# MEDICARE ADVANTAGE

## Plan Options and Enrollment Trends in Arkansas

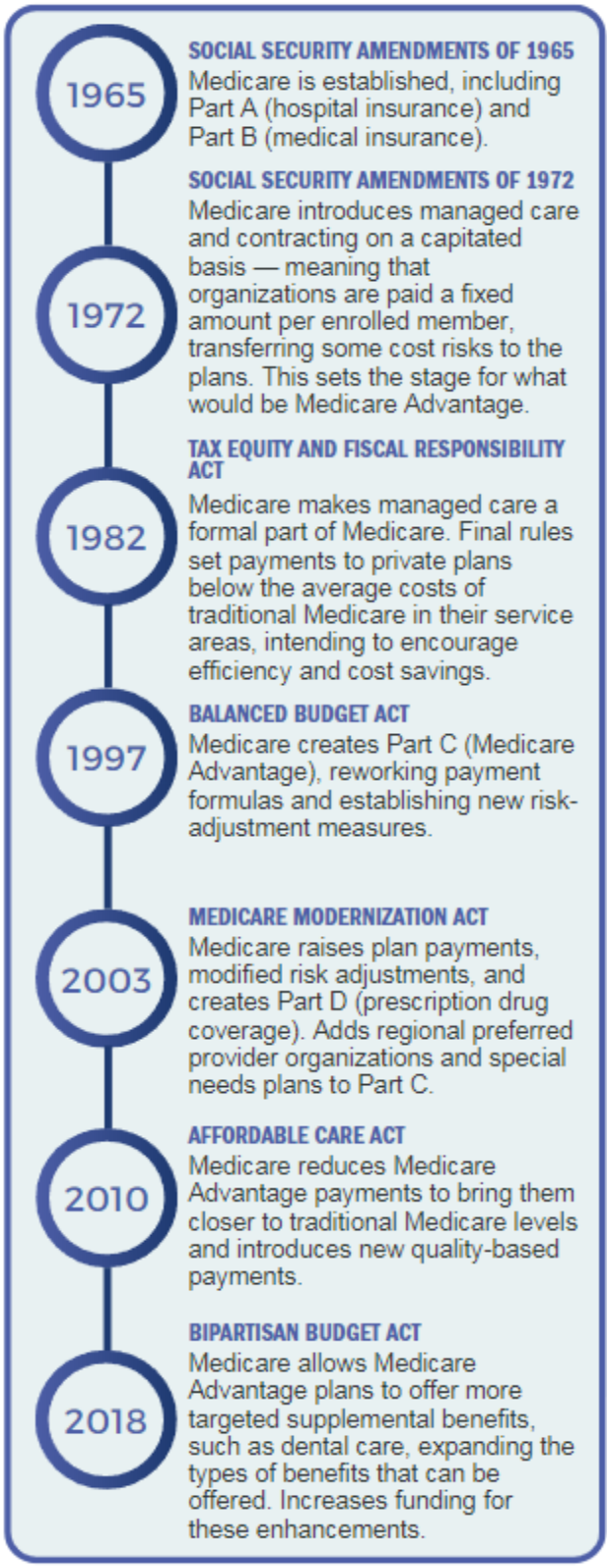
## Introduction

Medicare Advantage plans offer an alternative way for those who are eligible for Medicare to receive healthcare benefits. Unlike traditional Medicare, which is managed by the federal government, Medicare Advantage plans are offered by private insurance companies approved by Medicare. These plans provide the essential health services offered by traditional Medicare but may include additional benefits such as dental, vision, and hearing coverage, along with out-of-pocket spending caps and bundled services, enhancing their appeal to beneficiaries. While the Medicare Advantage program may offer several benefits, it also introduces complexities, such as limited access to in-network providers and varying cost-sharing models, that beneficiaries must navigate. This explainer provides an overview of Medicare Advantage, discusses recent enrollment trends in Arkansas, and discusses government oversight of the program.

## Overview

Medicare is a federal program that was established in 1965 to provide healthcare coverage primarily for seniors, originally encompassing Part A (hospital insurance) and Part B (medical insurance). Medicare Advantage (Part C) was established as part of the Balanced Budget Act of 1997 to provide additional choices for beneficiaries beyond the traditional Medicare program and incorporate the efficiencies and cost savings observed in private-sector managed care[1] (see Figure 1). Medicare Part D (prescription drug coverage) was established in 2003. Medicare Advantage plans consolidate Medicare Part A and Part B, with 89% of plans in 2024 also including Part D for prescription drug coverage.[3] A Medicare Advantage plan operates on a

FIGURE 1: TIMELINE OF KEY LEGISLATION[2]




fixed monthly payment from Medicare to the private company offering the plan. The plans cover all medically necessary services required by traditional Medicare but with varying out-of-pocket costs and service rules, such as prior authorization requirements for certain services or medications.

For patients, benefits of Medicare Advantage include potentially lower cost sharing compared to traditional Medicare, convenience of coordinated care, and often additional benefits such as dental, vision, and hearing care.[4] Unlike traditional Medicare, which allows beneficiaries to choose any provider accepting Medicare, Medicare Advantage plans often require enrollees to use a more limited network of providers — particularly in rural areas — which may restrict access to specialty care.[5]

## Types of Medicare Advantage Plans

Medicare Advantage plans come in several forms, each with its unique structure and rules.[6]

- **Health Maintenance Organization (HMO) Plans**: An HMO plan offer healthcare coverage through a network of providers, hospitals, and medical facilities that have a contract with the plan. These plans generally require a referral from a primary care doctor

for specialist visits to ensure coordinated care. In most cases, these plans cover prescription drugs.

- **Preferred Provider Organization (PPO) Plans:** There are two types of PPO plans within Medicare Advantage, regional and local.[7] A regional PPO plan is designed to serve a large area, either encompassing an entire state or multiple states as determined by Medicare. A local PPO plan serves a smaller area, such as a single county or a group of counties selected by the plan and approved by Medicare. Both types of PPO plans offer increased flexibility in choosing healthcare providers, allowing members to use out-of-network providers, but using 'preferred' providers within the network can result in lower costs. In most cases, these plans cover prescription drugs.

- **Private Fee-for-Service (PFFS) Plans:** PFFS plans set how much they pay for medical services and what the enrollee pays out of pocket. An enrollee can see any provider that agrees to the plan's terms, but using providers outside the plan's network might cost the enrollee more. PFFS plans may allow providers to charge up to 15% more than the usual Medicare rate, which may result in enrollees paying the difference between what the provider charges and the amount Medicare pays.

- **Special Needs Plans (SNPs):** SNP plans provide benefits for individuals with specific diseases or characteristics, offering specialized care for those needs. All SNPs must provide Part D coverage.

- **Medicare Medical Savings Account (MSA) Plans:** An MSA plan combines a high-deductible insurance plan with a medical savings account. MSA plans deposit funds into a savings account which enrollees can use to pay for healthcare expenses. The high-deductible plan pays for costs only after the beneficiary has reached the deductible and offers more flexibility in choosing healthcare providers. These plans do not offer prescription coverage, and there are specific tax implications for using the medical savings account. In 2024, Wisconsin will be the only state with an MSA plan available to its residents.[8]

## Eligibility and Enrollment

To be eligible for Medicare Advantage, individuals must first be enrolled in Medicare Part A and Part B. Once eligible, individuals can enroll in Medicare Advantage or change their Medicare Advantage plans during the following designated enrollment periods:[6]

- **Initial Enrollment Period**: Upon first becoming eligible for Medicare, a person can join a Medicare Advantage plan during an initial enrollment period. This seven-month window begins three months before a person's 65th birthday, includes the person's birth month, and extends through the three months following the person's birth month.
- **Annual Election Period**: Occurring from October 15 to December 7 each year, this period provides the opportunity for existing Medicare beneficiaries to switch to a Medicare Advantage plan, change their current plan, or revert to traditional Medicare.
- **Medicare Advantage Open Enrollment Period**: From January 1 to March 31 annually, a person enrolled in a Medicare Advantage plan has the option to switch to a different Medicare Advantage plan (with or without drug coverage) or drop the Medicare Advantage plan and switch back to traditional Medicare, with the opportunity to join a separate Medicare drug plan. During this period, a person with traditional Medicare cannot switch to a Medicare Advantage plan, join a Medicare drug plan, or switch from one Medicare drug plan to another.
- **Special Enrollment Periods**: These periods allow beneficiaries to make changes to their plans outside of the Annual Election Period due to specific life events, such as relocating to a new area or losing existing coverage.

As more Arkansas residents opt for Medicare Advantage (see below), resources such as the Seniors Health Insurance Information Program, which provides free Medicare counseling, are available to help beneficiaries navigate the program.[9] Beneficiaries are encouraged to utilize online resources such as the Medicare Plan Finder, a tool for comparing and selecting Medicare plans, to find the plan that aligns best with their healthcare needs and financial situation.[10]

## Medicare Advantage in Arkansas

Medicare Advantage plans have seen steady increases in enrollment over the past decade. As of 2023, about 43% of the eligible Medicare population in Arkansas had enrolled in Medicare

Advantage plans.[11] Figure 2 shows a consistent upward trend in Medicare Advantage enrollment from 2012 through 2024.[11] Figure 3 provides a county-by-county breakdown of enrollment as of December 2023, showing variations across the state, with some areas seeing over half of eligible beneficiaries opting for Medicare Advantage plans.[11]

FIGURE 2: PERCENTAGE OF MEDICARE-ELIGIBLE BENEFICIARIES ENROLLED IN MEDICARE ADVANTAGE, US VERSUS ARKANSAS

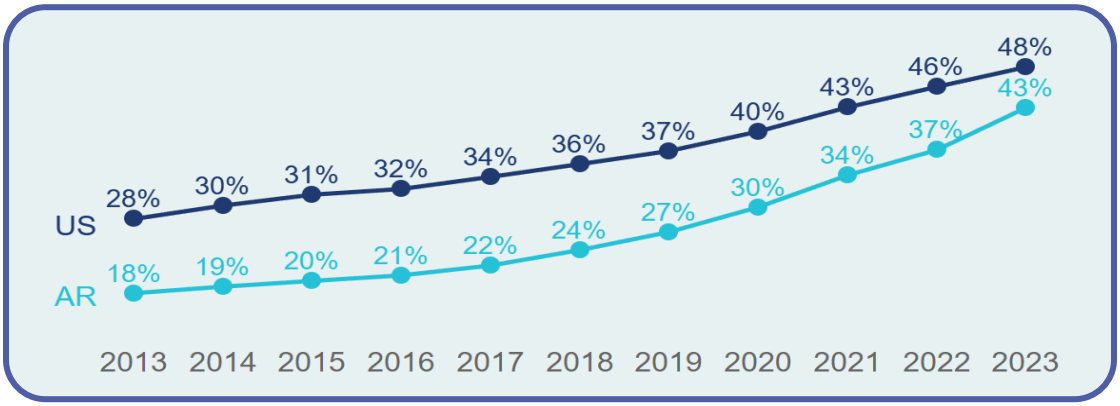
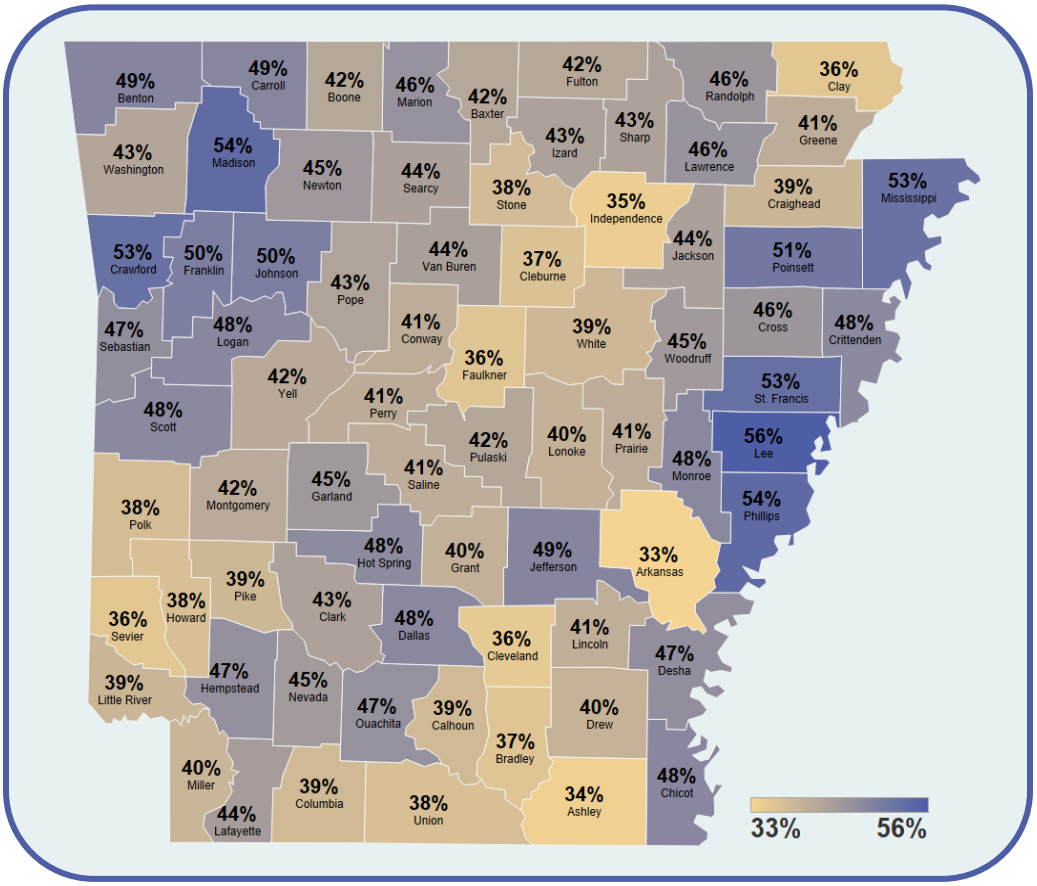



FIGURE 3: PERCENTAGE OF MEDICARE-ELIGIBLE BENEFICIARIES ENROLLED IN MEDICARE ADVANTAGE BY COUNTY, DECEMBER 2023

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A variety of Medicare Advantage plans are offered in Arkansas. Figure 4 shows the 2024 distribution of these plans in the state and nationally.[8] The move toward privatized Medicare options is signaled by the competition among insurers, as evidenced by the increase from 39 Medicare Advantage plans in 2014 to 58 in 2024[12] (see Figure 5). In Arkansas, UnitedHealth holds the largest market share with 36%, followed by Humana with 27%.[13]

The Medicare Advantage market in Arkansas reflects a growing but not yet dominant preference for these plans over traditional Medicare. Advertising and the perceived value of the plans are key drivers of their growing popularity. While these promotions can increase awareness, they can also sometimes lead to confusion among seniors regarding their options.[14] Recent measures by the Centers for Medicare and Medicaid Services (CMS) aim to curb misleading ads and standardize compensation for agents and brokers to avoid inappropriate steering of beneficiaries into unsuitable plans and encourage competition within the market.[15] (see "Marketing Practices").

FIGURE 4: TYPES OF MEDICARE ADVANTAGE PLANS BY LOCATION, 2024

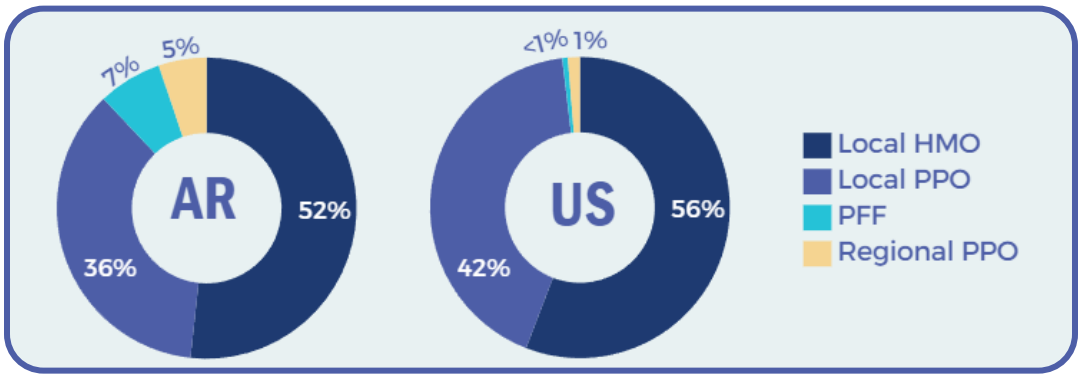



FIGURE 5: NUMBER OF MEDICARE ADVANTAGE PLANS IN ARKANSAS[8]

# Medicare Advantage Payment and Oversight

## PAYMENT RATES

CMS sets the rates of monthly per-person payments to Medicare Advantage plans annually. Medicare Advantage plans submit bids to cover Medicare Part A and Part B benefits.[16] These bids are evaluated against county-specific benchmarks.[17] The benchmark for each county is based on the projected Medicare fee-for-service (FFS) U.S. per capita cost (USPCC) and a county-level geographic index.[a] The result is the county-level FFS per capita cost. To set the actual benchmark for each county, the per capita cost is multiplied by a percentage that ranges from 95% to 115% depending on the county's FFS spending. These benchmarks are calculated to establish the maximum payment Medicare will make for a beneficiary in a Medicare Advantage plan.

Plans that demonstrate high quality of care, as indicated by the CMS five-star quality rating system, may receive increased payments, potentially 5% to 10% higher, as a reward for their performance. This system incentivizes plans to improve the quality of care they provide, allowing them to use the additional payments to offer better benefits or reduce cost sharing for enrollees without needing to charge higher supplemental premiums.[18]

When a plan's bid comes in below the benchmark, it receives a rebate — a percentage of the difference between its bid and the benchmark. This percentage is influenced by the plan's quality star rating: 50% for plans rated below 3.5 stars, 65% for plans rated 3.5 to 4.5 stars, and 70% for those rated 4.5 stars or higher.[19] These rebates must be used to benefit enrollees either by enhancing plan benefits or reducing their out-of-pocket costs.[18]

## REGULATORY OVERSIGHT

The government also provides regulatory oversight of Medicare Advantage plans to ensure that enrollees are protected and that plans adhere to established standards. Key aspects of this oversight include:

- **Marketing Practices**: Marketing of Medicare Advantage plans has come under scrutiny for practices that can mislead consumers, particularly the elderly and those with

[a] The county-level geographic index is called the average geographic adjustment (AGA). The AGA is based on historical county-level FFS Medicare spending weighted by local risk scores.

disabilities.[20] Aggressive tactics and deceptive advertisements may push enrollees towards plans that may not suit their needs. Dispite federal regulations that require clear and accurate information, many beneficiaries have continued to report deceptive practices. In April 2024, CMS issued a final rule to combat these issues by doing the following:[15]

- Prohibiting marketing organizations from sharing beneficiaries' contact information without express written consent. This is intended to address complaints about harassing solicitations.

- Revising agent and broker compensation structures. Agents and brokers, who help beneficiaries choose and enroll in plans, receive a commission from Medicare Advantage plans to cover the cost of enrollment services. Medicare limits these commissions to prevent excessive payouts. However, the commission caps do not apply to additional payments for administrative services, so some plans may use these payments to circumvent the caps. In response, CMS has finalized measures to standardize compensation for agents and brokers by eliminating separate payments for administrative services and applying a fixed compensation rate. This is intended to remove financial incentives for agents and brokers to steer beneficiaries toward plans that might not best meet their needs.

- **Network Requirements and Prior Authorization**: A Medicare Advantage plan is required to maintain a network of healthcare providers that is sufficient to offer covered services that meet the needs of the population served.[21] This means the network must include an adequate number of primary care doctors, specialists, hospitals, and other healthcare facilities to ensure enrollees can access care without unreasonable delay.[22] A Medicare Advantage plan may only use prior authorization to confirm medical necessity, must adhere to traditional Medicare coverage policies when making that confirmation, and must ensure that any prior authorizations are valid for the entire course of treatment.

- **Quality and Performance Standards**: Medicare Advantage plans are evaluated by CMS using a range of quality and performance measures, which are reflected in the CMS five-star quality rating system. [23] The star ratings are publicly reported to help

beneficiaries make informed decisions when choosing a plan. The criteria and methodology for calculating star ratings are updated regularly.

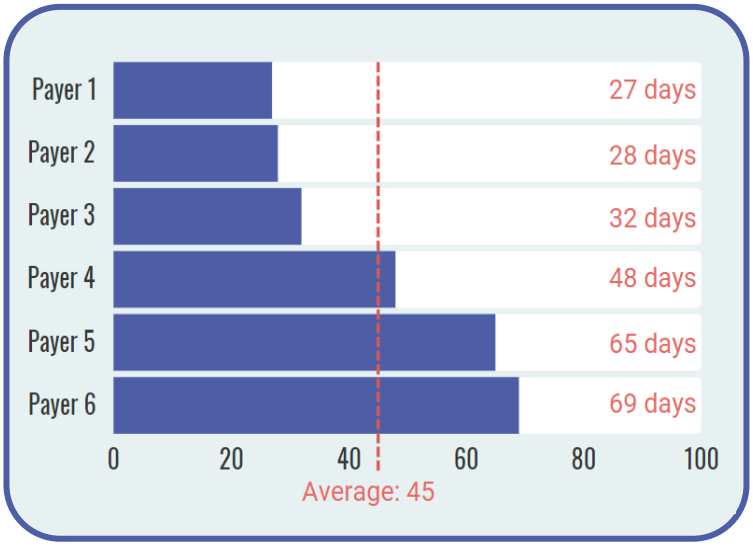
- **Transparency and Reporting**: Medicare Advantage plans are required to report information to CMS including details on plan benefits, network adequacy, and payments.[24] CMS has sought public input on enhancing data capabilities and program transparency.[25]

- **Expansion of Behavioral Health Access:** Some regulatory updates are intended to improve access to behavioral health services. These include updates broadening the workforce, filling service gaps, and refining payment models for behavioral health.[26]

## ADDRESSING PROVIDER COMPLAINTS

Providers have raised concerns about Medicare Advantage plans, particularly regarding delays in approval for care or provider payments due to prior authorization policies. Providers have also complained of a general lack of transparency about payment methods and coverage decisions.[27] In Arkansas, the average median time for Medicare Advantage plans to provide payment for inpatient stays in 2021 was 45 days across all payers. By payer, median payment times in 2021 ranged from 27 days to 69 days (see Figure 6). These issues adversely impact patient care and the financial stability of healthcare practices, and they have led to a growing dissatisfaction among hospitals and health systems, with some opting to terminate their contracts with certain Medicare Advantage plans due to

FIGURE 6: MEDIAN TIME TO PAYMENT FOR MEDICARE ADVANTAGE PLANS BY PAYER FOR INPATIENT STAYS, 2021[a]




[a] Data for this graphic were obtained from the Healthcare Transparency Initiative utilizing 2021 claims data. Time to payment is defined as the duration from the date of service to the final date the claim was paid.

unsustainable financial losses and excessive administrative burdens.[28] Ongoing monitoring is important to ensure that Medicare Advantage plans adhere to regulatory standards and effectively meet the needs of both providers and beneficiaries.

### IMPACT OF MEDICARE ADVANTAGE ON RURAL HOSPITALS[29]

Between 2019 and 2023, enrollment in Medicare Advantage plans by Medicare beneficiaries in rural areas increased by 48%. This shift has implications for critical access hospitals, which traditionally receive reimbursements from Medicare based on the cost of services, which is not required for Medicare Advantage plans. Unlike traditional Medicare, Medicare Advantage plans often provide reimbursement for these hospitals through negotiated rates that are typically lower than cost-based reimbursements, which can threaten the hospitals' financial stability, especially in states without Medicaid expansion.

One concern is the coverage of services that are essential for the financial stability of rural hospitals. In Medicare Advantage plans, benefits, choice of facility, costs, and coverage may differ from traditional Medicare and may not be aligned with services such as swing beds, which are hospital beds that can be used for either acute care or skilled nursing care, giving rural hospitals needed flexibility. Despite recent efforts to address administrative issues, especially regarding prior authorization decisions, issues remain in aligning Medicare Advantage payments with traditional Medicare's cost-based reimbursements for critical access hospitals and improving data transparency to help hospitals better understand beneficiary healthcare needs and negotiate rates. Further actions may be needed to ensure rural hospitals receive adequate financial support and can effectively navigate Medicare Advantage plan requirements.

## Conclusion

Medicare Advantage, as a component of the broader Medicare framework, extends a range of choices and benefits to its beneficiaries. With an increasing number of Arkansas residents opting for Medicare Advantage, it is important to examine the experiences of beneficiaries and the overarching impact of this rapid growth on the program's long-term viability. This will aid in making Medicare Advantage plans more sustainable, more equitable, and better aligned with the changing healthcare needs and preferences of Arkansas's aging population.

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