RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

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March 2013: Medicare Advantage Update

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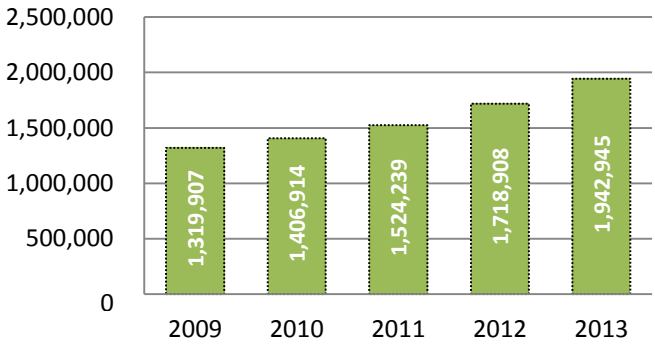
Key Data Findings[1]

- From March 2012 to March 2013, rural enrollment in Medicare Advantage (MA) and other prepaid plans increased by over 200,000 enrollees, to more than 1.9 million.
- Preferred provider organization (PPO) plan enrollment increased to nearly one million enrollees, accounting for more than 51% of the rural MA market (up from 48% in March 2012).
- Health maintenance organization (HMO) enrollment continued to grow in 2013, with over 31% of the rural MA market, while private fee-for-service (PFFS) plan enrollment decreased to less than 10% of market share.
- Despite recent changes to MA payment, rural MA enrollment continues to increase.

Enrollment

From March 2012 to March 2013, national MA and other prepaid plan enrollment increased from approximately 13.2 to 14.5 million enrollees (a 9.6% growth rate). Of this new total, approximately 13.4% of beneficiaries live in rural areas. Enrollment growth was disproportionately rural, increasing from 1.72 to 1.94 million enrollees (a 13.0% growth rate) (Figure 1). However, market composition is changing. Rural PPO plan enrollment increased to nearly one million beneficiaries, with nearly twice as many enrollees in local PPOs (649,046) as in regional PPOs (346,921). Rural HMO plan enrollment continued to increase, but not as rapidly as in PPO plans, while PFFS plan enrollment continued to decline in both rural and urban areas.

Figure 1. Rural Medicare Advantage and Other Prepaid Plan Enrollment, March 2009-2013



From 2009 to 2013, rural market share in PPO plans increased more than the national market share in PPO plans. PPO rural market share increased from 15.7% to 51.4% (a 35.7 percentage point increase), while national PPO market share increased from 12.4% to 29.1% (a 17.3 percentage point increase) (Figure 2). The increase in PPO market share is offset by the decrease in PFFS market share, particularly in rural areas, where PFFS market share has decreased more than its national counterpart.

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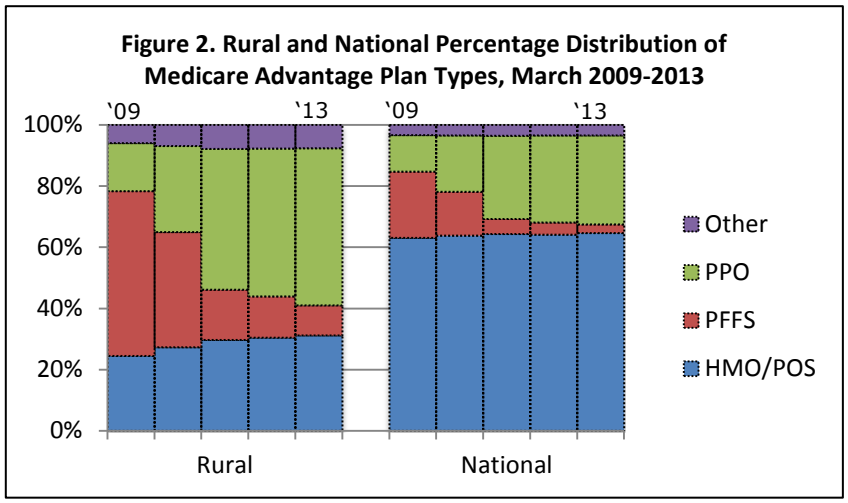

Geographically, there are some distinct patterns in MA enrollment (Table 1). Rural HMO/point-of-service (POS) plans are more popular in the Northeast and West than in the Midwest and South. Rural PPO market share is highest in the South. Rural PFFS enrollment, though fairly consistent across the regions, is also highest in the South. Generally, HMO plans tend to dominate urban MA enrollment while PPO plans tend to dominate rural MA enrollment. However, the magnitude of the difference in the rural-urban composition of the MA market varies by region. For example, HMO/POS plans dominate the Western market (with 83.9% of enrollees), but enrollment in HMO/POS plans in rural areas is only 41.6%. In the Northeast, the difference between the national and rural enrollment by plan type is significant, but not as dramatic as in the Western region. In the Midwest, PPOs remain the dominant plan type in both national and rural enrollment.

Table 1. Geographic Variation in MA Enrollment, in Thousands, March 2013

		HMO/POS		PFFS		PPO		Other	
		Enrollment	Percent	Enrollment	Percent	Enrollment	Percent	Enrollment	Percent
Northeast	Rural	121	45.4%	25	9.2%	119	44.7%	2	0.7%
	Total	1,926	70.6%	51	1.9%	731	26.8%	21	0.8%
Midwest	Rural	161	24.8%	55	8.5%	316	48.8%	115	17.8%
	Total	1,220	42.0%	97	3.3%	1,245	42.9%	340	11.7%
South	Rural	229	28.7%	92	11.5%	458	57.3%	20	2.5%
	Total	2,650	56.9%	223	4.8%	1,685	36.2%	100	2.1%
West	Rural	96	41.6%	18	7.9%	105	45.6%	11	4.9%
	Total	3118	83.9%	36	1.0%	516	13.9%	46	1.2%
United States	Rural	607	31.2%	190	9.8%	998	51.4%	148	7.6%
	Total	8914	63.6%	407	2.9%	4177	29.8%	507	3.6%

Note: Percentages out of total MA and other prepaid plan enrollment for each geographic region.

Discussion

The MA marketplace remains robust in 2013 in both rural and urban areas. Rural beneficiaries typically have less access than urban beneficiaries to the various plan types, particularly to HMO plans. However, rural beneficiaries are more likely to have access to PPO and PFFS plans than HMO plans,[2] which likely explains the rural-urban difference in enrollment patterns and composition of MA markets. These differences may also reflect the types of plans that have historically dominated private insurance markets in different regions of the country; the MA markets in many areas, not surprisingly, resemble these private markets. Preferences regarding methods of care provision and payment structure may also vary regionally and across urban and rural areas. For example, rural beneficiaries are continuing to enroll in MA and are showing a growing preference for PPO plans.

Changes in payment policy could affect future enrollment. A reduction in MA payment mandated by the Affordable Care Act(ACA) began in 2012 and continues to be phased in during 2013.[3] In addition, a large number of MA plans have been receiving quality-based bonus payments since 2012, with the majority of these plans unlikely to receive them after 2014, due to the end of the CMS demonstration that expanded the quality based bonus payments established by the ACA. Rural plans are disproportionately more likely to see their bonus payments end due to lower average quality ratings,[4] which, in combination with continued reductions in MA payment, could affect MA plan availability and enrollment in rural areas. We will continue monitoring enrollment to detect effects of these and other changes.

[1]Additional Medicare Advantage enrollment data available at http://www.public-health.uiowa.edu/rupri/maupdates/nstablesmaps.html.
[2]Congressional Budget Office. "The 2012 Long-Term Budget Outlook." Congress of the United States, June 2012.
[3]Kaiser Family Foundation. "Medicare Advantage Fact Sheet, " November 30, 2012. http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/
[4]RUPRI analysis of Centers for Medicare and Medicaid Services, 2012 Medicare Advantage Enrollment and Quality Data.