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Rural Medicare Advantage: Modest Enrollment Growth in 2010

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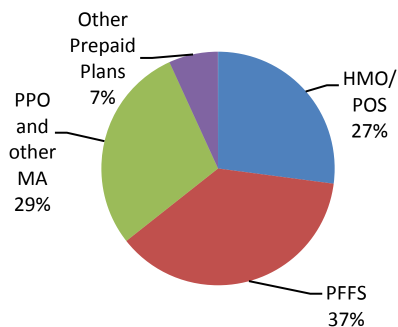
Despite a slight drop in enrollment and a dramatic shift in the landscape of the rural Medicare Advantage (MA) market in early 2010,[1] MA plans have experienced modest growth in enrollment in rural areas over the last two quarters of 2010. The majority of the growth is concentrated in preferred provider organization (PPO) plans, counteracting a decline in private fee-for-service (PFFS) plan enrollment. From December 2009 through June 2010, the landscape of the rural MA market has changed significantly, with a decline of 185,000 in enrollment in PFFS plans (26% decline) and a rise of 175,000 in enrollment in PPO plans (74% increase). This growth in PPO enrollment, along with continued growth in health maintenance organization (HMO) and prepaid plans, has led to a small net gain in total enrollment of 60,000 (4%).[2]

Figure 1. Enrollment in Medicare Advantage and Other Prepaid Plans by Plan Type, June 2010



Key Data Findings

Enrollment in MA Plans

- Rural MA enrollment increased fivefold (from 242 thousand to 1.45 million) from December 2005 to June 2009, as compared to a doubling in total MA enrollment during the same period (from 5.1 million to 11.5 million).
- Less than 15% of Medicare beneficiaries are enrolled in a MA plan in rural areas, as compared to over 28% in urban areas.
- From December 2009 to June 2010 enrollment in PFFS plans fell by over 185,000 in rural areas and by over 550,000 in urban areas. In contrast, PPO enrollment grew by 175,000 and 560,000 persons in rural and urban areas, respectively.
- Nine states have rural MA enrollment rates of 20% or greater, including Hawaii, Minnesota, New York, Ohio, Oregon, Pennsylvania, Utah, Wisconsin, and West Virginia.

Distribution of Enrollment

- PFFS plans have the largest share of enrollment in MA plans in rural areas, with 37% of the market share, while HMO/point-of-service (POS) plans have 69% of the market share in urban areas.
- The PFFS market share in rural areas has declined from 52% in December 2009 to 37% in June 2010, a much steeper drop than the drop in PFFS market share from 17% to 11% during the same time period in urban areas.
- PPO market share has increased to 29% in rural areas and 17% in urban areas as of June 2010.

Expectations for 2011. The shift in MA enrollment away from PFFS plans could continue into 2011 because the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires PFFS plans to form provider networks by 2011 in most locations. This requirement has already been a factor in some PFFS plans leaving the market with more likely to follow.[3] In addition, with the passage of the Patient Protection and Accountable Care Act (ACA) of 2010, benchmark payment rates for 2011 will remain unchanged at their 2010 rates. These factors, along with the implementation of ACA changes in payment structure and risk adjustments, could have a significant effect on MA plan availability, plan benefit structures, and beneficiary enrollment going forward. Rural MA enrollment will need to be monitored to determine the effects of any decline in availability of plans, or changes in benefits, on rural Medicare beneficiaries.

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[1] Kemper, L, TD McBride, K Mueller. "February 2010: A Dramatic Shift Away from Private Fee-for-Service Plans in Rural Medicare Advantage Enrollment," Brief No.2010-3, http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2010/March%202010%20MA%20032210.pdf
[2] Data presented here are based on state-county-plan enrollment files obtained from the Center for Medicare and Medicaid Services (CMS), merged with county-level indicators of rural-urban status as identified by the U.S. Department of Agriculture, Economic Research Service (ERS). Urban Influence Codes (UICs) were used to differentiate rural from urban counties. The enrollment data by county excludes enrollment in any county and plan if the plan enrolls 10 or fewer enrollees in that county (due to restrictions on data release by CMS) and excludes enrollees in Alaska and U.S. territories (due to data incompatibilities with geographic files).
[3] Gold, M, D Phelps, T Neuman, G Jacobson. "Medicare Advantage 2010 Data Spotlight, Plan Availability and Premiums." Kaiser Family Foundation, November 2009.

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