RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

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Medicare Advantage Enrollment Update 2017

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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

- Nationally, 1 in 3 Medicare beneficiaries is enrolled in an MA plan. In non-metropolitan areas, nearly 1 in 4 (23.5 percent) beneficiaries is enrolled in an MA plan.
- Enrollment in MA plans, measured either as an overall count or as a proportion of eligible Medicare beneficiaries, has increased in both metropolitan and non-metropolitan populations since 2004.
- Between 2015 and 2017, the proportion of non-metropolitan Medicare-eligible beneficiaries enrolled in local preferred provider organization (PPO), regional PPO, and "other" plans (including cost, health care pre-payment [HCPP], medical savings account [MSA] and demonstration plans) remained relatively steady. During the same period, the proportion of Medicare-eligible beneficiaries enrolled in health maintenance organization (HMO) plans increased slightly (from 28.5 percent in 2015 to 29.8 percent in 2017) while the proportion enrolled in private fee-for-service (PFFS) plans decreased slightly (from 5.6 percent in 2015 to 3.8 percent in 2017).

Enrollment Data and Trends

In March 2017, more than 19 million Medicare beneficiaries were enrolled in MA plans, representing 1 in 3 (33.5 percent) eligible Medicare beneficiaries (Figure 1). MA enrollment has increased steadily since 2004,[1] and the nearly 8 percent increase in the 2017 national growth rate is a significant increase over the 5.5 percent increase in 2016. Beneficiary enrollment in metropolitan counties topped 16.6 million (35.7 percent of eligible beneficiaries), a 7.9 percent rate of growth over 2016 metropolitan enrollment. Beneficiary enrollment in non-metropolitan counties was 2.4 million (23.5 percent of eligible beneficiaries), an 8.3 percent rate of growth over 2016 non-metropolitan enrollment. The 2017 growth rates in both metropolitan and non-metropolitan counties were significantly higher than the 2016 rates (5.5 percent and 5.2 percent, respectively).

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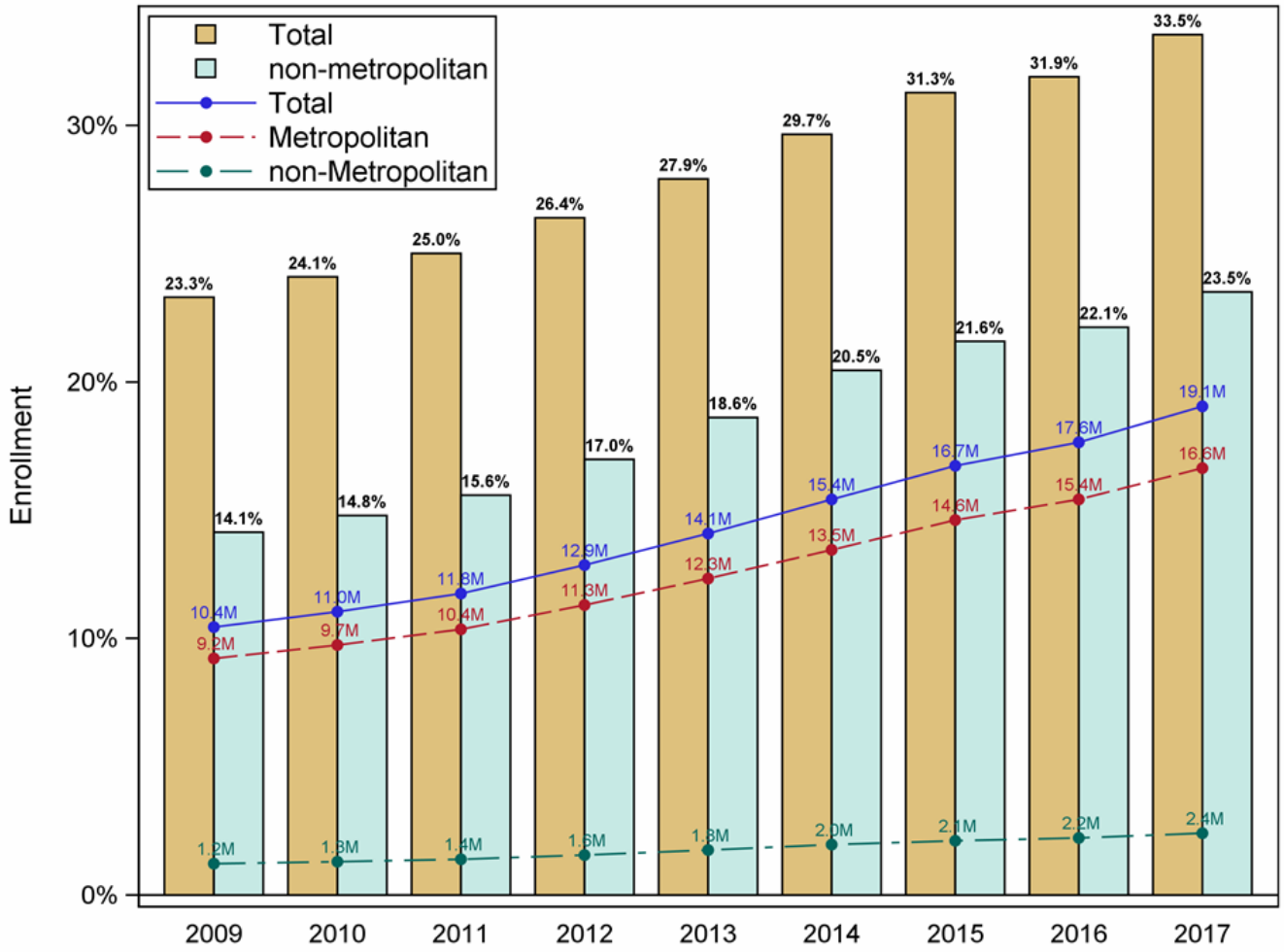
Figure 1. Enrollment in Medicare Advantage, March 2009-2017



Metropolitan	9,223,646 25.5%	9,744,067 26.3%	10,358,534 27.2%	11,303,996 28.6%	12,339,126 30.0%	13,455,547 31.7%	14,618,548 33.5%	15,422,539 34.1%	16,640,851 35.7%
Non-metropolitan	1,222,259 14.1%	1,299,589 14.8%	1,393,984 15.6%	1,559,261 17.0%	1,753,427 18.6%	1,966,261 20.5%	2,114,836 21.6%	2,225,321 22.1%	2,409,502 23.5%
Total	10,445,905 23.3%	11,043,656 24.1%	11,752,518 25.0%	12,863,257 26.4%	14,092,553 27.9%	15,421,808 29.7%	16,733,384 31.3%	17,647,860 31.9%	19,050,353 33.5%

Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage enrollment data.

Between March 2016 and March 2017, the total number of beneficiaries enrolled in MA plans increased in every state except one. North Dakota's small decline (n = 124) in the overall number of enrolled beneficiaries was the result of a significant increase in the number enrollees in PPOs and other MA plans that was offset by a slightly more significant decrease in the number of enrollees in prepaid plans. The proportion of eligible Medicare beneficiaries enrolled in MA and prepaid plans decreased slightly in three states—Hawaii, Idaho, and North Dakota.

Among non-metropolitan beneficiaries, the total number of beneficiaries enrolled in MA and prepaid plans decreased in only one state—Idaho. An increase in the number of Idaho's non-metropolitan beneficiaries enrolled in HMO/POS plans was offset by a larger decrease in the number of enrollees in PPOs and other MA plans. The proportion of eligible, non-metropolitan beneficiaries enrolled in MA and prepaid plans decreased in five states—Arizona, Hawaii, Idaho, North Dakota, and Oregon.

The majority of all MA enrollees are in HMO plans (Table 1 and Figure 2). Between 2009 and 2017, metropolitan enrollment in HMO plans remained relatively constant at around 67 percent of all MA enrollees. During the same period, non-metropolitan enrollment in HMO plans started at a much lower level (20.9 percent) and slowly increased to 29.8 percent in 2017. PFFS plans accounted for over half (54.5 percent) of non-metropolitan MA enrollees in 2009, but that proportion declined to 3.8 percent

in 2017. Metropolitan enrollment in PFFS plans also declined (although enrollment started at a much lower level: 17.8 percent), now accounting for only 0.6 percent of eligible beneficiaries. The decrease in PFFS enrollment has largely been offset by the increase in PPO enrollment in both local and regional plans, which are much more prevalent in non-metropolitan areas than in metropolitan areas.

Table 1. Enrollment in Medicare Advantage Plans, by Plan Type, 2009-2017

Overall

Year	Total MA Enrollees	% Total Eligible	MA Plan Enrollment					
			HMO	Local PPO	Reg. PPO	PFFS plan	Other	Unatt[1]
2009	10,445,905	23.3%	61.3%	7.9%	3.6%	22.1%	3.7%	1.3%
2010	11,043,656	24.1%	62.1%	11.2%	7.0%	14.5%	3.9%	1.4%
2011	11,752,518	25.0%	62.8%	17.7%	9.6%	4.9%	4.0%	1.0%
2012	12,863,257	26.4%	62.6%	21.4%	7.2%	3.9%	4.0%	0.9%
2013	14,092,553	27.9%	63.2%	22.1%	7.5%	2.9%	3.6%	0.7%
2014	15,421,808	29.7%	62.3%	23.6%	7.9%	2.0%	3.6%	0.6%
2015	16,733,384	31.3%	62.9%	23.9%	7.4%	1.5%	3.8%	0.6%
2016	17,647,860	31.9%	63.5%	23.5%	7.4%	1.3%	3.8%	0.5%
2017	19,050,353	33.5%	61.8%	25.9%	7.1%	1.0%	3.8%	0.5%

Metropolitan

Year	Total MA Enrollees	% Total Eligible	MA Plan Enrollment					
			HMO	Local PPO	Reg. PPO	PFFS plan	Other	Unatt[1]
2009	9,223,646	25.5%	66.7%	8.1%	3.2%	17.8%	3.5%	0.8%
2010	9,744,067	26.3%	67.2%	10.9%	6.0%	11.4%	3.5%	0.9%
2011	10,358,534	27.2%	67.7%	16.6%	8.2%	3.3%	3.5%	0.8%
2012	11,303,996	28.6%	67.6%	20.0%	5.9%	2.5%	3.4%	0.6%
2013	12,339,126	30.0%	68.3%	20.4%	6.1%	1.8%	3.0%	0.5%
2014	13,455,547	31.7%	67.3%	21.7%	6.4%	1.3%	3.0%	0.4%
2015	14,618,548	33.5%	67.9%	21.8%	5.9%	0.9%	3.1%	0.4%
2016	15,422,539	34.1%	68.3%	21.5%	6.0%	0.8%	3.1%	0.4%
2017	16,640,851	35.7%	66.4%	24.1%	5.5%	0.6%	3.1%	0.4%

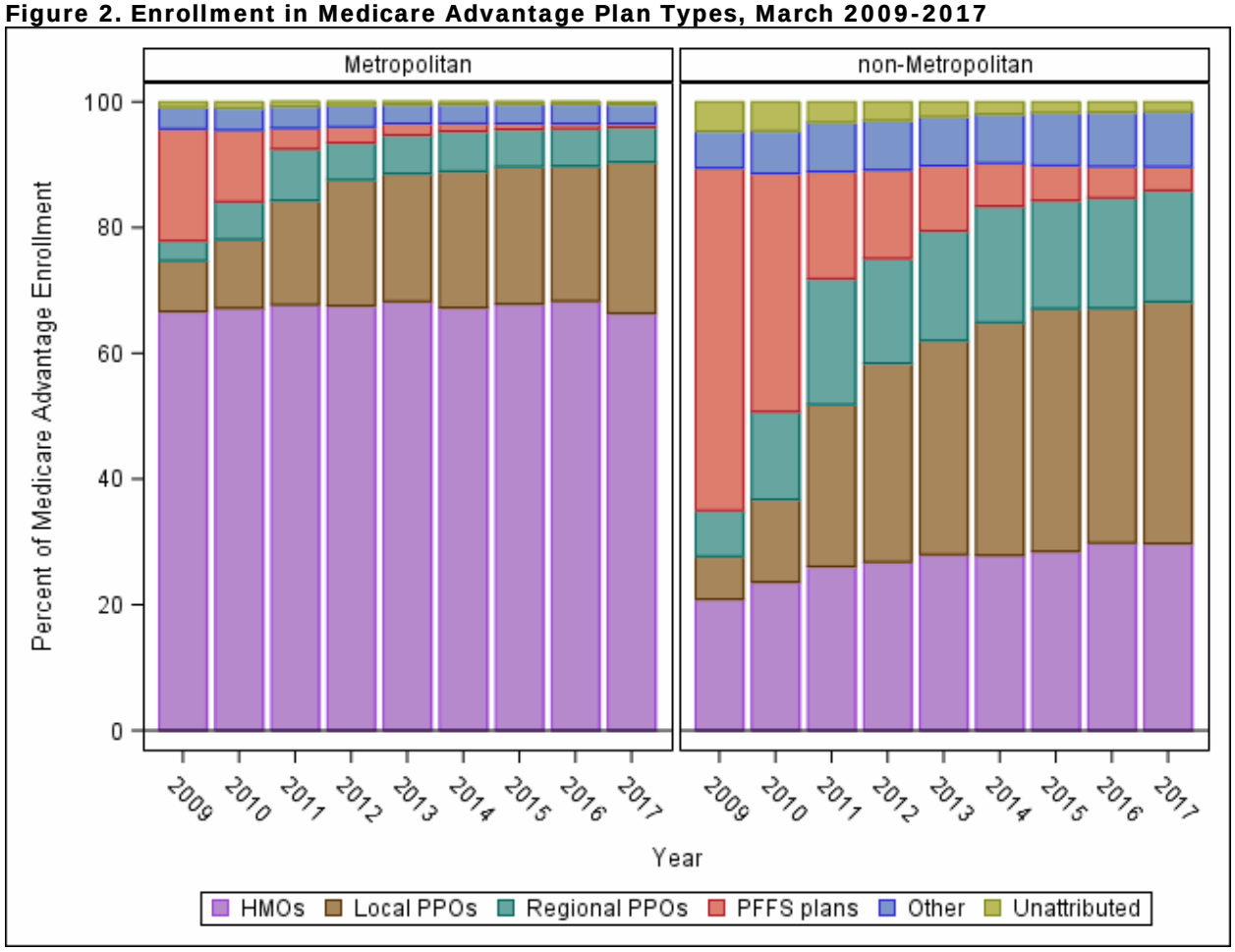
Non-metropolitan

Year	Total MA Enrollees	% Total Eligible	MA Plan Enrollment					
			HMO	Local PPO	Reg. PPO	PFFS plan	Other	Unatt[1]
2009	1,222,259	14.1%	20.9%	6.8%	7.3%	54.5%	5.9%	4.6%
2010	1,299,589	14.8%	23.6%	13.1%	14.0%	37.9%	6.8%	4.6%
2011	1,393,984	15.6%	26.1%	25.8%	20.0%	17.0%	7.9%	3.2%
2012	1,559,261	17.0%	26.8%	31.6%	16.7%	14.1%	7.9%	2.9%
2013	1,753,427	18.6%	28.0%	34.1%	17.4%	10.4%	7.8%	2.3%
2014	1,966,261	20.5%	27.9%	37.0%	18.5%	6.8%	7.8%	1.9%
2015	2,114,836	21.6%	28.5%	38.6%	17.2%	5.6%	8.4%	1.7%
2016	2,225,321	22.1%	29.9%	37.3%	17.5%	5.0%	8.6%	1.6%
2017	2,409,502	23.5%	29.8%	38.5%	17.7%	3.8%	8.8%	1.5%

Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage enrollment data.

[1] Beneficiaries for whom the Centers for Medicare & Medicaid Services does not provide attribution data because of small numbers of enrollees per plan per county (i.e., < 10).

Figure 2. Enrollment in Medicare Advantage Plan Types, March 2009-2017



Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage enrollment data.

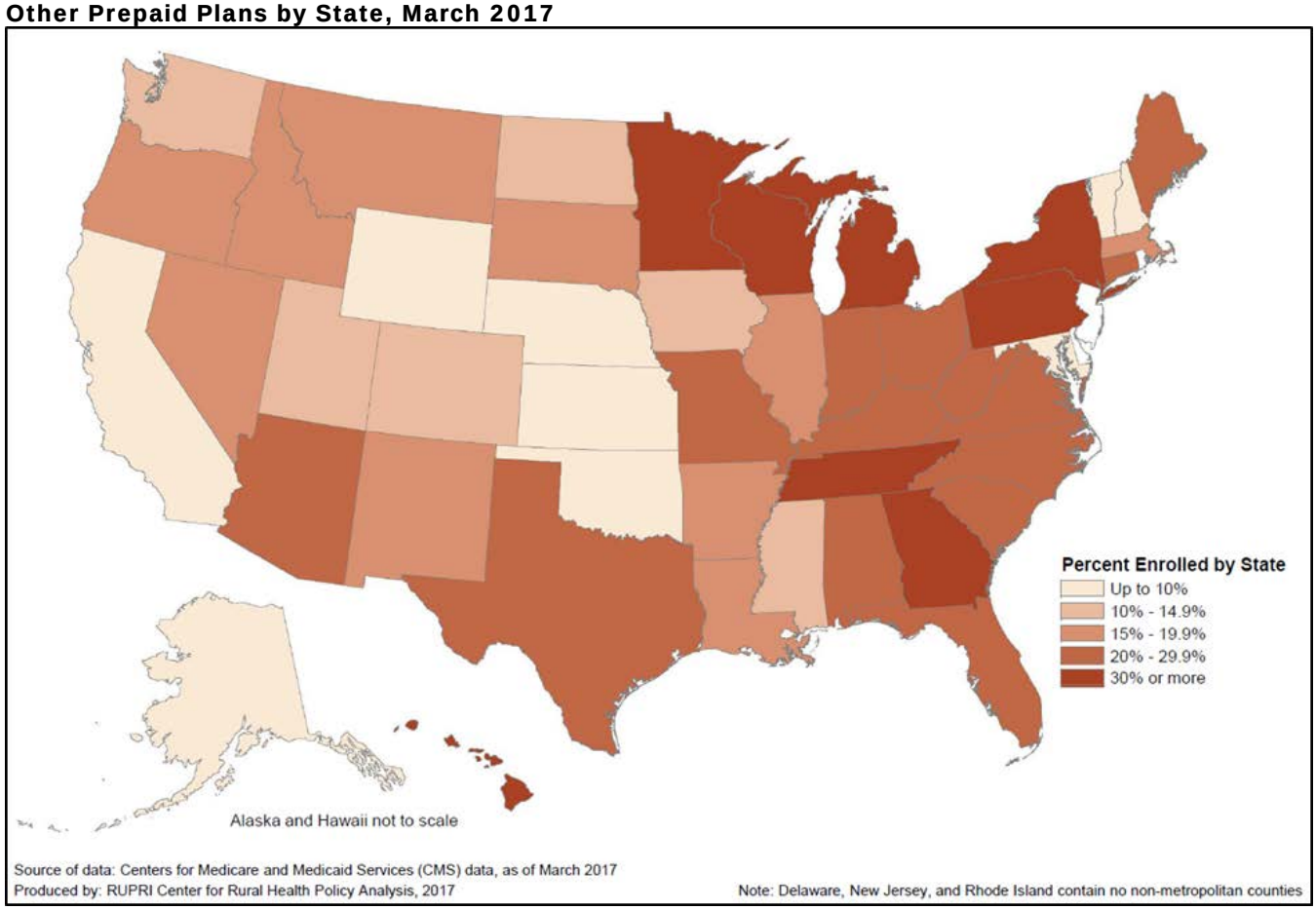
Discussion

MA enrollment has continued to increase in both metropolitan and non-metropolitan populations. One in three eligible beneficiaries (33.5 percent) are enrolled in some type of MA plan, with two-thirds (66.4 percent) of metropolitan enrollees in an HMO plan and over one-third (38.5 percent) of non-metropolitan enrollees in a local PPO plan. Another 29.8 percent of non-metropolitan enrollees are in HMO plans. As shown in Figure 3, non-metropolitan enrollment in MA and other prepaid plans varies across regions and states, with 9 states below 10 percent (e.g., Nebraska, Wyoming) and 8 states above 30 percent (e.g., Minnesota, Wisconsin). More state and national maps and tables can be found at http://ruprihealth.org/maupdates/nstablesmaps.html.

Payment reductions included in the Patient Protection and Affordable Care Act were fully phased into MA plans in 2017 and were expected to temper growth in MA enrollment. However, the impact of those cuts was mitigated by their phase-in over time and by the inclusion of bonus payments to plans based on quality measures.[2]

Sinaiko and Zeckhauser[3] suggest that several factors over the past several years have contributed to continued MA enrollment growth. Those factors include continued payments to plans exceeding expected fee-for-service costs, the likelihood that current MA enrollees will enroll in another MA plan if their original plan is terminated, and improved offerings by MA plans (including expanded physician networks). MA plans are likely to represent an attractive alternative to traditional Medicare for a substantial proportion of Medicare beneficiaries for the foreseeable future.

Figure 3. Percentage of Eligible Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and Other Prepaid Plans by State, March 2017



[1] Kaiser Family Foundation, State Health Facts, Medicare Advantage: Total Enrollment. http://www.kff.org/medicare/state-indicator/ma-total-enrollment/; accessed July 24, 2017.

[2] Medicare Payment Advisory Commission. (2016 Oct). Medicare Advantage program Payment System. Retrieved from http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_ma_final.pdf.

[3] Sinaiko AD, Zeckhauser R Medicare Advantage: what explains its robust health? Am J Manag Care. 2015;21(11):804-806.