RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

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Medicare Advantage Enrollment Update 2016

Fred Ullrich, BA, and Keith Mueller, PhD

Purpose

The RUPRI Center for Rural Health Policy Analysis reports annually on rural beneficiary enrollment in Medicare Advantage (MA) plans, noting any trends or new developments evident in the data. These reports are based on data through March of each year, capturing results of open enrollment periods.

Key Findings

- The number of non-metropolitan beneficiaries enrolled in MA and other prepaid plans increased to 2,189,300 as of March 2016, representing 21.8 percent of all non-metropolitan Medicare beneficiaries compared with 31.5 percent of beneficiaries enrolled in MA and other prepaid plans nationally.
- While non-metropolitan enrollment continued to increase through March 2016, the annual growth rate slowed to 5.5 percent, compared to 6.8 percent between March 2014 and March 2015.
- Enrollment in private fee-for-service MA plans continued to decline, both nationally and in non-metropolitan counties, while enrollment in other types of MA plans increased.
- The states with the highest percentage of non-metropolitan beneficiaries enrolled in MA plans continued to be Minnesota, Hawaii, Pennsylvania, Wisconsin, and New York, ranging from a high of 53.4 percent in Minnesota to 32.6 percent in New York.
- Non-metropolitan beneficiary enrollment (counts) in MA plans declined in five states: Hawaii, Idaho, Ohio, Washington, and Wyoming.

Enrollment Data and Trends

Between March 2015 and March 2016, national enrollment in MA and other prepaid plans increased from 16.7 to 17.6 million enrollees (from 31.1 percent to 31.5 percent of eligible beneficiaries). This 5.5 percent national growth rate is significantly lower than that seen in previous years (8.6 percent in 2015, 9.5 percent in 2014, and 9.8 percent in 2013). Between March 2015 and March 2016, non-metropolitan enrollment in MA and other prepaid plans increased from 2.1 to 2.2 million enrollees (from 21.2 percent to 21.8 percent of eligible beneficiaries) (Figure 1). The non-metropolitan growth rate was 5.3 percent and is also significantly lower than that seen in previous years (7.8 percent in 2015, 12.6 percent in 2014, and 13.1 percent in 2013). Until we have more data points (years of enrollment), we cannot say whether the differences represent a new trend of slower growth, a leveling off of growth rate, or enrollment changes that may be episodic. Notably, however, as of March

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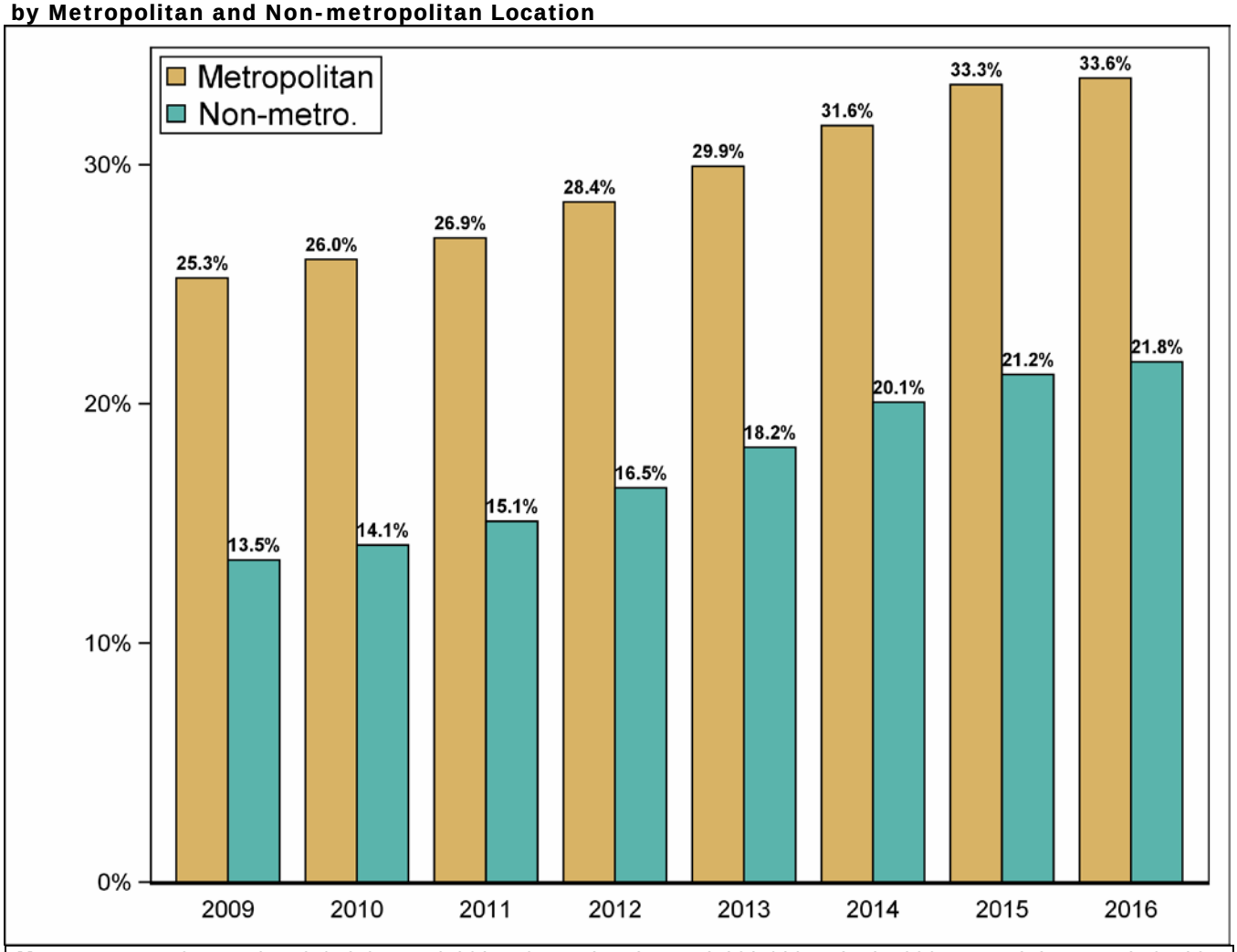
RUPRI RURAL POLICY RESEARCH INSTITUTE
RUPRI Center for Rural Health Policy Analysis,
University of Iowa College of Public Health,
Department of Health Management and Policy,
145 Riverside Dr., Iowa City, IA 52242-2007,
(319) 384-3830
http://www.public-health.uiowa.edu/rupri
E-mail: cph-rupri-inquiries@uiowa.edu

2016, 148 counties (4.7 percent of the 3,138 U.S. counties, only 4 are metropolitan) had zero enrollment in MA and other prepaid plans among the 147,163 beneficiaries residing in those counties. States in the Great Plains region, where frontier counties are prevalent, have the largest share of these zero-enrollment counties.

Figure 1. Percentage of Eligible Beneficiaries Enrolled in Medicare Advantage and Other Prepaid Plans, by Metropolitan and Non-metropolitan Location



Metro	9,147,507 25.3%	9,652,975 26.0%	10,290,149 26.9%	11,245,245 28.4%	12,290,609 29.9%	13,407,999 31.6%	14,573,344 33.3%	15,376,720 33.6%
Non-metropolitan	1,165,806 13.5%	1,240,085 14.1%	1,349,151 15.1%	1,513,613 16.5%	1,712,524 18.2%	1,928,162 20.1%	2,079,203 21.2%	2,189,300 21.8%

Nationally, the proportion of MA enrollment in health maintenance/point of service plans and "Other" plans[1] has been relatively consistent from 2009 through 2016, hovering between 61.4 percent and 63.7 percent, and 3.6 percent and 4.1 percent, respectively (Figure 2 and Table 1). We have reported previously the trends of the past several years away from PFFS plans into PPOs, which continued through 2016 (albeit to a lesser degree given low percentages of PFFS plans)[2][3][4]. Enrollment in both types of plans has increased in numbers of

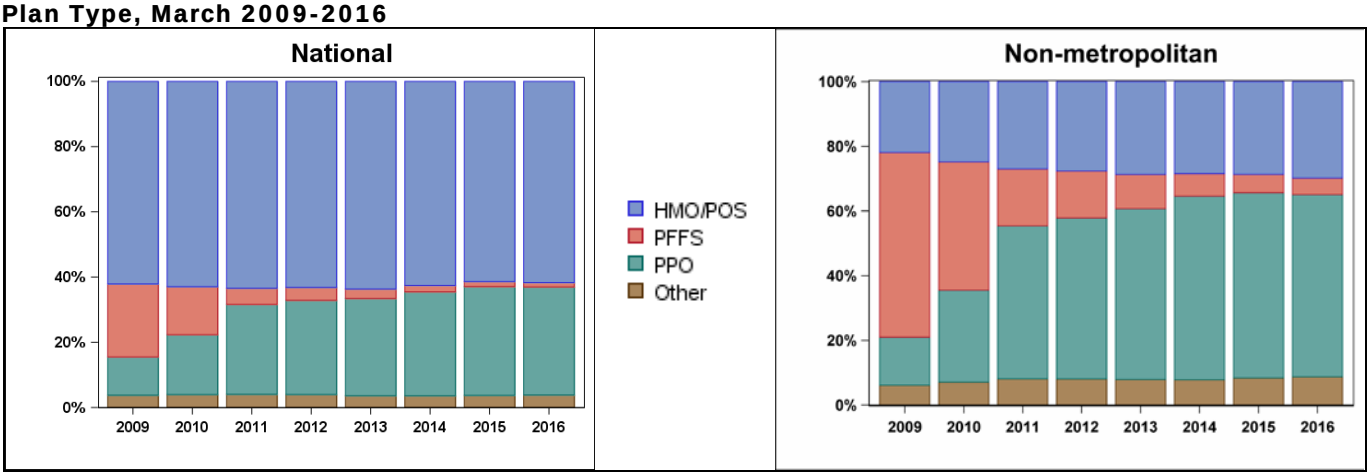
[1] Includes MSA (medical savings account) plans, CCP (coordinated care) plans, and demonstration/pilot programs.
[2] Finegan C, Ullrich F, & Mueller, K. "2015: Rural Medicare Advantage Enrollment Update," RUPRI Center for Rural Health Policy Analysis, July 2015.
[3] Kemper L, Barker A, McBride Timothy,& Mueller, K. "2014: Rural Medicare Advantage Enrollment Update," RUPRI Center for Rural Health Policy Analysis, January 2015.
[4] Sayavong S, Kemper L, Barker A, & McBride Timothy. "March 2013: Medicare Advantage Update," RUPRI Center for Rural Health Policy Analysis, September 2013.

enrollees, but not as a proportion of all MA enrollees. Non-metropolitan enrollment in MA plans has increased both numerically and proportionally in all plan types except private fee-for-service plans.

Between March 2015 and March 2016, the raw number of Medicare-eligible beneficiaries enrolled in MA and prepaid plans increased in all but three of the 50 states (Alaska and Wyoming had small decreases in the number of enrollees, and Ohio had a significant decline [65,688] in enrollees). The proportion of eligible Medicare beneficiaries enrolled in an MA or other prepaid plan decreased in nine states (Alaska, Arizona, Colorado, Hawaii, Idaho, Ohio, Pennsylvania, Washington, and Wyoming). Most of those decreases were between 0.1 and 0.3 percentage points, but MA and prepaid plan enrollment in Ohio decreased by 4.1 percentage points.

This pattern of increases and decreases is similar among Medicare-eligible beneficiaries living in non-metropolitan counties. The number of non-metropolitan enrollees in MA and prepaid plans increased in all but five states (Hawaii, Idaho, Ohio, Washington, and Wyoming). Decreases ranged from 61 enrollees in Wyoming to 19,403 enrollees in Ohio. The proportion of non-metropolitan enrollees in MA and prepaid plans increased in all but eight states (Colorado, Hawaii, Idaho, Nebraska, Ohio, Oregon, Washington, and Wyoming). Decreases ranged from 0.1 percentage point to a high of 4.8 percentage points in Ohio.

Figure 2. National and Non-metropolitan Percentage Distribution of Medicare Advantage Enrollment by Plan Type, March 2009-2016



Note: HMO/POS, health maintenance organization/point of service; PFFS, private fee-for-service; PPO, preferred provider organization.

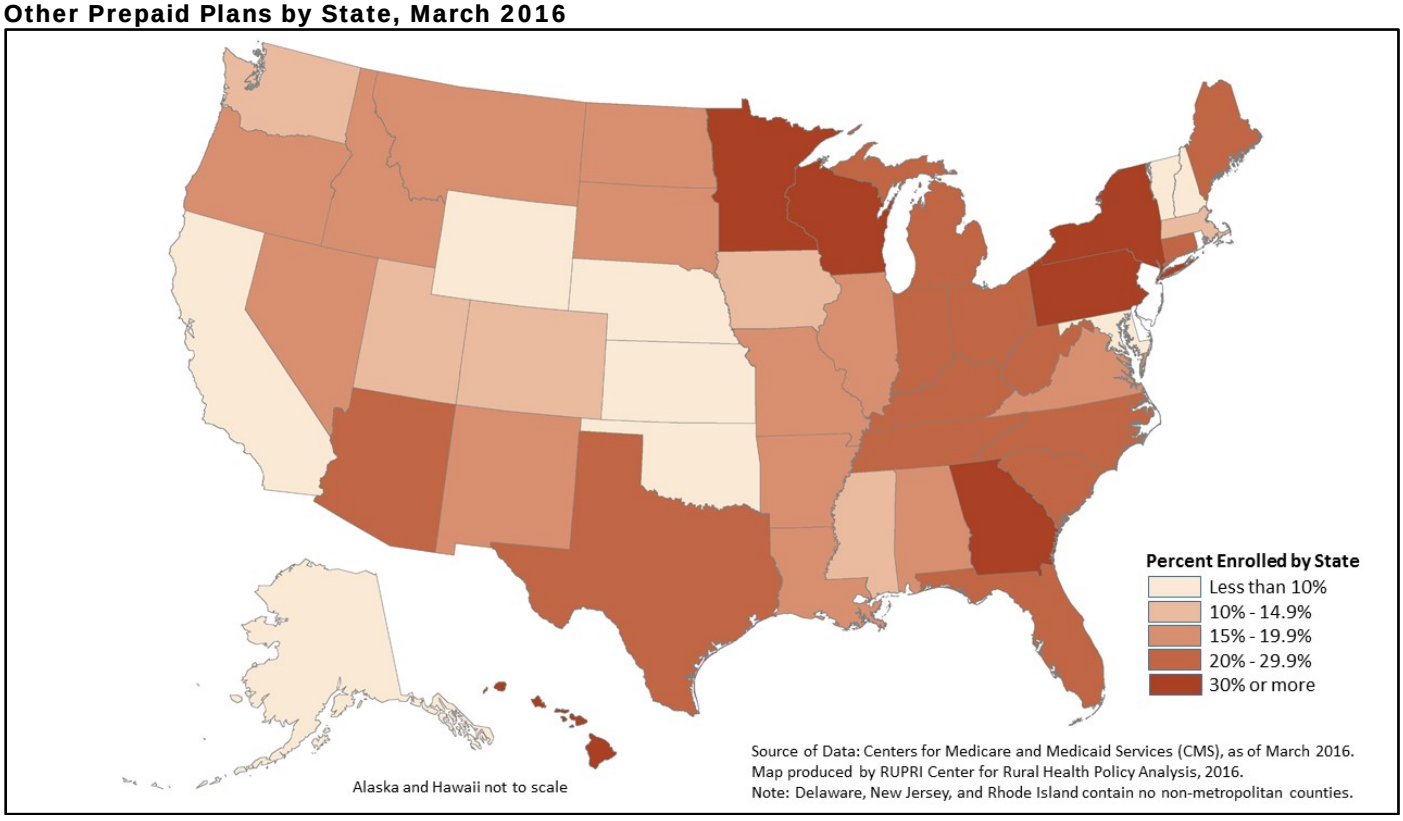
Table 1. National and Non-metropolitan Percentage Distribution of Medicare Advantage Enrollment by Plan Type, March 2009-2016

Year	HMO/POS				PPO				PFFS				Other			
	National		Non-metro.		National		Non-metro.		National		Non-metro.		National		Non-metro.	
2009	6,404,573	62.1%	255,371	21.9%	1,211,385	11.7%	173,518	14.9%	2,308,074	22.4%	665,789	57.1%	389,281	3.8%	71,128	6.1%
2010	6,856,710	62.9%	307,277	24.8%	2,000,838	18.4%	352,450	28.4%	1,602,975	14.7%	492,435	39.7%	432,537	4.0%	87,923	7.1%
2011	7,381,138	63.4%	363,939	27.0%	3,208,208	27.6%	638,869	47.4%	577,910	5.0%	237,435	17.6%	472,044	4.1%	108,908	8.1%
2012	8,058,126	63.2%	418,203	27.6%	3,686,738	28.9%	753,767	49.8%	505,068	4.0%	219,759	14.5%	508,926	4.0%	121,884	8.1%
2013	8,913,498	63.7%	491,018	28.7%	4,177,679	29.8%	904,701	52.8%	406,372	2.9%	181,789	10.6%	505,584	3.6%	135,016	7.9%
2014	9,592,468	62.5%	548,186	28.4%	4,887,740	31.9%	1,094,942	56.8%	304,035	2.0%	134,534	7.0%	551,918	3.6%	150,500	7.8%
2015	10,219,652	61.4%	595,620	28.6%	5,557,747	33.4%	1,191,039	57.3%	256,143	1.5%	118,236	5.7%	619,005	3.7%	174,308	8.4%
2016	10,836,345	61.7%	653,035	29.8%	5,821,521	33.1%	1,233,753	56.4%	234,094	1.3%	111,261	5.1%	674,060	3.8%	191,251	8.7%

Note: HMO/POS, health maintenance organization/point of service; PFFS, private fee-for-service; PPO, preferred provider organization.

The states with highest proportion of all MA and prepaid plan enrollees were Minnesota (55.1 percent), Hawaii (45.7 percent), Oregon (44.2 percent), California (41.3 percent), Florida (40.8 percent), and Pennsylvania (40.1 percent). The states with highest proportion of non-metropolitan MA and prepaid plan enrollees were Minnesota (53.4 percent), Hawaii (36.4 percent), Pennsylvania (36.4 percent), Wisconsin (35.7 percent), New York (32.6 percent) and Georgia (30.0 percent) (Figure 3).

Figure 3. Percentage of Eligible Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and Other Prepaid Plans by State, March 2016



Discussion

MA enrollment continues to grow, both nationally and in rural counties. More detailed information by state (tables and maps) is available from the RUPRI Center's web site: www.ruprihealth.org. Enrollment is lower in Great Plains and Mountain states, which is not surprising given the prevalence of sparsely populated counties that do not attract competing MA firms. However, continued enrollment growth overall and in rural areas indicates continued appeal of MA plans where they are offered and marketed. Less than 1% of metropolitan counties (0.9%, containing 0.3% of the metropolitan population) and over 6% of non-metropolitan counties (6.1%, containing 3.0% of the non-metropolitan population), had no MA plans offered in March 2016.The slowing pace of enrollment growth may be reversed as a new generation with previous experience with managed care plans (baby boomers) enters Medicare eligibility. Annual trends should continue to be monitored; continued slow enrollment growth could signal a need to adjust policies if maintaining viable MA options is desirable. Conversely, a return to higher growth rates could signal a viable market with no further adjustments needed.