RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

Brief No. 2021-3 FEBRUARY 2021 http://www.public-health.uiowa.edu/rupri/

Availability of Supplemental Benefits in Medicare Advantage Plans in Rural and Urban Areas

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Purpose

Enrollment in Medicare Advantage (MA) plans has consistently increased since the program's redesignation by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. MA plans have long included supplemental benefits not available in original Medicare, such as dental and vision coverage. Additional supplemental benefits are becoming available through MA plans, such as those serving beneficiaries with chronic conditions, per Title III of Division E of the Bipartisan Budget Act of 2018. This brief identifies differences in MA plans that include supplemental benefits available to rural (nonmetropolitan) and urban (metropolitan) enrollees. By better understanding the variation in MA plan offerings across the country, policymakers can take appropriate action to improve the value of plans available in rural regions.

Key Findings

- 3,120 MA plans are being offered in 2020—a 15.0 percent increase from 2019.
- Noncore counties (neither micropolitan nor metropolitan) average 2.7 fewer organizations providing MA plans than do metropolitan counties.
- Beneficiaries in noncore and micropolitan counties have significantly fewer MA plans to choose from, with most of the difference attributable to lower availability of health maintenance organization (HMO) and local preferred provider organization (PPO) plans.
- Among the 12 most common MA supplemental benefits, 11 are available in fewer nonmetropolitan counties compared to metropolitan counties.
- The difference in supplemental benefits is most prominent for hearing exams, eye exams, preventive dental care, fitness programs, remote access technologies, health education, and over-the-counter items.
- A smaller proportion of MA plans in nonmetropolitan counties than in metropolitan counties offer a zero-premium option.
- The average out-of-pocket maximum for all in-network Part A and Part B services for MA plans in noncore counties is $281 lower than in metropolitan counties.

RHRC Rural Health Research & Policy Centers
Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org

This project was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement/grant #U1C RH20419. The information, conclusions and opinions expressed in this policy brief are those of the authors and no endorsement by FORHP, HRSA, HHS is intended or should be inferred.

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Background

Growth in MA enrollment and in the number of participating insurers demonstrates the attractiveness of this innovative health care delivery model.[1,2] Yet in 2019, a considerable gap remained between rural and urban MA enrollment. Among rural Medicare beneficiaries, 24.6 percent were enrolled in an MA plan compared to 36.4 percent of all urban beneficiaries.[3] This disparity has, in part, been explained by limited plan availability, types of available MA plans, premium prices, and more narrow physician networks in rural areas.[4]

Given these gaps in plan availability, rural beneficiaries may not have access to plans offering supplemental benefits not covered in original Medicare.[5] Nationally, not only is the number of MA plans with supplemental benefits growing, but the array of benefits is also increasing.[6] Typically seen as a vehicle for demonstrating innovative health care delivery, in 2020 MA plans were authorized to offer a broader range of benefits.[6] For example, MA plans could previously cover transportation for physician visits, but the new rules expanded the scope of covered transportation services to include non-physician office visits (such as a nutritionist), and trips to the grocery store. . Further, as a way to address social determinants of health and special healthcare needs, more plans have been granted special authority to provide optional benefits for chronically ill Medicare beneficiaries.[7,8] However, if rural Medicare beneficiaries lack equal opportunities to enroll in plans providing such additional or supplemental benefits, the overall rural/urban MA enrollment disparity may be exacerbated.

Data and Methods

Publicly available data on MA plan availability and plan benefits to be offered in 2020 were downloaded from CMS websites in October 2019.[9] Medicare enrollment data for 2019 were also obtained.[10] All data were reported at the county level (or equivalent). Using 2013 Urban Influence Codes, we classified counties as metropolitan (1,2), micropolitan (3,5,8), or noncore (4,6,7,9-12). Noncore counties have no urban cluster with 10,000 or more people and do not have a high degree of integration with metropolitan or micropolitan counties. This analysis excluded the following types of MA plans: Special Needs Plans, employer-sponsored group plans, demonstrations, Health Care Prepayment Plans, Programs of All-inclusive Care for the Elderly plans, or plans for special populations. The final analysis included Health Maintenance Organization (HMO) plans, Regional Preferred Provider (PPO) plans, Local PPO plans, Prospective Fee-for-Service (PFFS) plans, cost plans, and Medicare Medical Savings Account plans. Supplemental benefits included in this analysis are those that are available to all Medicare beneficiaries (i.e., excluding those offered only to beneficiaries with chronic conditions, per the aforementioned expansions in the CHRONIC Care Act).

Results

MA Plan Availability – plan differences between types of counties

A total of 3,120 MA plans were offered in 2020, an increase of 15.0 percent in total plan offerings over 2019. Nationally, an average of 15.9 MA plans are available in all counties. Beneficiaries in metropolitan counties have a greater number of MA plans to select from both overall and across nearly all plan types (Table 1). Beneficiaries in noncore counties have a larger number of *Other* types of plans compared to other counties, largely due to the entry of Lasso Healthcare, which began offering Medicare medical savings accounts as MA plans in 17 states in 2019.[11] No MA plans are offered in seventy-eight counties in 2020 (6 metropolitan, 11 micropolitan, and 61 noncore) in six states: Alaska (all 29 county-equivalents), California (15 counties), Idaho (11 counties), Iowa (one county), Nebraska (14 counties), and Washington (8 counties).

Table 1. Average number of organizations offering MA plans, total MA plans, and plan types, by county type

	Noncore Counties (n=1,334)	Micropolitan Counties (n=641)	Metropolitan Counties (n=1,166)
Organizations	3.5	4.3	6.2
All plans	11.1	14.9	21.8
HMO plans	3.2	5.2	10.3
Regional PPO plans	2.0	2.3	2.4
Local PPO plans	3.7	5.6	7.6
PFFS plans	0.7	0.6	0.6
Other plans*	1.6	1.2	1.0

Source: CMS Landscape Files for 2020.
*Other includes cost plans and Medicare medical savings accounts.

Available Supplemental Benefits in MA Plans – benefit differences between types of counties

Table 2 shows the average proportion of MA plans offering supplemental benefits by county type. The list of supplemental benefits is not exhaustive but includes the most frequently covered services. There is a nearly perfect monotonic increase in proportion of plans offering each type of supplemental benefit moving from noncore to metropolitan counties.

Table 2. Proportion of MA plans offering supplemental benefits, by county type, 2020; ordered by benefits most often included in plans

Supplemental Benefits	Noncore Counties	Micropolitan Counties	Metropolitan Counties
Eye exams	85.4%	90.2%	94.1%
Fitness programs	69.7%	80.0%	87.7%
Hearing exams	73.2%	80.6%	86.0%
Preventive dental care	73.4%	80.9%	86.9%
Remote access technologies*	42.6%	49.4%	56.3%
Over-the-counter items	54.5%	60.6%	66.9%
Health education	29.5%	35.5%	40.1%
Transportation services	10.3%	15.2%	23.0%
Smoking and tobacco cessation services	15.3%	20.3%	21.4%
Personal emergency response systems	8.3%	10.3%	11.3%
In-home safety assessment	2.8%	3.7%	3.0%
Post discharge, in-home med. Reconciliation	1.0%	1.9%	1.8%

Source: CMS Plan Benefit Files for 2020.
*Including web/phone-based technologies and nursing hotline.

Available Supplemental Benefits in MA Plans – premium differences between types of counties

Fewer than half (43.3 percent) of the MA plans offered in 2020 have a $0 monthly premium (note that this does not include the standard Part B premium). A plan may have a $0 premium if that plan's bid to the federal government does not exceed the county benchmark.[12] Zero dollar premium plans are most frequently offered by local HMO and Local PPO plans (46.2 percent and 32.3 percent, respectively. Table 3 shows that there is a

monotonic increase across county type in the proportion of plans with a $0 monthly premium and the average number of $0 plans available. Average maximum out-of-pocket costs are lower in noncore counties than in micropolitan counties (a difference of $207 or 4.1 percent) and lower in noncore counties than metropolitan counties (a difference of $281 or 5.5 percent).

Table 3. MA plan premiums, by county type

	Noncore Counties	Micropolitan Counties	Metropolitan Counties
Plans with $0 premium	38.7%	39.9%	47.2%
Average number of $0 premium plans available	4.5	6.1	10.4
Counties with no $0 premium plans	63 (4.9%)	25 (4.0%)	18 (1.6%)
Counties with one $0 premium plan	165 (13.0%)	50 (7.9%)	33 (2.8%)
Average maximum out-of-pocket	$4,819	$5,026	$5,100

Source: CMS Landscape Files for 2020.

Discussion

Medicare beneficiaries in nonmetropolitan counties have less choice when deciding to enroll in an MA program. The finding that more organizations providing MA plans operate in metropolitan counties, leading to a greater number of plans, supports existing evidence. However, much of the previous research on specific types of MA plans focused on enrollment differences by counties. Taking a supply perspective, this brief builds upon previous RUPRI Center research to further illuminate the significant discrepancy in the number of HMO and local PPO plans available to rural and nonrural Medicare beneficiaries.[13] Identifying this gap helps improve our understanding of rural MA enrollment decisions, as both HMOs and local PPOs offer beneficiaries a unique set of options to either minimize costs or join a plan with a broader physician network.[14] The absence of those options may limit the perceived value of enrolling in an MA plan instead of in original Medicare.

We found that the average out-of-pocket maximum for MA plans in nonmetropolitan counties is slightly lower than in metropolitan counties; and that MA plans in nonmetropolitan counties offer fewer supplemental benefits to all beneficiaries. Over the past decade, MA plans dramatically increased their coverage of vision and dental services, fitness programs, and other benefits typically not covered by original Medicare. Across a variety of supplemental benefits, 5-15 percent fewer plans that are available to nonmetropolitan beneficiaries cover those services. The number of plans including over-the-counter benefits is also disproportionately lower in nonmetropolitan counties, as is the case for preventive services such as health education and smoking cessation. Some of the most recent additions to MA supplemental benefits are coverage for transportation and telehealth services. Given the nature of rural health systems, Medicare beneficiaries in nonmetropolitan counties would benefit from such services. Yet plans in nonmetropolitan areas are 7.8 to 12.7 percentage points less likely than plans in metropolitan areas to cover these services. Limited plan availability, especially for HMOs and local PPOs, combined with fewer zero-premium plans and plans covering supplemental benefits, likely reinforces lower MA enrollment.

Policymakers are expected to continue supporting MA as a vehicle for targeting benefits not covered under traditional Medicare, such as those included in the CHRONIC Care Act provisions incorporated into the Bipartisan Budget Act of 2018; examples are home-delivered meals and expanded access to telehealth services.[15] Amid this growth in coverage options, the rural-urban disparity should not be ignored. By understanding the mechanisms driving the various disparities in the range of services offered, policymakers will be better equipped

to mitigate health inequities across the rural-urban continuum and better able to evaluate and modify existing policies exacerbating these effects.

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