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Rural Enrollment in Medicare Advantage Is Concentrated in Private Fee-for-Service Plans

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Introduction

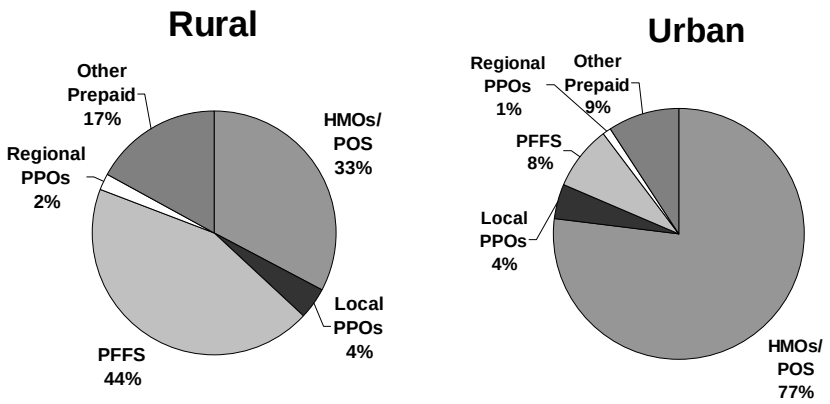
Enrollment in Medicare Advantage (MA) plans more than doubled in rural areas in 2006, the first year of the MA program. However, rural enrollment remains well below urban enrollment as a percentage of the eligible population. This policy brief provides findings about enrollment in the newly designed MA program in rural and urban areas across the United States and updates previous findings published in RUPRI Center policy briefs. Analysis of rural-urban differences in costs to beneficiaries that compares type of plan will be released in a policy brief in June 2007.

Key Findings

As of November 2006 (date of release by CMS [CMS 2006]),

- Over 500,000 rural Medicare beneficiaries were enrolled in an MA plan, more than twice the number that were enrolled in MA plans in 2005.
- Despite significant growth in MA plans, only 5.6% of rural persons were enrolled in MA plans in November 2006, compared to 17.5% of urban persons.
- About 44% of rural persons enrolled in MA or prepaid plans were in private fee-for-service (PFFS) plans, compared to only 8% of urban persons.
- Only about 33% of rural persons enrolled in MA or prepaid plans were in HMOs, compared to over three-quarters (77%) of urban persons.
- PFFS enrollment in rural areas in November 2006 was concentrated in several PFFS plans, with about 40% of the rural persons in MA or prepaid plans enrolled in just three PFFS contracts serving about 2,000 counties in the United States.

Figure 1. Enrollment in Medicare Advantage and Other Prepaid Plans by Rural and Urban (Nonmetropolitan and Metropolitan) Area and by Type of Plan



SOURCE: RUPRI Center for Rural Health Policy Analysis.

Enrollment in MA Plans

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created the MA program, superseding the Medicare+Choice program. The MMA created new options for MA, including regional PPOs, and established new levels of minimum payment. By November 2006, over 500,000 rural beneficiaries were enrolled in MA plans, more than twice as many as were enrolled in December 2005 (Table 1).[1] However, only 5.6% of rural Medicare beneficiaries were enrolled in MA plans in November 2006, compared to 17.5% of urban beneficiaries.

Table 1. Enrollment in Medicare Advantage and Other Prepaid Plans, by Location of Residence and by Type of Plan, November 2006 and December 2005

	November 2006			December 2005		
Type of Plan	Rural	Urban	Total	Rural	Urban	Total
Medicare Advantage	**512,943**	**5,924,645**	**6,437,588**	**241,706**	**4,898,088**	**5,139,794**
HMOs/POS	202,489	5,014,027	5,216,516	174,789	4,679,423	4,854,212
Local PPO	25,654	286,979	312,633	3,524	81,444	84,968
Regional PPO	14,194	75,199	89,393	0	0	0
PFFS	270,606	548,440	819,046	63,393	137,221	200,614
Other prepaid plans[a]	**104,131**	**589,776**	**693,907**	**105,197**	**688,231**	**793,428**
TOTAL	617,074	6,514,421	7,131,495	346,903	5,586,319	5,933,222
	Percent of Total			Percent of Total		
Medicare Advantage	**83.1%**	**90.9%**	**90.3%**	**69.7%**	**87.7%**	**86.6%**
HMOs/POS	32.8%	77.0%	73.1%	50.4%	83.8%	81.8%
Local PPO	4.2%	4.4%	4.4%	1.0%	1.5%	1.4%
Regional PPO	2.3%	1.2%	1.3%	0.0%	0.0%	0.0%
PFFS	43.9%	8.4%	11.5%	18.3%	2.5%	3.4%
Other prepaid plans	**16.9%**	**9.1%**	**9.7%**	**30.3%**	**12.3%**	**13.4%**
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: RUPRI Center for Rural Health Policy Analysis, based on CMS data as of November 17, 2006.

Note: 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, roughly 600,000 MA enrollees, (due to data incompatibilities with geographic files).

[a]"Other prepaid plans" includes cost plans and demonstration plans.

Despite the new option of a regional PPO, virtually all growth in MA plans in rural areas in 2006 was in PFFS plans. By November 2006, enrollment in these plans grew from over 60,000 to over 270,000; about 44% of enrollment in rural areas was in PFFS plans, compared to only 8% in urban areas (Figure 1). While over three-quarters of MA enrollees in urban areas were in HMO plans, only about one-third of rural persons were enrolled in HMO plans.

Concentration of MA Enrollment

Much of the MA enrollment is concentrated in a few states where either PFFS plans are popular or HMO plans are strong (Table 2). Further, MA and prepaid enrollment in rural areas is concentrated in a few organizations holding contracts with CMS (Table 3). Almost half of rural MA enrollees are in the top five contracts, ranked by enrollment, and the top contract, held by Humana Insurance Company, enrolls over 25% of the rural MA enrollees in over 2,000 rural counties. The top three contracts in rural areas are PFFS contracts, enrolling 38% of the rural enrollees in MA and prepaid plans. These three contracts, along with the contract held by Sterling Life Insurance Company, show that most rural persons have the choice of several PFFS plans, and that most people choosing to enroll in MA plans are choosing from among these dominant organizations.

Table 2. Medicare Advantage and Other Prepaid Plan Enrollment, Ranked by Total Enrollment in Rural Areas, November 2006

State	Total Enrolled in MA and Prepaid Plans	Total enrollment by type of MA or Prepaid Plan				
		PFFS	Local PPO	Regional PPO	HMOs/POS	Other Prepaid Plans[a]
PA	64,909	5,919	4,136	11	52,353	2,490
MN	47,264	22,958	-	-	1,845	22,461
WI	45,043	25,825	1,556	56	13,520	4,086
NC	33,796	18,711	232	38	14,744	71
OR	32,270	4,083	3,807	-	13,113	11,267
NY	30,287	4,136	4,575	422	20,828	326
TN	23,935	6,874	18		16,656	387
OH	19,590	8,852	770	956	8,217	795
HI	18,521	81	117	1,610	5,735	10,978
AZ	18,397	7,788	259	461	9,687	202
VA	18,036	12,892	19	-	2,124	3,001
TX	16,744	7,924	183	1,520	1,702	5,415
KY	14,770	6,990	44	1,236	1,725	4,775
MO	14,763	9,479	56	-	4,760	468
IL	14,440	7,347	2,227	14	1,660	3,192
IA	14,301	10,358	-	-	215	3,728
WV	13,816	1,219	840	-	535	11,222
IN	13,785	11,298	448	156	-	1,883
GA	13,770	13,550	220	-	-	-
FL	12,532	337	1,123	4,348	6,656	68
MI	11,570	10,488	-	404	678	-
WA	11,138	4,804	152	-	6,073	109
AL	11,131	2,654	389	-	7,976	112
AR	10,380	10,098	-	-	152	130
CO	10,236	2,420	-	-	170	7,646
MS	8,101	7,686	-	25	390	-
SC	7,793	7,577	-	216	-	-
CA	7,455	434	-	1,210	5,419	392
LA	6,822	5,245	-	288	1,289	-
ID	6,638	4,515	14	-	900	1,209
NV	6,347	300	-	854	1,231	3,962
NE	6,140	4,906	-	115	110	1,009
NM	6,034	2,430	3,013	-	266	325
MT	6,008	5,310	604	78	-	16
OK	5,240	4,297	85	-	710	148
UT	4,315	3,392	238	-	126	559
KS	3,078	2,445	-	-	-	633
ND	2,912	2,298	-	-	-	614
WY	1,462	1,082	-	-	-	380
SD	1,041	1,001	-	16	24	-
CT	895	-	14	-	881	-
ME	552	154	398	-	-	-
DE	361	115	78	131	19	18
VT	185	185	-	-	-	-
NH	149	149	-	-	-	-
MD	122	-	39	29	-	54
Total	617,074	270,606	25,654	14,194	202,489	104,131

Source: RUPRI Center for Rural Health Policy Analysis, based on CMS data as of November 17, 2006.

Note: Excludes enrollment in any county and plan if the plan enrolls 10 or fewer enrollees in that county (due to restrictions on data releases by CMS). New Jersey, Rhode Island, and the District of Columbia are not shown as they have no rural counties. Data are also not shown for U.S. territories and Alaska, since rural/urban county classifications are not available for these areas. And data are not shown for Massachusetts because CMS does not report MA enrollment for the rural counties in Massachusetts due to data reporting concerns.

[a]"Other prepaid plans" includes cost plans and demonstration plans.

Table 3. Top Medicare Advantage and Other Prepaid Plans, Ranked by Total Enrollment in Rural Areas, November 2006

Rank of Contract	Organization Name	Plan Type	Number of Counties Served	Total Enrolled in Contract	Cumulative Percent of Total Rural Enrollment
1	Humana Insurance Company	PFFS	2,008	154,804	25%
2	PacifiCare Life and Health Insurance Company	PFFS	1,987	47,172	33%
3	UniCare Life and Health Insurance Company	PFFS	1,966	33,547	38%
4	United Mine Workers of America	HCPP - 1833 Cost	642	24,763	42%
5	Geisinger Health Plan	HMO/HMOPOS	25	20,565	46%
6	Keystone Health Plan West, Inc.	HMO/HMOPOS	58	18,579	49%
7	Sterling Life Insurance Company	PFFS	1,299	16,249	51%
8	Hawaii Medical Service Association	1876 Cost	21	10,945	53%
9	Regence BlueCross BlueShield of Oregon	1876 Cost	54	10,879	55%
10	Cariten Health Plan	HMO/HMOPOS	75	10,709	56%

Source: RUPRI Center for Rural Health Policy Analysis, based on CMS data as of November 17, 2006.

Note: 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, roughly 600,000 MA enrollees, (due to data incompatibilities with geographic files).

Conclusions and Policy Implications

Enrollment by rural beneficiaries in MA plans grew rapidly in 2006, with most of the increase attributable to a few PFFS plans. PFFS plans predominate in rural areas because they are offered in most rural counties, while other MA choices are not (e.g., HMO, PPOs). PFFS plans do not typically form provider networks, instead paying providers either what would have been Medicare payments or based on a fee schedule developed by the plan. Enrollees are told to see any provider. Therefore, PFFS plans may be more feasible in rural areas than are PPOs or HMOs, both of which require forming provider networks. Regional PPOs, which are required to assure local access, are available in 21 regions. However, they are not experiencing rapid growth in enrollment. Possible explanations for their limited growth include beneficiary preference for other products, plan preference for enrollment in local rather than regional plans affecting marketing, and insufficient incentive for plans to aggressively seek enrollment (e.g., the stabilization fund bonus payments are not effective until 2008). Also, lower payment rates in rural areas make PFFS plans a viable option for organizations, which may not find it feasible to offer HMOs and PPOs in most rural counties. The enrollment patterns outlined here, and the concentration of enrollment in a few organizations, represent challenges to the goal of expanded beneficiary choices through the MA program.

References

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Penrod, J., McBride, T. D., & Mueller, K. (2001). Geographic variation in determinants of Medicare managed care enrollment. *Health Services Research, 36*(4), 733-750.

Note

[1]Data for this report was prepared by obtaining state-county-plan level enrollment files and payment rate files from CMS (CMS 2006). The data were processed at the county level, merging these with county-level indicators of rural-urban status as identified by the U.S. Department of Agriculture, Economic Research Service (ERS). Urban Influence Codes (UIC) were used to differentiate rural from urban counties. The Medicare-eligible population for December 2005 by county was used here for all the analysis, since data for 2006 county-level Medicare eligibles has not been released by CMS. 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 enrollees in Alaska and U.S. territories (due to data incompatibilities with geographic files), resulting in about 600,000 MA and prepaid plan enrollees not included here.