management System and Enrollment Database data.

Table 4-6
Prescription drug benefits in basic HMO plans, 2000–2005

Type of Drug Benefit	Percent of contract enrollees						
	11/2000	6/2001	4/2002	4/2003	2/2004	4/2004	6/2005
No Benefit	16.8	30.3	27.9	31.0	31.4	28.6	24.8
Generics Only	4.8	7.3	20.7	26.8	41.3	32.0	35.8
Generics and Brand Name	78.4	62.4	51.4	42.1	27.3	39.4	39.4

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Medicare Modernization Act payment increases took effect in March 2004.

SOURCE: RTI analysis of CMS Health Plan Management System, and Enrollment Database data.

from 27 to 39 percent, and the proportion in contracts with basic plans with no drug benefit declined from 31 percent in early 2004 to 29 percent later in 2004 and 25 percent in 2005. However, in 2005, drug coverage was much less generous than in 2000. Only 39 percent of enrollees versus 78 percent in 2000 were in contracts with basic plans that had brand coverage, and 25 percent were in contracts with basic plans that had no drug benefit in 2005 versus 17 percent in 2000.

Selected Non-Drug Benefits. *Table 4-7* shows trends 2000 to 2005 in selected major additional non-drug²⁵ benefits sometimes covered by MA plans. For all benefits except podiatry, the percentage of beneficiaries in contracts with basic HMO plans covering the additional non-drug benefits declined from 2000 through early 2004, then rose post-MMA (later 2004 and 2005), but remained lower in 2005 than in 2000. The extent of changes in coverage varied across benefits. Hearing and dental benefits suffered especially sharp declines early in the decade, and coverage had only partially recovered by 2005. Most HMO basic plan enrollees had vision benefits throughout our analysis period, and a few had chiropractic benefits. Overall, these trends showed a significant decline in generosity of HMO additional benefits early in the decade that was not reversed by BIPA, but a partial restoration of benefits post-MMA.

Cost Sharing. *Table 4-8* shows trends 2000 to 2005 in basic HMO plan cost sharing for selected services. Cost sharing increased substantially in the early years of the decade, then declined or stabilized post-MMA. For example, less than one percent of enrollees were in contracts with basic plans with a primary care physician copayment greater than \$15 in 2000. This percentage rose to 24 percent by early 2004, then fell to 12 to 13 percent post-MMA. The percentage of enrollees with a basic plan specialist physician copayment greater than \$15 rose from 9 percent in 2000 to 71 percent in early 2004, then moderated to 60 percent in 2005. Only about half of enrollees were in a contract with a basic plan with more than a \$40 emergency room copayment in 2000, but from 2003 on, 90 percent or more were, with no decline post-MMA.

²⁵ Additional to standard Medicare fee-for-service benefits, that is, not covered under traditional Medicare.

Table 4-7
Additional benefits in basic HMO plans, 2000–2005

Benefit	Percent of enrollees with listed benefit in their contract's basic plan						
	Pre-BIPA					Post-MMA	
	11/2000	6/2001	4/2002	4/2003	2/2004	4/2004	6/2005
Vision	96.5%	95.3%	88.3%	88.7%	87.7%	92.7%	93.4%
Hearing	92.4	79.5	58.9	57.3	54.0	61.7	62.9
Dental ¹	48.1	31.2	22.0	19.3	16.4	20.2	25.3
Podiatry	28.2	30.2	27.8	27.5	29.3	30.0	28.8
Chiropractic	7.7	5.9	4.8	4.8	2.2	3.4	4.1

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Medicare Modernization Act payment increases took effect in March 2004.

¹Preventative and comprehensive dental coverage.

SOURCE: RTI analysis of CMS Health Plan Management System and Enrollment Database data.

Table 4-8
Cost sharing for selected services in basic HMO plans, 2000–2005

	Percent of contract enrollees						
	Pre-BIPA		Post-BIPA		Pre-MMA		Post-MMA
	11/2000	6/2001	4/2002	4/2003	2/2004	4/2004	6/2005
Primary Care							
Physician Copayment:							
\$0	9.7	5.3	5.6	6.5	9.0	10.9	14.7
\$1–\$5	29.1	22.9	12.8	5.8	6.1	15.0	21.4
\$5.01–\$10	53.3	55.8	58.0	45.5	39.8	44.1	34.1
\$10.01–\$15	7.1	13.3	20.2	17.8	21.1	18.2	17.2
\$15.01+	0.7	2.7	3.5	24.5	23.9	11.7	12.6
Coinsurance	0.0	0.0	0.1	0.4	0.4	0.4	1.1
Specialist Physician							
Copayment:							
\$0	10.0	5.6	3.5	4.0	4.9	3.8	5.8
\$1–\$5	24.7	17.0	6.8	1.7	1.1	1.9	4.9
\$5.01–\$10	37.0	36.9	35.2	11.7	8.8	20.9	17.4
\$10.01–\$15	19.0	19.1	14.2	19.1	13.9	13.2	11.6
\$15.01+	9.3	21.3	40.4	63.5	71.4	60.2	60.2
Coinsurance	0.0	0.0	0.1	0.5	1.9	1.2	1.1
Emergency Room							
Copayment:							
\$0	3.3	4.4	4.9	4.3	6.3	2.7	2.4
\$1–\$20	13.8	12.5	0.5	0.0	0.0	0.0	0.0
\$20.01–\$40	33.6	30.3	12.2	5.6	2.3	2.3	2.5
\$40.01–\$50	49.2	52.9	82.3	90.1	91.4	95.0	95.1
Any Cost Sharing							
Acute Hospital							
Admission	19.5	32.6	77.5	82.2	88.3	86.5	86.5
Hospital Outpatient	30.1	43.5	70.8	57.7	59.8	59.8	59.2
X-Ray Services	10.9	30.5	30.2	43.9	67.4	66.3	67.5
Laboratory Services	5.9	27.9	19.7	26.7	46.4	43.4	44.9

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Medicare Modernization Act payment increases took effect in March 2004.

SOURCE: RTI analysis of CMS Health Plan Management System and Enrollment Database data.

Hospital use represents potentially the largest source of cost sharing for MA enrollees. In 2000, only 19 percent of enrollees were in contracts with basic HMO plans that charged any cost sharing for acute hospital admissions. This percentage rose to 88 percent in early 2004 and remained near that level through 2005 despite the March 2004 MMA payment increases. In 2000, only 30 percent of enrollees were in contracts with basic plans that charged for use of hospital outpatient services. This percentage doubled and stabilized at about 60 percent from 2003 on. The percentage of enrollees in contracts with basic plans that required cost sharing for X-ray and clinical laboratory services rose sharply through early 2004, and then leveled off, but did not decline, with the MMA payment increases in March 2004.

Overall, the picture is of increasing cost sharing from 2000 to 2005. Sharp increases occurred early in this period, despite the implementation of BIPA in March 2001. Post MMA, some declines are evident, such as in physician visit copayments, but cost sharing for many services appears to have leveled off rather than been rolled back. Cost sharing, however, is complex, and the trends presented in this section do not measure all aspects of changes in cost sharing. For example, for hospital use, we looked only at the percentage of enrollees charged any cost sharing, not changes in the level of cost sharing imposed. The next section takes a more comprehensive look at changes in cost sharing pre- and post-MMA in 2004.

Effect of the Medicare Modernization Act on Beneficiary Out-of-pocket Costs

The result of changes in plan premiums, benefits, and cost sharing may be summarized as changes in enrollee out-of-pocket costs. Out-of-pocket costs are the total expenditures that enrollees pay for their medical care.²⁶ Changes in out-of-pocket costs summarize financial benefits to enrollees of the additional financing provided under the MMA. Out-of-pocket costs do not measure all uses of MMA financing that are of value to enrollees. In particular, plans reported using some of the MMA financing to maintain or expand provider networks. Access to providers is not captured by out-of-pocket costs.

CMS and its contractor Fu Associates have estimated out-of-pocket costs for enrollees in each Medicare Advantage plan. These data estimate out-of-pocket costs of a beneficiary using the same medical services in each area, without reflecting any area- or plan-specific differences in utilization that may exist. Thus, the data compare out-of-pocket costs consistently across plans, but they do not necessarily accurately estimate actual out-of-pocket costs when medical care utilization patterns differ across areas. Consistent data are available to estimate the change in out-of-pocket costs arising from the implementation of MMA payment increases in March 2004. As in other analyses in this chapter, to analyze changes in a consistent type of plan, we limit our analyses to basic plans in HMO contracts.

Overall Change. *Table 4-9* shows estimated changes in enrollee monthly out-of-pocket costs from February to April 2004. In this short-run period, the implementation of the MMA is estimated to have reduced the average enrollee's monthly out-of-pocket costs by \$23.27, or 5.9 percent. Nearly half of the reduction, or \$10.62, was due to lower premiums, with almost all of that reduction in the plan premium rather than the Medicare Part B premium.²⁷ About one-third of the reduction, or \$7.52, was due to improved prescription drug benefits. The remaining one-fifth, or \$5.10, was due to lower cost sharing or improved benefits for non-drug medical care. Half of the reduction in medical costs resulted from better coverage of acute hospital inpatient costs.

²⁶ Excluding long-term care expenditures.

²⁷ Because of slight differences in the sample of plans available for the two analyses, numerical results for premiums in the out-of-pocket cost analysis may differ slightly from the premium results presented earlier in this chapter.

Table 4-9
Change in estimated monthly out-of-pocket (OOP) costs of enrollees in basic HMO plans,
February to April 2004
(Pre/Post MMA)

	Average estimated OOP cost			
	2/04	4/04	Change	% Change
Total	\$394.13	\$370.86	-\$23.27	-5.9%
Total Premium	100.41	89.79	-10.62	-10.6
Medicare Part B Premium	66.48	65.67	-0.81	-1.2
HMO Plan Premium	33.93	24.12	-9.81	-28.9
Prescription Drugs	220.04	212.52	-7.52	-3.4
Medical Care, Total	73.66	68.56	-5.10	-6.9
Acute Inpatient Hospital	25.71	23.15	-2.56	-10.0
Outpatient Hospital	0.90	0.79	-0.11	-12.2
Primary Care Physician	3.37	2.85	-0.52	-15.4
Physician Specialist	7.04	6.53	-0.51	-7.2
Emergency Room	1.33	1.30	-0.03	-2.3
Dental ¹	20.56	20.25	-0.31	-1.5
Durable Medical Equipment	3.14	3.12	-0.02	-0.6
Home Health Agency	0.37	0.33	-0.04	-10.8
Other Services	11.24	10.24	-1.00	-8.9

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Weighted by contract/county enrollment. Medicare Modernization Act payment increases took effect in March 2004.

¹Preventative and comprehensive dental.

SOURCE: RTI analysis of CMS Health Plan Management System, out-of-pocket cost estimates, and Enrollment Database data.

Change by Health Status. Plans can distribute changes in out-of-pocket costs across premiums, benefits, and cost sharing in ways that differentially affect (and differentially attract) enrollees in good and poor health. For example, reductions in premiums benefit all enrollees equally since MA plans are required to charge the same premiums to all their enrollees. But reductions in cost sharing will disproportionately benefit sicker enrollees who use medical services more heavily.

Enrollees of all health statuses benefited from post-MMA reductions in out-of-pocket costs (*Table 4-10*). Reductions in premiums do not vary by health status. Reductions in out-of-pocket costs for prescription drugs and medical care are larger for enrollees in poorer health status, who consume more of these services. The estimated total reduction in monthly out-of-pocket costs was \$17.21, or 6.9 percent, for enrollees in excellent health compared to \$29.63, or 5.6 percent, for enrollees in poor health. The post-MMA changes reverse some of the substantial

increases in out-of-pocket costs that had been imposed on MA enrollees in poor health through increased cost sharing and benefit reductions earlier in the decade (Achman and Harris, 2005).

Change by Urbanicity. *Table 4-11* shows estimated changes in total monthly out-of-pocket costs by urbanicity. Large urban areas benefited the most on average from MMA payment increases (see *Table 1-4*) and they show the largest reduction in out-of-pocket costs post-MMA. Rural areas not adjacent to urban areas show little reduction in out-of-pocket costs post-MMA, but less than one percent of HMO enrollees resided in such areas. Reductions in medium and small urban, and rural urban-adjacent areas lie between these two extremes. Large variations in simulated out-of-pocket costs by urbanicity remained post-MMA, with small urban and rural HMO enrollees estimated to pay considerably higher amounts out-of-pocket than HMO enrollees in large urban areas. Perhaps related to this, less than six percent of Medicare HMO enrollment was in small urban and rural areas.

Change by Region. *Table 4-12* shows estimated changes in total monthly out-of-pocket costs by Census region. The largest estimated reduction in out-of-pocket costs post-MMA occurred in the South. The second largest occurred in the Northeast. These two regions benefited the most from MMA payment increases, but the Northeast benefited more than the South (*Table 1-5*). The Midwest benefited the least from the MMA on average, and out-of-pocket costs declined the least there. Post-MMA, estimated out-of-pocket costs were highest in the Midwest, 23 percent greater than in the South, the lowest-cost region.

Change by County Payment Rate Change. *Table 4-13* shows changes in estimated total out-of-pocket costs by change in county payment rate from February to April 2004 (pre to post MMA). As was true of premiums, there is a strong inverse relationship between payment increases and out-of-pocket cost reductions. For example, in counties where payment rose \$100 or more, out-of-pocket costs fell by \$64.55 on average, while in counties where payment increased less than \$25, out-of-pocket costs fell by only \$11.49 on average. This establishes a clear relationship between extra financing provided under the MMA and reductions in MA plan enrollee out-of-pocket costs.

Table 4-10
Change in estimated monthly out-of-pocket (OOP) costs of enrollees in basic HMO plans
by enrollee health status, February to April 2004
(Pre/Post MMA)

Health status	Cost category	Average estimated OOP cost			
		2/04	4/04	Change	% Change
Overall		\$394.13	\$370.86	-\$23.27	-5.9%
Excellent	Total cost	250.20	232.99	-17.21	-6.9
	Total premium ¹	100.41	89.79	-10.62	-10.6
	Prescription drugs	98.23	94.12	-4.11	-4.2
	Medical care	51.56	49.08	-2.48	-4.8
Very good	Total cost	304.53	285.41	-19.12	-6.3
	Total premium ¹	100.41	89.79	-10.62	-10.6
	Prescription drugs	154.92	149.31	-5.61	-3.6
	Medical care	49.20	46.32	-2.88	-5.9
Good	Total cost	364.94	343.19	-21.75	-6.0
	Total premium ¹	100.41	89.79	-10.62	-10.6
	Prescription drugs	200.26	193.16	-7.10	-3.5
	Medical care	64.27	60.25	-4.02	-6.3
Fair	Total cost	425.57	400.93	-24.64	-5.8
	Total premium ¹	100.41	89.79	-10.62	-10.6
	Prescription drugs	248.83	240.51	-8.32	-3.3
	Medical care	76.33	70.64	-5.69	-7.5
Poor	Total cost	531.83	502.20	-29.63	-5.6
	Total premium ¹	100.41	89.79	-10.62	-10.6
	Prescription drugs	321.19	311.00	-10.19	-3.2
	Medical care	110.23	101.41	-8.82	-8.0

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Weighted by contract/county enrollment. Medicare Modernization Act payment increases took effect in March 2004.

¹Includes Medicare Part B premium (less any plan Part B premium reduction) and HMO plan premium.

SOURCE: RTI analysis of CMS Health Plan Management System, out-of-pocket cost estimates, and Enrollment Database data.

Table 4-11
Change in estimated monthly out-of-pocket (OOP) cost of enrollees in basic HMO plans by
urbanicity, February to April 2004
(Pre/Post MMA)

	Number of counties	2/04 % HMO enrollment	Average estimated OOP cost			
			2/04	4/04	Change	% Change
Total	3,120	100.0%	\$394.13	\$370.86	-\$23.27	-5.9%
<u>Urban</u>	1,089	97.3	393.06	369.50	-23.56	-6.0
Large Urban	414	78.5	387.68	362.15	-25.53	-6.6
Medium Urban	324	16.1	413.41	398.30	-15.11	-3.7
Small Urban	351	2.7	428.31	411.04	-17.27	-4.0
<u>Rural</u>	2,031	2.7	432.27	419.23	-13.04	-3.0
Rural Urban- Adjacent	1,061	2.5	430.69	416.77	-13.92	-3.2
Rural Non-Adjacent	970	0.2	448.57	444.67	-3.90	-0.9

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Weighted by contract/county enrollment. Medicare Modernization Act payment increases took effect in March 2004.

SOURCE: RTI analysis of CMS Health Plan Management System, out-of-pocket cost estimates, and Enrollment Database data.

Table 4-12
Change in estimated monthly out-of-pocket (OOP) cost of enrollees in basic HMO plans by
census region, February to April 2004
(Pre/Post MMA)

	Number of counties	2/04 % HMO enrollment	Average estimated OOP cost			
			2/04	4/04	Change	% Change
Total	3,121	100.0%	\$394.13	\$370.86	-\$23.27	-5.9%
<u>Census Region</u>						
Northeast	217	27.3	417.76	394.62	-23.14	-5.5
Midwest	1,056	10.4	429.49	412.48	-17.01	-4.0
South	1,425	19.8	370.78	335.81	-34.97	-9.4
West	423	42.6	381.15	361.80	-19.35	-5.1

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Weighted by contract/county enrollment. Medicare Modernization Act payment increases took effect in March 2004.

SOURCE: RTI analysis of CMS Health Plan Management System, out-of-pocket cost estimates, and Enrollment Database data.

Table 4-13
Change in estimated out-of-pocket (OOP) costs of enrollees in basic HMO plans by change in county payment rate,
February to April 2004
(Pre/Post MMA)

Change in county payment rate	Number of counties	2/04 % HMO enrollment	Average payment rate				Average estimated OOP cost			
			2/04	4/04	Change	% Change	2/04	4/04	Change	% Change
All counties	3,121	100.0%	\$649.08	\$694.11	\$45.03	6.9%	\$394.13	\$370.86	-23.27	-5.9%
<u>Change</u>										
<\$25	2,064	33.7	591.36	613.19	21.83	3.7	410.45	398.96	-11.49	-2.8
\$25–49.99	378	38.2	712.44	747.99	35.55	5.0	375.46	356.55	-18.91	-5.0
\$50–74.99	211	9.9	617.27	676.92	59.65	9.7	412.63	378.26	-34.37	-8.3
\$75–99.99	267	13.3	637.33	724.29	86.96	13.6	391.53	349.10	-42.43	-10.8
\$100+	201	5.0	647.41	781.74	134.33	20.7	398.70	334.15	-64.55	-16.2
<u>% Change</u>										
2%–4.9%	2,168	55.9	654.86	679.84	24.98	3.8	391.39	377.73	-13.66	-3.5
5%–9.9%	333	21.5	651.35	697.60	46.25	7.1	399.23	376.34	-22.89	-5.7
10%–14.9%	337	13.8	637.47	715.37	77.9	12.2	391.47	353.05	-38.42	-9.8
15%–19.9%	133	5.7	607.42	706.77	99.35	16.4	410.13	343.06	-67.07	-16.4
20.0%+	150	3.1	657.62	806.43	148.81	22.6	390.48	340.86	-49.62	-12.7

NOTE: Includes HMO and HMO-POS plan types. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam. Basic plans are a contract's lowest premium plan in a service area county. Weighted by contract/county enrollment. Medicare Modernization Act payment increases took effect in March 2004.

SOURCE: RTI analysis of CMS Health Plan Management System, out-of-pocket cost estimates, and Enrollment Database data.

Overall, the enrollment-weighted county payment rate rose by \$45.03 post-MMA (*Table 4-13*). Enrollment-weighted average out-of-pocket costs fell by \$23.27. Hence, basic HMO plans used very close to one-half (52 percent) of extra MMA payments in 2004 to reduce enrollee out-of-pocket costs. This is consistent with plans' reports that they used 53 percent of extra 2004 MMA payments to lower premiums, enhance benefits, or cut cost sharing (see *Table 1-6*).

Summary of MMA Effects. About half of the additional 2004 MMA financing was used by plans to lower enrollee out-of-pocket costs. The 2004 MMA payment increases reduced MA plan enrollee out-of-pocket costs by \$23.27 per month on average, or \$279.24 per year. Nearly half of the reduction was due to lower premiums, about one-third to improved prescription drug benefits, and about one-fifth to lower cost sharing or improved benefits for non-drug medical care. Reductions occurred in all urban-rural and regional areas, but were largest on average in large cities, in the South, and in counties with the largest payment increases. Even after the BBA, BBRA, BIPA, and MMA payment changes, substantial urban-rural and regional disparities in estimated MA plan enrollee out-of-pocket costs remained, with estimated enrollee costs highest in rural areas and in the Midwest.

4.3.2 Multivariate Analysis

In addition to the descriptive trend analysis of plan premiums presented previously in this chapter, we estimated a statistical model explaining changes in plan premiums by changes in Medicare county payment rates. This model allowed us to examine the extent to which plan premium changes were related to changes in the MA county payment rate as modified by the MMA and BIPA.

Our models were estimated on the sample of basic plans in HMO contracts by service area county over the period 2000 to 2005, and are weighted by contract/county enrollment. We estimated both year-by-year change models (e.g., change from 2000 to 2001, change from 2001 to 2002) and a single model pooling all the year-by-year changes. For a contract/county to be included in the modeling sample, the contract had to offer a plan in the county for both time periods over which a change is measured. For example, plans that entered or withdrew from the county during the time period will not be included because the change cannot be defined for these contracts/counties.²⁸

In addition to payment changes, we experimented with including in the model other factors expected to explain premium changes. We expected that plan costs of providing medical care and inter-plan competition for enrollees would have the most important impacts on plan premiums. We included measures of these factors in some of our models.

Our regression results indicated that higher Medicare county payment rates lower plan premiums, by about \$2 for every \$10 increase in the payment rate.²⁹ A similar effect of higher

²⁸ Statistical estimates can be valid and unbiased even in the presence of these sample exclusions. See Woolridge (2001), Chapter 10.

²⁹ The other \$8 of the \$10 payment increase could be used to increase provider payments, augment plan benefits, reduce beneficiary cost sharing, or, possibly, enhance plan profits. Because of data limitations, we were not able to estimate the magnitude of these other uses of payment increases in a multivariate model.

payments on plan premiums has been found by other researchers (Gurol and Ellis, 2005). MMA 2004 and BIPA payment increases are estimated to have significantly reduced premiums below what they otherwise would have been. However, changes in individual plans' premiums are also strongly affected by factors other than payment changes, such as underlying medical cost inflation, ability to obtain payment discounts from providers, and competitive position vis-à-vis other plans and supplemental insurance options. Therefore, the relationship between payment changes and plan premiums is complex; it can vary over time and across areas (as other factors interact with payment changes) to produce observed changes in premiums.

CHAPTER 5 ENROLLMENT

5.1 Introduction

In this chapter, we investigate the impact of Medicare plan payment reforms on enrollment. We focus on payment changes mandated by Congress in (1) the Balanced Budget Act of 1997 (BBA), (2) the Benefits Improvement and Protection Act of 2000 (BIPA), and, (3) the Medicare Modernization Act of 2003 (MMA).³⁰ We use both primary and secondary data analysis to determine the impact of these legislated changes on enrollment. In Section 5.2, we present results from our interviews with MA organizations. In Section 5.3, we present results of our analysis of Medicare enrollment data with descriptive statistics (discussed in Section 5.3.1) and findings from our multivariate analysis (summarized in Section 5.3.2).

5.2 Medicare Advantage Organization Perspectives

After a period of steady growth in Medicare plans in the early to mid 1990s, the BBA's payment rate provisions of the late 1990s resulted in a significant loss of enrollment among several of the MA organizations we interviewed. One large insurer lost about one-third of their Medicare risk membership through service area withdrawals in counties that received only the 2 percent minimum payment increase. However, enrollment for several local plans remained relatively stable throughout this period. This stability was particularly true for MA organizations who reported more positive experiences of the BBA payment changes, such as the minimum floor-payment rate. Payment modifications under BIPA somewhat curtailed the sharp declines in membership experienced by most MA organizations, and for some MA organizations, stabilized membership. For example, one organization stated, "With BIPA, we shored up core benefits in some markets and it slowed the exodus of our membership, but didn't stop it." On the other hand, payment increases resulting from the MMA have positively impacted enrollment for all the MA organizations we interviewed, although some plans have benefited more robustly in membership gains than others during the last two years.

While some MA organizations attributed enrollment losses or gains to the recent legislative initiatives, a considerable number of plans attributed changes in enrollment to other factors. For example, one small MA organization commented, "we have not changed our marketing efforts due to any legislative initiatives, and can't directly attribute enrollment trends to payment legislation." This organization cited increased competition in their market as a key driver in slowing their enrollment growth. Another MCO attributed a steady loss of their Medicare managed care membership at least partially to the instability of provider contracting. This particular organization reported that physicians in large group practices have signed exclusive provider contracts with other MA organizations, and the loss of these providers has resulted in lower membership.

³⁰ We do not focus on the Balanced Budget Refinement Act of 1999 (BBRA), because if there were impacts of the BBRA on enrollment, they would have been relatively minor compared to the BBA, BIPA, and MMA.

MA organizations that withdrew from markets in the late 1990s are concerned that their credibility has been lost and may not be easily restored in the current climate of improved payment to plans. One organization noted, “We have felt some ‘bad-will’ from beneficiaries after these plan withdrawals, and their trust is not easily regained.” This MA organization has increased marketing efforts to attract former members, but they still must overcome some distrust among beneficiaries whom they perceive have misdirected blame solely on the market withdrawals. Beneficiaries adopting a “wait and see” attitude may limit short-run post-MMA enrollment increases. Despite these setbacks, most MA organizations viewed the positive developments of the MMA as an opportunity to attract beneficiaries new to Medicare Advantage and expand into new service areas to spur enrollment growth in their Medicare products.

5.3 Secondary Data Analysis

In this section, we present results from our descriptive and multivariate analysis of enrollment in Medicare Advantage (or the predecessor Medicare+Choice program) for 2000–2005. As in the secondary data analyses of plan availability and benefits, enrollment data are presented for a specific month and year. However, because the enrollment data files were not subject to some of the file availability issues noted in Chapter 2, we present enrollment figures consistently for April of each year in our analysis.

Our analysis sample of Medicare private plan enrollment is restricted to Medicare Advantage enrollment. *Table 5-1* shows total Medicare private plan and total Medicare Advantage enrollment for 2000–2005. As shown in the table, total Medicare private plan enrollment was 5.7 million in 2005, compared with 5.1 million for total Medicare Advantage enrollment.

For our analyses that depend on geographic designation, we exclude enrollees residing outside the service area of the Medicare Advantage plan, and also exclude enrollment outside the United States (Puerto Rico, Virgin Islands, Guam). The analyses that depend on geographic designation include the descriptive analyses of enrollment by urbanicity and Census Region, and the multivariate analysis of the impact of legislative payment changes on enrollment. Enrollment for the restricted Medicare Advantage sample was 4.6 million in 2005 (*Table 5-1*).

5.3.1 Descriptive Analysis

Overall Enrollment and Disenrollment. *Table 5-2* shows overall enrollment and disenrollment statistics for Medicare Advantage over 2000–2005. Overall enrollment significantly declined between 2000 and 2003, falling from about 6.2 million enrollees in 2000 to 5.6 million in 2001, 5.0 million in 2002, and finally 4.7 million in 2003. Although the number of new enrollees declined slightly over 2001–2003, the primary reason for the decline in enrollment was disenrollment due to reasons other than death (901,780 in 2001; 848,482 in 2002; and 537,437 in 2003—see *Table 5-2*). The decline in enrollment in the early part of this decade was likely in large part a response to the BBA payment changes coupled with rising medical cost inflation, which caused many plans to withdraw or contract service areas, creating “involuntary” disenrollment. In addition, BBA payment constraints combined with medical cost inflation caused many plans to raise premiums and reduce benefits for enrollees, which also contributed to the decline in enrollment.

Table 5-1
Medicare Advantage enrollment analysis sample, 2000–2005¹

Enrollment	2000	Post-BIPA			Post-MMA	
		2001	2002	2003	2004	2005
Total Medicare Private Plan ²	6,849,181	6,202,358	5,546,175	5,293,857	5,318,001	5,680,715
Total Medicare Advantage ³	6,234,416	5,617,675	5,005,178	4,668,582	4,693,789	5,083,069
Medicare Advantage restricted by geographic designation ⁴	5,874,978	5,288,966	4,687,569	4,340,009	4,306,366	4,576,549

NOTES:

¹ Data are for April of each year.

² Includes Medicare Advantage plan types and other Medicare private plans such as cost and demonstration plans.

³ Includes HMO, HMOPOS, PPO (including PPO demonstration), PSO, and PFFS plan types.

⁴ Excludes enrollees residing outside the service area of the Medicare Advantage plan, and enrollment in Puerto Rico, the Virgin Islands, and Guam.

SOURCE: RTI analysis of Medicare Enrollment Database.

BIPA may have slowed enrollment losses over this time period (2000–2003), which would be consistent with results from our MA organization interviews (see Section 5.2). However, any BIPA impact was not strong enough to reverse the substantial overall decline in enrollment that occurred, following BBA payment changes.

Table 5-2 also shows possible impacts of MMA payment changes on enrollment. In 2005, enrollment rose 389,280, which was an 8.3 percent increase from the prior year, and the only significant increase this decade.³¹ We attribute this gain partially to MMA payment changes, which is consistent with results from our MA organization interviews. In addition to rising overall enrollment, beginning in 2004, there is an upward trend in the number of new enrollees, increasing from 8.8 percent of total enrollment in 2003 to 10.4 percent in 2004 and 14.9 percent in 2005. Finally, Medicare Advantage penetration was 11.9 percent in 2005, at its highest level since 2002. Although enrollment rose in 2005, the impact of MMA payment changes on enrollment are less pronounced than they are on plan availability. For example, the total number of Medicare Advantage contracts increased by 62.4 percent in 2005 (see *Table 3-1*), compared with only a 8.3 percent increase in Medicare Advantage enrollment.

³¹ There were slight increases in enrollment between 1999 and 2000, and between 2003 and 2004.

**Table 5-2
Enrollment and disenrollment in Medicare Advantage, 2000–2005¹**

Enrollment/Disenrollment	2000	Post-BIPA			Post-MMA	
		2001	2002	2003	2004	2005
Total Enrollment	6,234,416	5,617,675	5,005,178	4,668,582	4,693,789	5,083,069
Continuing ²	–	5,084,152	4,536,303	4,260,164	4,204,409	4,325,455
% of total enrollment	–	90.5	90.6	91.3	89.6	85.1
New ³	–	533,523	468,875	408,418	489,380	757,614
% of total enrollment	–	9.5	9.4	8.8	10.4	14.9
Change in Enrollment ⁴	–	-616,741	-612,497	-336,596	25,207	389,280
% Change in enrollment	–	-9.9	-10.9	-6.7	0.5	8.3
	–	–	–	–	–	–
Total Disenrollment ⁵	–	1,150,264	1,081,372	745,014	464,173	368,334
Due to Death	–	248,484	232,890	207,577	198,488	193,441
% of total disenrollment	–	21.6	21.5	27.8	42.8	52.5
Due to Other Reasons ⁶	–	901,780	848,482	537,437	265,685	174,893
% of total disenrollment	–	78.4	78.5	72.1	57.2	47.5
Medicare Advantage Penetration ⁷	15.8%	14.0%	12.2%	11.3%	11.1%	11.9%

NOTES: Includes HMO, HMOPOS, PPO (including PPO demonstration), PSO, and PFFS plan types.

¹ Data are for April of each year.

² Continuing enrollees are enrolled in current and prior year.

³ New enrollees are enrolled in current year but not in prior year.

⁴ Change in enrollment is defined as change from prior year.

⁵ Disenrollees are enrolled in prior year but not current year.

⁶ Disenrollment due to other reasons includes voluntary and involuntary disenrollment (except for death).

⁷ Medicare Advantage (MA) penetration is defined as MA enrollment divided by the sum of MA and fee-for-service enrollment.

SOURCE: RTI analysis of Medicare Enrollment Database.

Enrollment by Contract Type. *Table 5-3* shows enrollment for Medicare Advantage by contract type over 2000–2005. Health maintenance organizations (HMO) have been the dominant contract type for Medicare Advantage, with between 93.9 to 99.6 percent of total enrollment over 2000–2005. Thus, the enrollment statistics for HMO will, in many respects, mirror the results for overall enrollment (*Table 5-2*). The HMO enrollment share is gradually declining, though. Only about 60 percent (237,492) of the increase in MA enrollment in 2005 was from HMOs.

Table 5-3
Enrollment in Medicare Advantage, by contract type, 2000–2005¹

Contract Type	2000	Post-BIPA			Post-MMA	
		2001	2002	2003	2004	2005
Total Enrollment	6,234,416	5,617,675	5,005,178	4,668,582	4,693,789	5,083,069
HMO	6,206,531	5,576,588	4,944,305	4,562,303	4,536,064	4,773,556
Change	–	-629,943	-632,283	-382,002	-26,239	237,492
% change	–	-10.1	-11.3	-7.7	-0.6	5.2
% of total enrollment	99.6	99.3	98.8	97.7	96.6	93.9
PPO	12,888	15,953	22,868	66,543	102,577	181,141
change	–	3,065	6,915	43,675	36,034	78,564
% change	–	23.8	43.3	191.0	54.2	76.6
% of total enrollment	0.2	0.3	0.5	1.4	2.2	3.6
PSO	14,997	12,217	15,599	19,152	24,180	31,951
change	–	-2,780	3,382	3,553	5,028	7,771
% change	–	-18.5	27.7	22.8	26.3	32.1
% of total enrollment	0.2	0.2	0.3	0.4	0.5	0.6
PFFS	0	12,917	22,406	20,584	30,968	96,421
change	–	–	9,489	-1,822	10,384	65,453
% change	–	–	73.5	-8.1	50.4	211.4
% of total enrollment	0.0	0.2	0.5	0.4	0.7	1.9

NOTES: Includes HMO, HMOPOS, PPO (including PPO demonstration), PSO, and PFFS plan types.

¹ Data are for April of each year.

SOURCE: RTI analysis of Medicare Enrollment Database.

Although the HMO remains the dominant contract type for Medicare Advantage, there has been a small but steady increase in non-HMO enrollment as a percentage of total enrollment, from 0.5 percent in 2000 to 6.1 percent in 2005. One important reason for this trend is an increase in preferred provider organization (PPO) enrollment, which grew from 0.2 percent of overall enrollment in 2000 to 3.6 percent in 2005. The Medicare PPO Demonstration, which runs from January 2003 through December 2005, represents the majority of the increase in PPO enrollment. In addition to demonstration PPO enrollment, non-demonstration PPO enrollment contributed to the increase in overall PPO enrollment in 2005. PPO enrollment in 2005 increased by 78,564, and although not shown in **Table 5-3**, well over half of the increase was in non-demonstration PPOs. One important reason for the increase in non-demonstration PPO enrollment is the 2006–2007 moratorium on local-PPO entry, which provided MCOs with an incentive to enter local PPO markets in 2005.

In addition to the increases in PPO enrollment, there have been increases in private fee-for-service (PFFS) enrollment, especially recently; as a percent of total Medicare Advantage enrollment, however, PFFS enrollment remains quite small. In 2005, PFFS was at 1.9 percent of overall enrollment, up from 0.7 percent in 2004, and 0.2 percent in 2001. MMA payment increases may have affected this relatively large percentage increase in PFFS enrollment of 65,453 in 2005. Under the MMA, the minimum payment rate increased to 100 percent of Medicare FFS costs, in addition to an increase in the floor payment rates. PFFS plans, because of their lack of a formal provider network, have located more often than other plan types in floor counties.

Enrollment by Urbanicity.³² **Table 5-4** shows enrollment in Medicare Advantage by urbanicity over 2000–2005. Urban enrollment consistently comprised the vast majority of total enrollment, ranging from 96.5 to 97.9 percent over 2000–2005. It is however informative to examine subcategories of urban enrollment, including large urban, medium urban, and small urban enrollment.³³ Roughly speaking, over 2000–2005, large urban enrollment as a percentage of urban enrollment was around 80 percent, with medium urban enrollment around 17 percent, and small urban enrollment the remaining 3 percent. Large urban enrollment has been more stable over 2000–2005 than medium and small urban enrollment. In 2001 and 2002, large urban enrollment decreased by -8.1 and -10.8 percent, respectively, compared with -14.0 and -15.0 percent for medium urban enrollment, and -17.6 and -13.7 percent for small urban enrollment.³⁴ Enrollment showed some evidence of rebounding in 2004 in medium and small urban counties, while large urban counties continued to show decreasing enrollment relative to 2003. However, by 2005, enrollment in all urban areas increased. In 2005, large urban enrollment increased by 4.5 percent, compared with an 8.3 percent increase for medium urban enrollment, and a 20.4

³² As discussed at the beginning of Section 5.3, for the descriptive analysis of enrollment by urbanicity, we exclude enrollees residing outside the service area of the Medicare Advantage plan, and exclude enrollment outside the United States (Puerto Rico, Virgin Islands, Guam).

³³ Large urban is defined as counties in metropolitan areas with at least 1,000,000 in total population, medium urban is defined as counties in metropolitan areas with between 250,000 and 999,999 in total population, and small urban is defined as counties in metropolitan areas with less than 250,000 in total population.

³⁴ In 2003, large urban enrollment had a slightly higher percentage decrease than medium urban enrollment, and a slightly lower percentage decrease than small urban enrollment.

Table 5-4
Enrollment in Medicare Advantage, by urbanicity, 2000–2005¹

Urbanicity	2000	Post-BIPA			Post-MMA	
		2001	2002	2003	2004	2005
Total enrollment	5,874,978	5,288,966	4,687,569	4,340,009	4,306,366	4,576,549
Urban	5,715,725	5,176,464	4,577,633	4,227,638	4,182,598	4,416,523
Change	–	-539,261	-598,831	-349,995	-45,040	233,925
% change	–	-9.4	-11.6	-7.6	-1.1	5.6
% of total enrollment	97.3	97.9	97.7	97.4	97.1	96.5
MA penetration ²	18.91%	16.83%	14.64%	13.37%	13.05%	13.57%
Large Urban	4,526,419	4,159,610	3,711,609	3,423,158	3,361,345	3,511,929
Change	–	-366,809	-448,001	-288,451	-61,813	150,584
% change	–	-8.1	-10.8	-7.8	-1.8	4.5
% of total urban enrollment	79.2	80.4	81.1	81	80.4	79.5
MA penetration ²	24.55%	22.16%	19.49%	17.81%	17.29%	17.82%
Medium Urban	1,010,267	869,281	738,643	687,515	695,840	753,624
Change	–	-140,986	-130,638	-51,128	8,325	57,784
% change	–	-14	-15	-6.9	1.2	8.3
% of total urban enrollment	17.7	16.8	16.1	16.3	16.6	17.1
MA penetration ²	13.01%	11.01%	9.18%	8.43%	8.39%	8.94%
Small Urban	179,039	147,573	127,381	116,965	125,413	150,970
Change	–	-31,466	-20,192	-10,416	8,448	25,557
% change	–	-17.6	-13.7	-8.2	7.2	20.4
% of total urban enrollment	3.1	2.9	2.8	2.8	3	3.4
MA penetration ²	4.45%	3.60%	3.05%	2.75%	2.90%	3.42%
Rural	159,253	112,502	109,936	112,371	123,768	160,026
Change	–	-46,751	-2,566	2,435	11,397	36,258
% change	–	-29.4	-2.3	2.2	10.1	29.3
% of total enrollment	2.7	2.1	2.4	2.6	2.9	3.5
MA penetration ²	1.92%	1.34%	1.29%	1.30%	1.41%	1.81%
Rural Urban-Adjacent	148,814	103,133	100,225	102,202	112,094	141,695
Change	–	-45,681	-2,908	1,977	9,892	29,601
% change	–	-30.7	-2.8	2	9.7	26.4
% of total rural enrollment	93.4	91.7	91.2	91	90.6	88.5
MA penetration ²	2.77%	1.89%	1.81%	1.82%	1.96%	2.45%
Rural Non-Adjacent	10,439	9,369	9,711	10,169	11,674	18,331
Change	–	-1,070	342	458	1,505	6,657
% change	–	-10.3	3.7	4.7	14.8	57
% of total rural enrollment	6.6	8.3	8.8	9	9.4	11.5
MA penetration ²	0.35%	0.31%	0.32%	0.33%	0.38%	0.60%

NOTES: Includes HMO, HMOPOS, PPO (including PPO demonstration), PSO, and PFFS plan types. Excludes enrollees residing outside the service area of the Medicare Advantage plan, and enrollment in Puerto Rico, the Virgin Islands, and Guam.

¹ Data are for April of each year.

² MA (Medicare Advantage) penetration is defined as MA enrollment divided by the sum of MA and fee-for-service enrollment.

SOURCE: RTI analysis of Medicare Enrollment Database.

percent increase for small urban enrollment. We also analyzed changes in MA penetration. In general, we observed that MA penetration rates changed little (less than around 1 percentage point) in urban counties. An exception is found in small urban counties where MA penetration decreased by about 1.5 percentage points between 2000 and 2004, then rebounded by 0.5 percentage points (to 3.42 percent) in 2005.

It is difficult to explain enrollment trends for large, medium, and small urban counties in the context of the legislated payment changes. Over 2000–2003, actual payments, relative to what would they would have been in the absence of BIPA, were on average higher for medium/small urban counties (*Table 1-4*). However, these counties had the more pronounced percentage reductions in enrollment. Similarly, over 2004–2005, actual payments, relative to what would they would have been in the absence of MMA, were higher on average for large urban counties (*Table 1-4*); yet these counties had the less pronounced percentage increases in enrollment.

Somewhat different patterns emerge when analyzing enrollment in rural counties. In 2001, there was a 29.4 percent decrease in rural enrollment. This decrease was surprising due to the BBA-mandated floor payment rate and the BIPA-mandated increase in the floor payment rate, each of which was intended to stabilize, and even increase, rural enrollment. The decline in rural enrollment might reflect retraction of a prior overexpansion by plans in extending their service areas to rural areas when it was not a viable business proposition.

Unlike urban enrollment, over 2001–2003, rural enrollment experienced only a one-time substantial decrease, and then remained relatively stable until the MMA payment changes took effect. In 2005, there was a noticeable increase of 36,258 in rural enrollment, with 29,601 in “rural urban-adjacent” areas, and 6,657 in “rural non-adjacent” areas. Despite this increase in enrollment in 2005, MA penetration rates in all rural counties and in rural urban-adjacent counties changed little. MA penetration rates in rural counties are consistently between 1 and 2 percent. Penetration in rural non-adjacent counties did increase, rising from 0.38 percent in 2004 to 0.60 percent in 2005. However, even with this increase, penetration in rural non-adjacent counties remained quite small.

Enrollment by Census Region.³⁵ *Table 5-5* shows enrollment by census region (Northeast, South, Midwest, West) over 2000–2005. The West census region has the largest MA markets. As a percentage of total enrollment, the West census region ranged from 36.8 percent to 42.1 percent of total enrollment. In addition, the West census region has had the most stable enrollment trends. For example, the West census region had the smallest percentage declines in enrollment over 2001–2003 (-3.9, -7.9, and -4.6 percent), and the smallest percentage increase in enrollment in 2005 (0.9 percent). Possible contributors to this relative stability in the West census region are the size and maturity of this market, and the business model of one very large HMO that primarily serves this region. This MA organization commented, “We generally don’t exit markets. Because we are a group-model HMO and hospital-based, we have many fixed

³⁵ As discussed at the beginning of Section 5.3, for the descriptive analysis of enrollment by Census Region, we exclude enrollees residing outside the service area of the Medicare Advantage plan, and exclude enrollment outside the United States (Puerto Rico, Virgin Islands, Guam).

costs. Thus, we need the Medicare managed care market to support our model. Our approach fosters stability.” MA penetration rates overall were highest in the West, though these rates showed small but consistent annual decreases between 2000 and 2005.

Table 5-5
Enrollment in Medicare Advantage, by census region, 2000–2005¹

Census Region	Post-BIPA				Post-MMA	
	2000	2001	2002	2003	2004	2005
Total Enrollment	5,874,978	5,288,966	4,687,569	4,340,009	4,306,366	4,576,549
Northeast	1,529,209	1,379,412	1,266,824	1,195,159	1,202,350	1,297,318
Change	–	-149,797	-112,588	-71,665	7,191	94,968
% change	–	-9.8	-8.2	-5.7	0.6	7.9
% of total enrollment	26	26.1	27	27.5	27.9	28.3
MA penetration ²	18.86%	16.84%	15.35%	14.43%	14.46%	15.45%
Midwest	741,907	692,261	543,000	447,418	457,442	506,370
Change	–	-49,646	-149,261	-95,582	10,024	48,928
% change	–	-6.7	-21.6	-17.6	2.2	10.7
% of total enrollment	12.6	13.1	11.6	10.3	10.6	11.1
MA penetration ²	8.04%	7.41%	5.76%	4.72%	4.78%	5.24%
South	1,440,178	1,138,315	963,681	871,055	870,466	980,769
Change	–	-301,863	-174,634	-92,626	-589	110,303
% change	–	-21	-15.3	-9.6	-0.1	12.7
% of total enrollment	24.5	21.5	20.6	20.1	20.2	21.4
MA penetration ²	10.38%	8.05%	6.67%	5.92%	5.81%	6.42%
West	2,163,684	2,078,978	1,914,064	1,826,377	1,776,108	1,792,092
Change	–	-84,706	-164,914	-87,687	-50,269	15,984
% change	–	-3.9	-7.9	-4.6	-2.8	0.9
% of total enrollment	36.8	39.3	40.8	42.1	41.2	39.2
MA penetration ²	29.70%	27.88%	25.09%	23.48%	22.41%	22.15%

NOTES: Includes HMO, HMOPOS, PPO (including PPO demonstration), PSO, and PFFS plan types. Excludes enrollees residing outside the service area of the Medicare Advantage plan, and enrollment in Puerto Rico, the Virgin Islands, and Guam.

¹ Data are for April of each year.

² MA (Medicare Advantage) penetration is defined as MA enrollment divided by the sum of MA and fee-for-service enrollment.

SOURCE: RTI analysis of Medicare Enrollment Database.

As shown in *Table 5-5*, the South census region appears to have the most enrollment instability, followed by the Midwest census region. The South census region had two consecutive years (2001–2002) with double-digit percentage decreases in enrollment (-21.0 and -15.3 percent), and likewise, the Midwest census region had two consecutive years (2002–2003) with double-digit percentage decreases in enrollment (-21.6 and -17.6 percent). In addition, in

2005, the South and Midwest census regions each had double-digit percentage increases in enrollment (12.7 and 10.7 percent, respectively). In contrast, neither the West nor Northeast census regions had double-digit percentage changes in enrollment in any year over 2000–2005. Penetration rates consistently decreased in the South, Midwest and West between 2000 and 2004, increasing again only slightly in 2005.

Finally, we examined enrollment trends for census regions in the context of the legislated payment changes. Over 2000–2003, actual payments relative to what would they would have been in the absence of BIPA were on average highest for the Midwest census region (*Table 1-5*), and yet this region had relatively large percentage reductions in enrollment over this time period. On the other hand, for the post-MMA period, MMA payment increases were on average highest for the Northeast and South census regions, and in 2005, these regions had relatively high absolute and percentage increases in enrollment, with an increase of 94,968 (7.9 percent) in the Northeast census region, and 110,303 (12.7 percent) in the South census region. However, MMA payment increases were on average lowest for the Midwest census region, and yet in percentage terms, this region had the second highest increase in enrollment in 2005 (10.7 percent).

Enrollment by Beneficiary Characteristics. *Table 5-6* shows enrollment by beneficiary characteristics over 2000–2005. Age was broken down into the following categories: under 65, 65–74, 75–84, and 85 and older. Beneficiaries aged 65–74 represented the highest percentage of total enrollment, ranging from 52.9 percent in 2000 to 46.8 percent in 2005. Close behind were beneficiaries in the 75–84 age group, representing 31.6 percent of total enrollment in 2000 and 34.9 percent in 2005. Decreases in enrollment were noted for all age groups between 2000 and 2003, and the largest declines occurred among younger beneficiaries. In 2004, after the MMA, small increases were found for all age groups except the 65–74 age group (where a continued but smaller decrease in enrollment occurred). However, by 2005, enrollment increases occurred in all age groups.

As shown in *Table 5-6*, the enrollment experience of males and females appeared to be broadly similar over 2000–2005, with males having slightly higher percentage reductions in enrollment through 2004, and a slightly higher percentage increase in 2005. Finally, the enrollment experience of whites versus blacks appeared to be broadly similar over 2000–2004. However, in 2005, whites only had an enrollment increase of 7.4 percent, compared with a 14.0 percent increase for blacks.

5.3.2 Multivariate Analysis³⁶

In this section, we used results from a multivariate analysis to estimate the impact of legislated payment changes on Medicare Advantage enrollment. We restricted our multivariate analysis to the impact of MMA payment changes on HMO enrollment in the post-MMA period (2004-2005). Further, we restricted the analysis to counties with positive HMO enrollment in both 2004 and 2005. HMO enrollment increased by 136,865 between 2004 and 2005 (*Table 5-3*), with 118,680 (87 percent) of the increase in the 577 counties having positive HMO enrollment in both years.

³⁶ As discussed at the beginning of Section 5.3, for the multivariate analysis of the impact of legislated payment changes on enrollment, we exclude enrollees residing outside the service area of the Medicare Advantage plan, and exclude enrollment outside the United States (Puerto Rico, Virgin Islands, Guam).

Table 5-6
Enrollment in Medicare Advantage, by beneficiary characteristics, 2000–2005¹

Beneficiary Characteristics	2000	Post-BIPA			Post-MMA	
		2001	2002	2003	2004	2005
Total Enrollment	6,234,416	5,617,675	5,005,178	4,668,582	4,693,789	5,083,069
Age						
Under 65	451,430	393,499	348,093	326,046	337,702	399,791
Change	–	-57,931	-45,406	-22,047	11,656	62,089
% change	–	-12.8	-11.5	-6.3	3.6	18.4
% of total enrollment	7.2	7.0	7.0	7.0	7.2	7.9
65-74	3,296,166	2,890,586	2,496,296	2,265,156	2,229,106	2,381,055
Change	–	-405,580	-394,290	-231,140	-36,050	151,949
% change	–	-12.3	-13.6	-9.3	-1.6	6.8
% of total enrollment	52.9	51.5	49.9	48.5	47.5	46.8
75-84	1,968,170	1,837,687	1,692,555	1,620,006	1,653,633	1,776,346
Change	–	-130,483	-145,132	-72,549	33,627	122,713
% change	–	-6.6	-7.9	-4.3	2.1	7.4
% of total enrollment	31.6	32.7	33.8	34.7	35.2	34.9
85 and older	518,650	495,903	468,234	457,374	473,348	525,877
Change	–	-22,747	-27,669	-10,860	15,974	52,529
% change	–	-4.4	-5.6	-2.3	3.5	11.1
% of total enrollment	8.3	8.8	9.4	9.8	10.1	10.3
Sex						
Male	2,681,795	2,395,583	2,115,292	1,968,676	1,979,139	2,149,973
Change	–	-286,212	-280,291	-146,616	10,463	170,834
% change	–	-10.7	-11.7	-6.9	0.5	8.6
% of total enrollment	43.0	42.6	42.3	42.2	42.2	42.3
Female	3,552,621	3,222,092	2,889,886	2,699,906	2,714,650	2,933,096
Change	–	-330,529	-332,206	-189,980	14,744	218,446
% change	–	-9.3	-10.3	-6.6	0.5	8.0
% of total enrollment	57.0	57.4	57.7	57.8	57.8	57.7
Race						
White	5,317,949	4,772,277	4,229,731	3,931,458	3,936,523	4,226,484
Change	–	-545,672	-542,546	-298,273	5,065	289,961
% change	–	-10.3	-11.4	-7.1	0.1	7.4
% of total enrollment	85.3	85.0	84.5	84.2	83.9	83.1
Black	543,963	490,122	442,213	411,777	419,690	478,279
Change	–	-53,841	-47,909	-30,436	7,913	58,589
% change	–	-9.9	-9.8	-6.9	1.9	14.0
% of total enrollment	8.7	8.7	8.8	8.8	8.9	9.4
Other	372,504	355,276	333,234	325,347	337,576	378,306
Change	–	-17,228	-22,042	-7,887	12,229	40,730
% change	–	-4.6	-6.2	-2.4	3.8	12.1
% of total enrollment	6.0	6.3	6.7	7.0	7.2	7.4

NOTES: Includes HMO, HMOPOS, PPO (including PPO demonstration), PSO, and PFFS plan types.

¹ Data are for April of each year.

SOURCE: RTI analysis of Medicare Enrollment Database.

We used multivariate regression analysis to estimate the impact of MMA payment changes on the change in HMO enrollment between 2004 and 2005, holding other factors constant. **Table 5-7** shows the results. As shown in the table, we estimate that for every \$1 in MMA payment increase per county, the average county increase in HMO enrollment was 2.33 beneficiaries. Therefore the total per dollar increase in enrollment is an estimated 1,344 beneficiaries across all 577 counties in our analysis.³⁷ Since the average county MMA payment increase is \$52, we estimated the impact of MMA payment changes on the change in HMO enrollment is an additional 122 enrollees per county, adding to a total of 70,394³⁸ additional enrollees across all 577 counties analyzed.

Table 5-7
Estimated impact of MMA payment increase on change in Medicare Advantage HMO enrollment between 2004 and 2005

	Estimated per \$1 impact MMA payment increase on change in HMO enrollment	Average MMA per county payment increase	Total estimated Impact of MMA Payment Increase on Change in HMO Enrollment
County average	2.33	\$52.30	122
Total across all counties	1,344	–	70,394

NOTES:

- 1 Change in HMO enrollment measured between April 2004 and April 2005.
- 2 MMA payment increase defined as actual Medicare Advantage A + B aged monthly payment rate in April 2005 minus the simulated payment rate in the absence of MMA.
- 3 Restricted to the 577 counties with positive HMO enrollment in both April 2004 and April 2005.
- 4 Excludes enrollees residing outside the service area of the HMO, and enrollment in Puerto Rico, the Virgin Islands, and Guam.

SOURCE: RTI analysis of Medicare Enrollment database.

In Section 5.2.1, we presented results from our descriptive analysis of enrollment, and based on those results, we partially attributed the increase in Medicare Advantage enrollment between 2004 and 2005 to MMA payment changes, which was consistent with our plan interviews (Section 5.1). Comparing our estimate of 70,394 additional enrollees to our finding of an actual increase of 118,680 total HMO enrollees between 2004 and 2005 (in these same 577 counties), we estimate that 59 percent³⁹ of the increase in HMO enrollment in the post-MMA period is attributable to MMA payment changes. The results from our multivariate analysis presented in this section were thus consistent with our descriptive analysis, as well as our plan interviews.

³⁷ $2.33 \times 577 = 1,344$

³⁸ $122 \times 577 = 70,394$

³⁹ $70,394 / 118,680 = 0.59$

CHAPTER 6 SUMMARY AND CONCLUSIONS

The purpose of this congressionally-mandated report is to describe the impacts of recent legislation (the BBRA, BIPA, and the MMA) on the availability of, and benefits offered under, Medicare Advantage (MA) plans. To meet the mandate, this study analyzed plan availability, plan premiums, benefits and cost sharing, and enrollment and disenrollment. This chapter presents a summary of the findings and draws conclusions regarding the impact of additional funding provided to MA plans under the MMA.

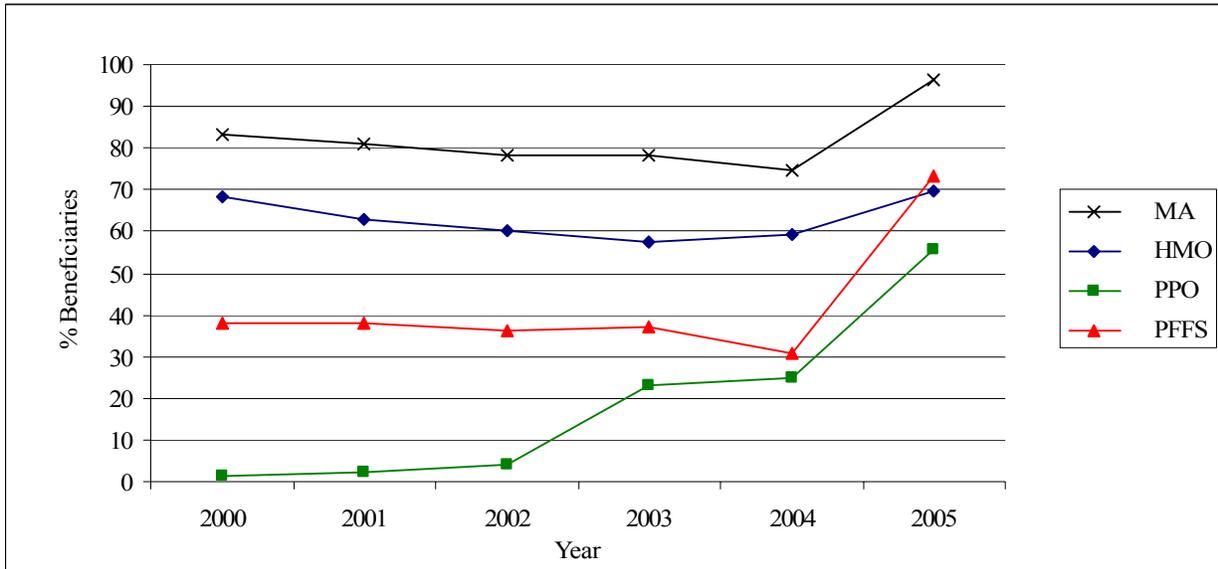
6.1 Plan Availability

In general, Medicare plan availability decreased substantially after the implementation of the BBA, and despite interim legislation (BBRA and BIPA) aimed at addressing some of the negative effects of the BBA, availability only improved significantly under the MMA.

The majority of MA organizations with whom we spoke said legislated changes to payment rates under the BBA combined with rising medical cost inflation prompted a general contraction in their participation in the Medicare program. Most of these MA organizations perceived that the BBA reduced payment rate increases to a level that, in some areas, prompted them to terminate or shrink service areas. In contrast, these MA organizations universally considered payment rates under the MMA for the Medicare Advantage program positively. One plan described the MMA, in comparison to the BBRA and BIPA, as “the major turnaround legislation.”

Consistent with feedback from the MA organizations, the post-BBA implementation period showed a marked decrease in the percentage of Medicare beneficiaries with access to a MA plan (**Figure 6-1**). In 2000, the year marking full implementation of the BBA payment (including risk adjustment) provisions and after passage of the BBRA, a Medicare HMO was available to 68 percent of Medicare beneficiaries. By April 2003, the percentage with access had fallen to 57 percent. Plan availability did not improve markedly until after the MMA in 2005; this was the first full year that MA organizations had the opportunity to re-contract while taking advantage of the substantial MMA March 2004 and 2005 payment increases, as well as the permanent increase in the minimum MA payment update factor. In response to these MMA factors, the percentage of beneficiaries with access to MA plans (HMOs, PPOs, PFFS) rose sharply in 2005. Access to all types of MA plans increased, especially local PPOs and PFFS plans, whose availability more than doubled from 2004 to 2005. The PPO increase included a large number of new non-demonstration contracts for the first time. Medicare HMOs were available to 70 percent of Medicare beneficiaries and Medicare PPOs to 56 percent by June 2005. By mid-2005, availability of MA plans was greater than at the beginning of the analysis period in 2000, with nearly all Medicare beneficiaries (96 percent) having access to at least one MA plan in 2005.

Figure 6-1
Percentage of beneficiaries with access to a Medicare Advantage plan, by contract type



SOURCE: RTI analysis of CMS Health Plan Management Systems data.

To affect plan availability, payment increases must be viewed as long term by MA organizations; short term or temporary payment improvements appeared to have little effect.

In our discussions, MA organizations emphasized that the most important factor in their decisions about where to make plans available is the long-term adequacy of Medicare payment rates in an area. The MMA provisions establishing local FFS costs as a minimum payment rate for each county, and establishing a minimum payment update percentage of the national Medicare spending growth rate, were seen as key in ensuring that Medicare payment rates are adequate now and in the future. In contrast, short-term bonus payments have little influence on MCO decisions about where to offer plans. Even if a bonus payment made it temporarily financially viable to offer a plan in an area, once the bonus ended, the plan would again become unprofitable if long-run payment rates were not adequate. In the short run, bonus payments may not fully offset the high fixed costs of establishing health plans in new service areas, including the costs of provider network development, marketing, and administration.

Both the BBRA and BIPA included temporary payment increases, these measures did little to improve plan availability. By 2001, after passage of BIPA, plan availability declined from 2000, despite the fact that BIPA temporarily increased rates by 3 percent rather than 2 percent and increased urban and minimum floor rates in March 2001. In 2002, when minimum increases returned to 2 percent, availability declined yet again.

Despite a focus on improving access to managed care in rural and underserved areas, geographic disparities continue. Managed care availability outside of large and medium urban areas improved under the MMA, but remains relatively poor. However, access to PFFS plans rose sharply in all areas, especially rural areas.

MA organizations with whom we spoke noted the continued difficulty in expanding plans to rural areas, primarily because of issues related to provider networks. Floor payment rates, established under the BBA, were initially insufficient to overcome this problem, according to many MA organizations. To look at how the legislated payment changes impacted access to Medicare plans, we analyzed plan participation by urban designation. We analyzed the percent of counties with at least one HMO, PPO or PFFS contract by a range of urban/rural categories, from 2000 to 2005.

Urban counties continue to enjoy the greatest access to Medicare HMO and PPO plans. However, between 2000 and 2005, the percentage of large urban counties with at least one Medicare HMO declined from 75.8 percent to 63.3 percent. Some of the decline may arise from a substitution of PPO offerings for HMOs in large urban counties. The percentage of large urban counties with at least one Medicare PPO increased from 1.2 percent to 57.0 percent. The percentage of medium urban counties with an HMO rose from 49.1 percent in 2000 to 58.6 percent in 2005, due to a large increase from 2004 to 2005. Likewise, the availability of PPOs increased to 46.3 percent of medium urban counties in 2005. HMO access also increased substantially in 2005 (32.5 percent) in small urban counties to a greater level than in 2000 (25.9 percent). The availability of PPO plans also increased. However, the availability of HMO and PPO plans remained limited in small urban counties, well below availability in larger urban counties. The availability of HMO and PPO plans in rural counties varied by population and proximity to urban areas, but was low throughout the period for both categories of rural counties compared to all categories of urban counties. The availability of both HMO and PPO plans has improved in 2005 to a level exceeding availability in 2000. In rural areas adjacent to an urban area, 25.1 percent of the counties had an HMO plan in 2005 and 15.1 percent had a PPO plan. For rural counties not adjacent to an urban area, only 7.4 percent had an HMO plan and 7.5 percent had a PPO plan. PFFS plans, which do not require a provider network, were an exception to the geographic patterns of the network-based HMO and PPO plans and were more widely available in rural areas than in urban areas. Overall, over 95 percent of rural counties had access to a PFFS plan.

6.2 Plan Premiums, Benefits, and Cost Sharing

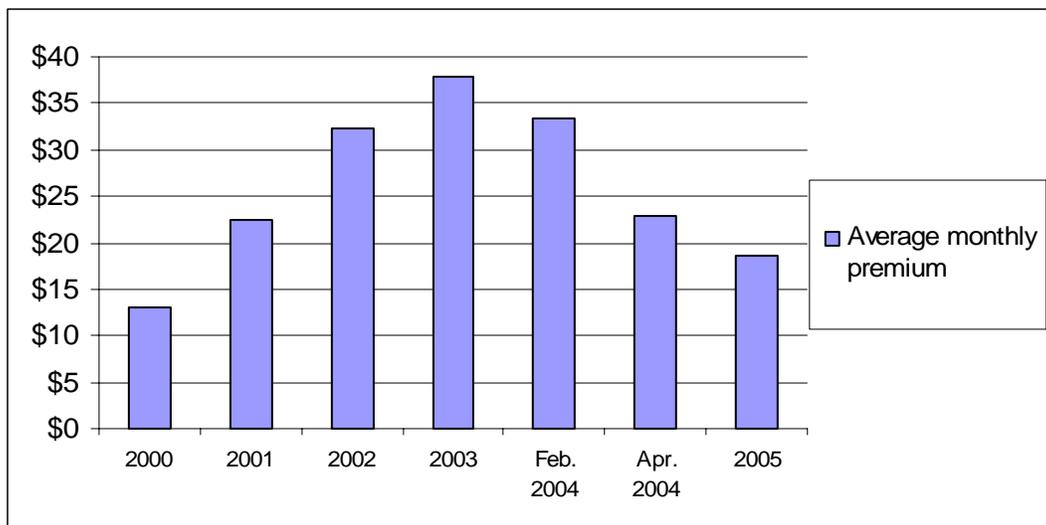
Plan premiums and cost sharing generally increased, and benefits decreased, in response to the BBA. These conditions improved somewhat after passage of the MMA, with many plans lowering premiums and cost sharing, and improving benefits, after the March 2004 MMA payment increases.

All MA organizations we interviewed modified benefit offerings in response to legislative changes to payment rates imposed from the 1997 BBA to the 2003 MMA. The degree of benefit changes varied among the plans, but by and large the payment rate constraints of the BBA coupled with higher medical care costs prompted significant reductions. During the post-BBA period of the late 1990s and early 2000s, MA organizations raised premiums and cost-sharing requirements (e.g., copayments, coinsurance), reduced or eliminated prescription drug coverage, eliminated or raised out-of-pocket maximums, and scaled back on other benefits and services such as dental coverage. The payment increases of the 2000 BIPA did help stop benefit reductions in some areas. However, it was not until the 2003 MMA that the MA organizations

we interviewed began to restore and enhance benefits that beneficiaries experienced before the BBA payment changes prompted reductions.

In addition to our discussions with MA organizations, we analyzed trends in HMO plan premiums, benefits, and cost sharing from 2000 to 2005.⁴⁰ Premiums, together with cost sharing, determine the affordability of MA plans for Medicare beneficiaries. Medicare HMO plans became considerably less affordable between 2000 and 2003. Average monthly premiums rose sharply, nearly tripling over this period from \$12.95 to \$37.87 (**Figure 6-2**). The proportion of enrollees in zero-premium plans was cut nearly in half. This was clearly a period of retrenchment as plans responded to the payment update restrictions of the BBA and rising medical cost inflation by attempting to raise revenue through higher premiums. The implementation of BIPA in March 2001 resulted in reductions in plan premiums compared to those in effect in January/February 2001 (GAO, 2001). Even after incorporating the effects of BIPA, average plan premiums nearly doubled from November 2000 to June 2001 (post-BIPA). This trend began to reverse after passage of the MMA. In March 2004, plans responded to the implementation of the MMA payment increases by reducing average premiums by \$10.49 or 31.5 percent. In 2005, a further four-dollar reduction in average premiums occurred as the MMA payment changes continued to take hold, and average premiums fell to about half their peak level in 2003. In addition, the proportion of enrollees in plans offering a zero-premium package increased to 57.7 percent in 2005.

Figure 6-2
Average monthly premiums in basic HMO plans, 2000–2005



SOURCE: RTI analysis of CMS Health Plan Management Systems data.

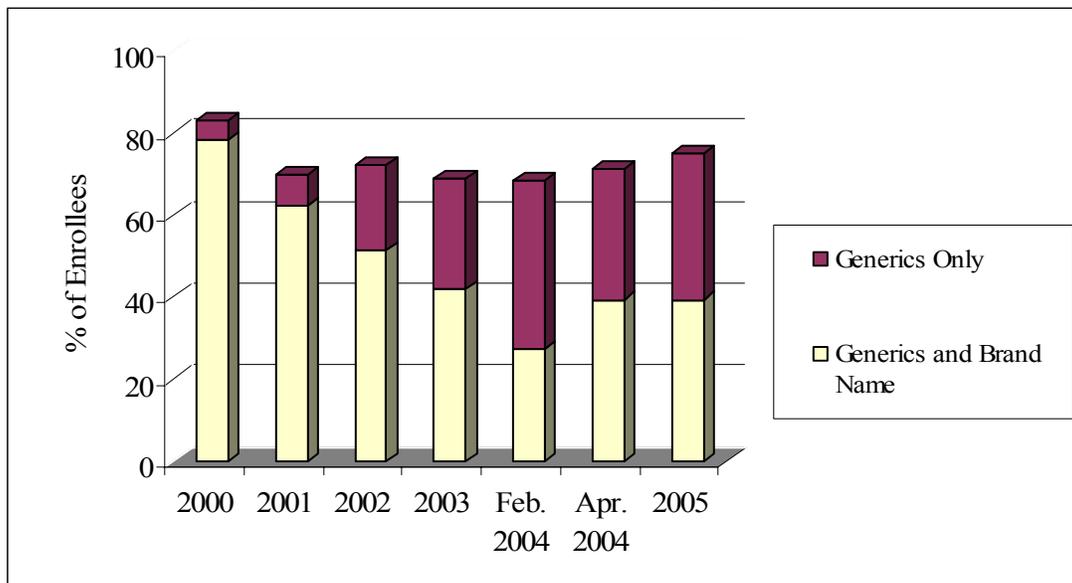
⁴⁰ All premium, benefits, and cost sharing statistics refer to basic HMO plans, which are the lowest-premium plans offered in a county by an HMO contract. Enrollment is all enrollees in the contract offering the basic plan.

To further examine the relationship between additional financing and changes in premiums, it is helpful to compare changes in premiums across geographic areas with differing levels of payment increases. If additional financing affected plan premiums, one would expect to observe changes in geographic areas where greater additional financing was provided. As expected, the amount of premium reductions is inversely related to the amount of payment increase. Overall, the MMA increased Medicare payment per member per month by \$45.03 in 2004. In counties where average payment rose by less than \$25 per member per month, the average premium fell by \$5.37 or 14 percent. In counties where average payment rose by \$100 or more, the average premium fell by \$26.18 or 74 percent.

Benefits

Coverage of prescription drugs—especially brand name drugs—is often one of the most valuable and attractive additional benefits offered by MA plans. **Figure 6-3** shows trends 2000 to 2005 in coverage of prescription drugs in basic HMO plans. In 2000, 78.4 percent of enrollees had some coverage for brand name drugs. By early 2004, this number had sunk to only 27.3 percent. Over the same period, the proportion of enrollees without any drug benefit had nearly doubled from 16.8 to 31.4 percent. The implementation of BIPA in 2001 did not stop the reduction in drug coverage. With the implementation of the MMA in March 2004, drug coverage improved. The proportion of enrollees with brand name drug coverage increased from 27.3 to 39.4 percent, and the proportion with no drug benefit declined from 31.4 percent in early 2004 to 24.8 percent in 2005. However, in 2005, drug coverage was much less generous than in 2000. Only 39.4 percent of enrollees versus 78.4 percent in 2000 had brand name drug coverage, and 24.8 percent had no drug benefit in 2005 versus 16.8 percent in 2000. Additional non-drug benefits show a similar pattern of a significant decline in generosity early in the decade that was not reversed by BIPA, but a partial restoration of benefits post-MMA.

Figure 6-3
Prescription drug benefits in basic HMO plans, 2000–2005



SOURCE: RTI analysis of CMS Health Plan Management Systems, and Enrollment Database data

Cost Sharing

Beneficiary cost sharing liability increased substantially in the early years of the decade, then declined or stabilized post-MMA. For example, less than one percent of enrollees were in plans with a primary care physician copayment greater than \$15 in 2000. This percentage rose to 23.9 percent by early 2004, then fell to 12.6 percent post-MMA. The percentage of enrollees with a specialist physician copayment greater than \$15 rose from 9.3 percent in 2000 to 71.4 percent in early 2004, then moderated to 60.2 percent in 2005.

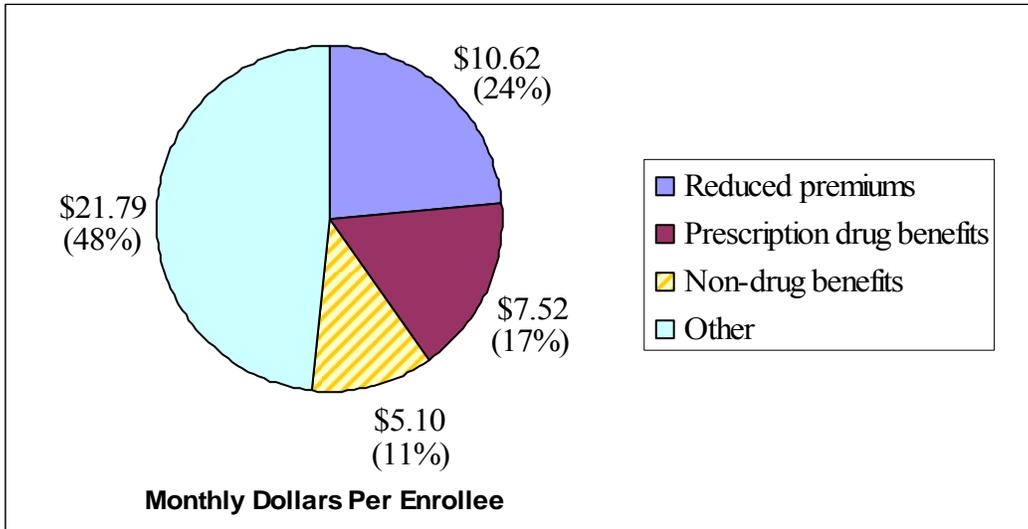
In 2000, only 19.5 percent of enrollees in basic HMO plans were charged any cost sharing for acute hospital admissions. This percentage rose to 88.3 percent in early 2004 and remained near that level through 2005 despite the March 2004 MMA payment increases. In 2000, only 30.1 percent of enrollees were charged for use of hospital outpatient services. This percentage doubled and stabilized at about 60 percent from 2003 on. The percentage of enrollees paying cost sharing for X-ray and clinical laboratory services rose sharply through early 2004, and then leveled off, but did not decline, with the MMA payment increases in March 2004.

Overall, the picture is of increasing cost sharing from 2000 to 2005. Sharp increases occurred early in this period, despite the implementation of BIPA in March 2001. Post MMA, some declines are evident, such as in physician visit copayments, but cost sharing for many services appears to have leveled off rather than been rolled back.

Out-of-Pocket Costs

The result of changes in plan premiums, benefits, and cost-sharing can be summarized as changes in enrollee out-of-pocket costs. We estimated HMO plan short-run uses of 2004 MMA payment increases (**Figure 6-4**). We calculated that in 2004, the MMA raised the average Medicare payment per member per month by \$45.03. About half of this amount—\$23.27—was used by plans to lower enrollee out-of-pocket costs for medical care. This reduction represented 5.9 percent of enrollee total out-of-pocket costs for medical cost. Nearly half of the 2004 out-of-pocket cost reduction was due to lower premiums (\$10.62), about one-third to improved prescription drug benefits (\$7.52), and about one-fifth (\$5.10) to lower cost sharing or improved benefits for non-drug medical care. Other uses of the additional payments would include costs associated with increased access to providers and contributions to a benefit stabilization fund. The relationship between increased plan payments and reduced enrollee out-of-pocket costs is especially evident when changes are compared across geographic areas with differing levels of payment increases. In counties where payment rose by \$100 or more per member per month in 2004, average out-of-pocket costs fell by \$64.55 or 16.2 percent, while in counties where payment increased less than \$25, average out-of-pocket costs fell by only \$11.49 or 2.8 percent. Reductions in HMO enrollee out-of-pocket costs occurred in all urban, rural, and regional areas, but were largest on average in large cities, in the South, and in counties with the largest payment increases. Even after the BBA, BBRA, BIPA, and MMA payment changes, substantial urban-rural and regional disparities in estimated MA plan enrollee out-of-pocket costs remained, with estimated enrollee costs highest in rural areas and in the Midwest.

Figure 6-4
Estimated Medicare Advantage plan use of additional 2004 Medicare Modernization Act financing



SOURCE: RTI analysis of CMS county payment rate and plan out-of-pocket cost files.

NOTE: “Other” includes uses that did not reduce enrollee out-of-pocket medical costs.

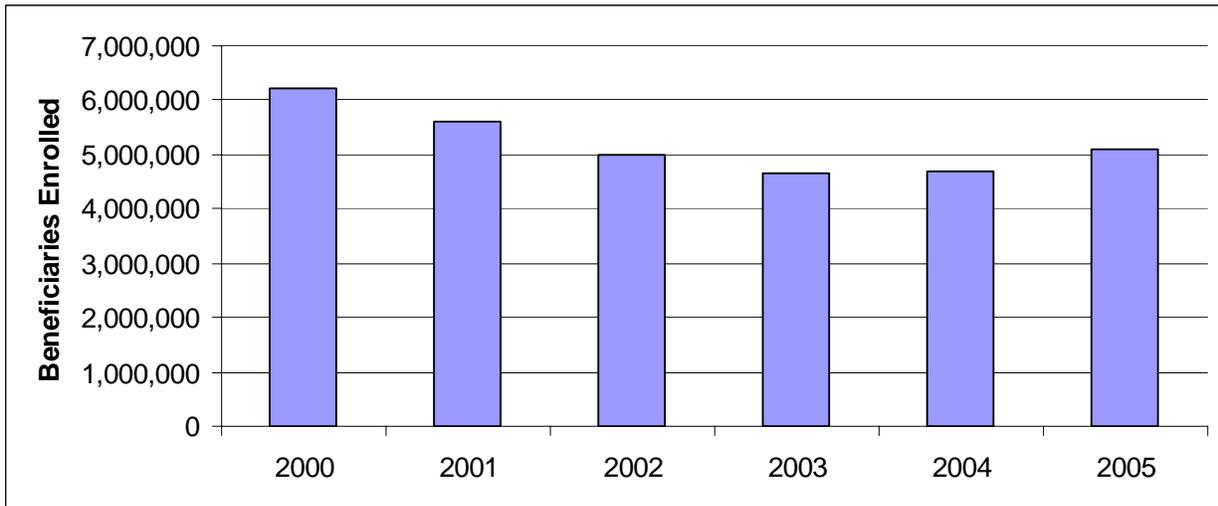
6.3 Enrollment

MA plan enrollments decreased steadily through 2003, began to stabilize in 2004, and rebounded somewhat in 2005 after the passage and full implementation of the MMA.

After a period of steady growth in Medicare plans in the early to mid 1990s, the BBA’s payment rate provisions of the late 1990s resulted in a significant loss of enrollment among many of the MA organizations with whom we spoke. On the other hand, enrollment for several local plans remained relatively stable throughout this period. This was particularly true for MA organizations who reported more positive experiences of the BBA payment changes, such as the minimum floor payment rate. Payment modifications under BIPA somewhat curtailed the sharp declines in enrollment experienced by most plans, and, for some plans, stabilized enrollment. However, payment increases resulting from the MMA positively impacted enrollment for all the MA organizations we interviewed, although some plans have benefited more robustly than others in enrollment gains during the last two years.

We analyzed enrollment and disenrollment trends using CMS secondary data. Overall MA enrollment significantly declined between 2000 and 2003, falling from 6.2 million enrollees in 2000 to 5.6 million in 2001, 5.0 million in 2002, and finally 4.7 million in 2003. Enrollment began to stabilize in 2004, and rebounded in 2005 to 5.1 million. Thus, while the MMA appeared to have had a positive effect on Medicare Advantage enrollment, the number of beneficiaries enrolled in plans remained well below (by approximately 1.1 million) 2000 levels. These trends are shown in *Figure 6-5*.

Figure 6-5
Medicare Advantage enrollment trends



SOURCE: RTI analysis of the Medicare Enrollment Database.

Although the number of new enrollees declined slightly over 2001 to 2003, the primary reason for the decline in enrollment was disenrollment due to reasons other than death. The decline in enrollment in the early part of this decade was likely in large part a response to the BBA payment changes coupled with rising medical cost inflation, which caused many plans to withdraw or contract service areas, creating “involuntary” disenrollment. In addition, BBA payment constraints combined with medical cost inflation caused many plans to raise premiums and reduce benefits for enrollees, which also contributed to the decline in enrollment.

Enrollments in urban counties continue to dominate the MA program throughout this time period. Enrollment in rural counties has improved slightly as of 2005, though overall rural enrollment remained small.

The legislative initiatives were focused, in part, on improving availability of Medicare plans to underserved areas. Therefore, we examined trends in Medicare Advantage by urbanicity over 2000 to 2005. Urban enrollment consistently comprised the vast majority of total enrollment ranging from a high point of 97.9 percent of total enrollment in 2001 to a low point of 96.5 percent in 2005.

Somewhat different patterns characterized enrollment trends in rural versus urban counties. In 2001, there was a 29.4 percent decrease in rural enrollment, which might be surprising considering the BBA-mandated floor payment rate, and the BIPA-mandated increase in the floor payment rate, each of which intended to stabilize, and even increase, rural enrollment. The decline in rural enrollment might reflect retraction of a prior overexpansion by plans in extending their service areas to rural areas when it was not a viable business proposition.

Unlike urban enrollment, over 2001 to 2003, rural enrollment experienced only a one-time substantial decrease, and then remained relatively stable until the MMA payment changes took effect. In 2005, there was a noticeable increase in rural enrollment. As a result over

the entire period from 2000 to 2005, enrollment remained stable in rural counties but fell by 22.7 percent in urban counties.

6.4 Conclusions on Impact of Additional Financing

A major focus of the legislative changes to Medicare managed care following the BBA was to provide additional financing to MA plans. The analyses and discussions with plans support the following conclusions about the impact of additional financing:

Medicare payment rates are an important determinant of MA plan availability, premiums, and benefits.

Medicare payment rates are an important determinant of MA plan availability, premiums, and benefits. Significant changes in payments of the type implemented under the BBA clearly had an effect on Medicare plan availability, benefits and premiums, and beneficiary enrollment, especially because they were implemented during a period when plans' costs of purchasing medical care were rising significantly. These impacts occurred despite the fact that payment update reductions in largely urban areas were, in theory, to be offset by payment increases (through the establishment of minimum floor payments) to rural counties. Our analyses suggest that, even with additional funding to rural areas that began under the BBA, plan availability to rural counties remains relatively poor. The actual impact of the BBA was focused on the urban counties where plans were located and where payment updates were cut. Offsetting positive impacts in rural areas generally failed to materialize because there were no plans in these counties to take advantage of them.

Short-term or temporary payment increases appear to have little effect on plan availability or benefits, and hence enrollment. Congress enacted, through the BBRA and BIPA, a series of temporary fixes to stop the withdrawal of plans from the M+C program. But MA organization decisions to participate in specific counties and offer improved benefits are complex and costly business decisions with long term consequences. Hence, payment increases that were not guaranteed beyond a year or two did little to improve the post-BBA situation. With few exceptions, plan availability, benefits and enrollment did not rebound until passage of the MMA, with its permanent restructuring of the program under the Medicare Advantage aegis. Long term payment adequacy is the key issue for encouraging improvements in plan availability and benefits.

Payment changes are not likely to substantially change geographic disparities in the availability of Medicare managed care plans (HMOs and local PPOs).

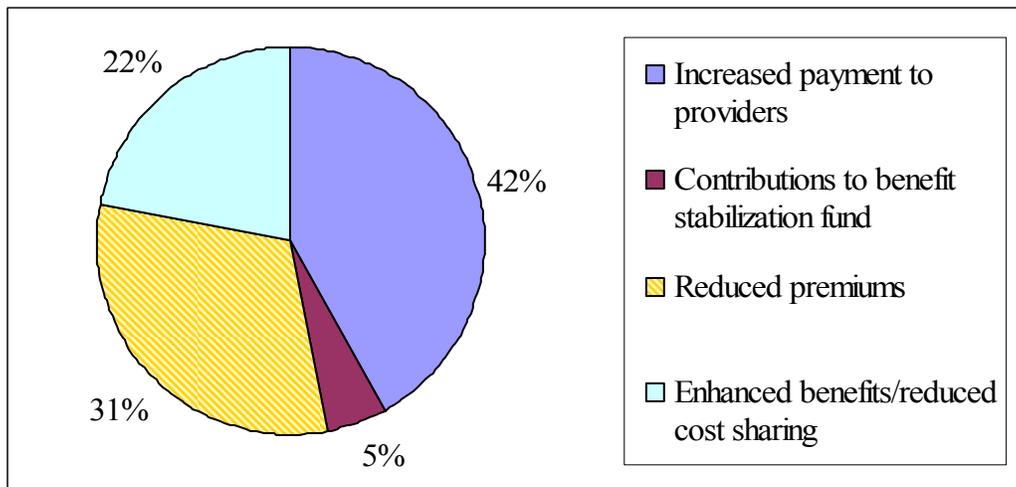
Improving access to managed care (HMOs and local PPOs) in rural areas to levels comparable to urban counties appeared to be a more intractable problem that will take more than payment increases to solve. Despite payment increases in traditionally low-payment areas such as rural areas, substantial geographic disparities in availability and benefits of Medicare managed care plans remained in 2005. MMA 2004 payment increases somewhat improved availability and benefits of managed care plans in rural and small urban areas, but these remained far below the levels in large urban areas. Inherent characteristics of rural areas such as less provider competition and discounting, as well as fewer enrollees over which to spread fixed costs, make these areas less attractive to managed care plans, despite payment rates higher than per capita

costs in the traditional FFS program. MA organizations argue that managed care in sparsely populated areas with few providers simply is not feasible.

Extra Medicare payments to plans are likely to be used for a variety of purposes.

Plans used extra Medicare payments to increase provider payments, offset medical cost increases, and reduce enrollee out-of-pocket costs (**Figure 6-6**). About half of the extra 2004 MMA financing was used to lower enrollee out-of-pocket costs by cutting premiums and improving benefits. Average HMO premiums fell by 31 percent in 2004, and total enrollee out-of-pocket costs fell by 6 percent. Plans reported that the other half of extra 2004 MMA financing was used to defray cost increases for existing benefits, including higher provider payments and greater utilization of medical services.

Figure 6-6
Reported Medicare Advantage plan use of additional 2004 Medicare Modernization Act financing



SOURCE: CMS (2004).

GLOSSARY

AAPCC – Adjusted Average Per Capita Cost
ACR – Adjusted Community Rate
ACRP – Adjusted Community Rate Proposal
BBA – Balanced Budget Act of 1997
BBRA – Balanced Budget Reform Act of 1999
BIPA – Benefits Improvement and Protection Act of 2000
CMS – Centers for Medicare & Medicaid Services
CMS-HCC – CMS Hierarchical Condition Category
EDB – Medicare Enrollment Database
FFS – Fee for Service
GAO – Government Accountability Office (formerly General Accounting Office)
GME – Graduate Medical Education
HHS – U.S. Department of Health and Human Services
HMO – Health Maintenance Organization
HPMS – Health Plan Management System
M+C – Medicare+Choice
MA – Medicare Advantage
MCBS – Medicare Current Beneficiary Survey
MCO – Managed Care Organization
MMA – Medicare Prescription Drug Improvement and Modernization Act of 2003
MSA – Metropolitan Statistical Area
PFFS – Private Fee for Service
PIP-DCG – Principal Inpatient Diagnostic Cost Group
POS – Point of Service
PPO – Preferred Provider Organization
RTC – Report to Congress

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