Why some rural enrollees in Medicare Advantage are switching to traditional Medicare

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More than one out of every 10 seniors (10.5%) enrolled in a Medicare Advantage plan, also known as a Medicare managed care option, and

living in a rural area, switched to traditional Medicare during 2010-2016. The switch was driven primarily due to low satisfaction with care access, according to a study published this week in *Health Affairs* from researchers at Drexel University's Dornsife School of Public Health. By contrast, only 1.7% of rural traditional Medicare enrollees made the switch to Medicare Advantage during this period.

The findings, among the first to look at rates of switching between the two options among rural versus nonrural enrollees, found a similar, yet more muted, effect among nonrural enrollees, with 2.2% of traditional Medicare enrollees and 5% of Medicare Advantage enrollees making the switch.

Switching was most common among Medicare Advantage enrollees who experienced higher costs, such as hospitalization or long-term facility stay. Among those requiring more expensive services, rural enrollees were about twice as likely to switch from Medicare Advantage to traditional Medicare as nonrural enrollees (16.8% versus 8.3%), suggesting that limited provider options in rural areas were a major factor leading consumers to change their coverage plan.

"We studied 11 factors that might make someone switch their health insurance and found that much of this transfer from Medicare Advantage to traditional Medicare among rural residents came from limited provider availability. However, care quality or out-of-pocket costs played a limited role." said lead author Sungchul Park, Ph.D., an assistant professor in the Dornsife School of Public Health. "It's not that rural patients were sicker than nonrural patients, they might just have a much tougher time than their counterparts did when it came to finding an approved medical provider."

Unlike traditional Medicare, which is administered by the Centers for Medicare and Medicaid Services, Medicare Advantage is operated by

private companies approved by the government. Both traditional Medicare and Medicare Advantage include hospital (Part A) and medical (Part B) insurance. However, funding for the two programs differs and influences how they're delivered. In traditional Medicare, the federal government pays for services performed, but the government pays Medicare Advantage insurers using fixed, pre-negotiated rates. This creates incentive for Medicare Advantage plans to implement cost-saving measures, such as programs to keep their enrollees healthy, implement networks and require prior authorization restrictions to care.

"Medicare Advantage plans might have lower premiums and/or supplemental coverage in some areas, but that value is not enough for patients in more restrictive provider networks that prevent them from accessing care they need," said Park. "We found that levels of satisfaction with out-of-pocket costs had little very little influence in patients who decided to change their plan."

Data was gathered from a nationally representative sample of seniors over age 65 from the Medicare Current Beneficiary Survey from 2010-2016, (expect for 2014, when data was not reported), including demographics, socioeconomic characteristics, health data and satisfaction with care. Rural residency was based on county-level 2013 data from the Department of Agriculture.

The authors suggest the importance of developing policies to incentivize the health care workforce to practice in rural areas. For example, loan repayment or forgiveness programs may attract needed health care professionals to areas of shortages. Also, the federal government could consider changing Medicare Advantage network adequacy standards for rural areas to make sure that there are enough providers included. Finally, offering a rural payment add-on for Medicare Advantage plans that operate in rural areas may improve access to high-quality Medicare Advantage plans among rural enrollees.

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