RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

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Medicare Advantage Enrollment Update 2018

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Background and Purpose

This policy brief continues the RUPRI Center series that updates enrollment of rural beneficiaries in Medicare Advantage plans. Annual updates track changes in total enrollment and patterns that emerge, such as shifts among the types of MA plans (health maintenance organizations [HMOs], preferred provider organizations [PPOs], and other types of coordinated care plans), and regional and state differences.

Key Findings

- Rural beneficiary enrollment in MA plans increased 9.5 percent from 2017 to 2018, from 2.4 million to 2.6 million.
- Rural beneficiary enrollment in private fee-for-service MA plans declined sharply (from 54.5 percent of all MA plan enrollment to 3.9 percent) between 2009 and 2018, while rural enrollment in HMOs and local PPOs increased to 30.4 percent and 40.5 percent, respectively, of all MA plan enrollment.

Methods

March enrollment data are used in this series of annual updates because it is the first month after open enrollment closes each year and reflects net enrollment each year. We use nonmetropolitan designation of counties as the definition of rural because data are reported by county. The terms rural and nonmetropolitan are used interchangeably in this brief.

Results/Findings

In March 2018, more than 20.5 million Medicare beneficiaries (34.3 percent of eligible beneficiaries) were enrolled in MA plans (Figure 1). The national rate of enrollment growth moderated in 2018, 2.4 percent from 2017, in comparison to 5.0 percent the year before. The nonmetropolitan rate of MA enrollment was lower than the national rate (24.6 percent, 2.64 million beneficiaries), but growth in the nonmetropolitan enrollment rate in MA plans was higher than the national rate in 2018 at 4.7 percent. Between March 2017 and March 2018, the total number of beneficiaries enrolled in MA plans—both overall and in nonmetropolitan counties—increased in every state except one (Montana).[i]

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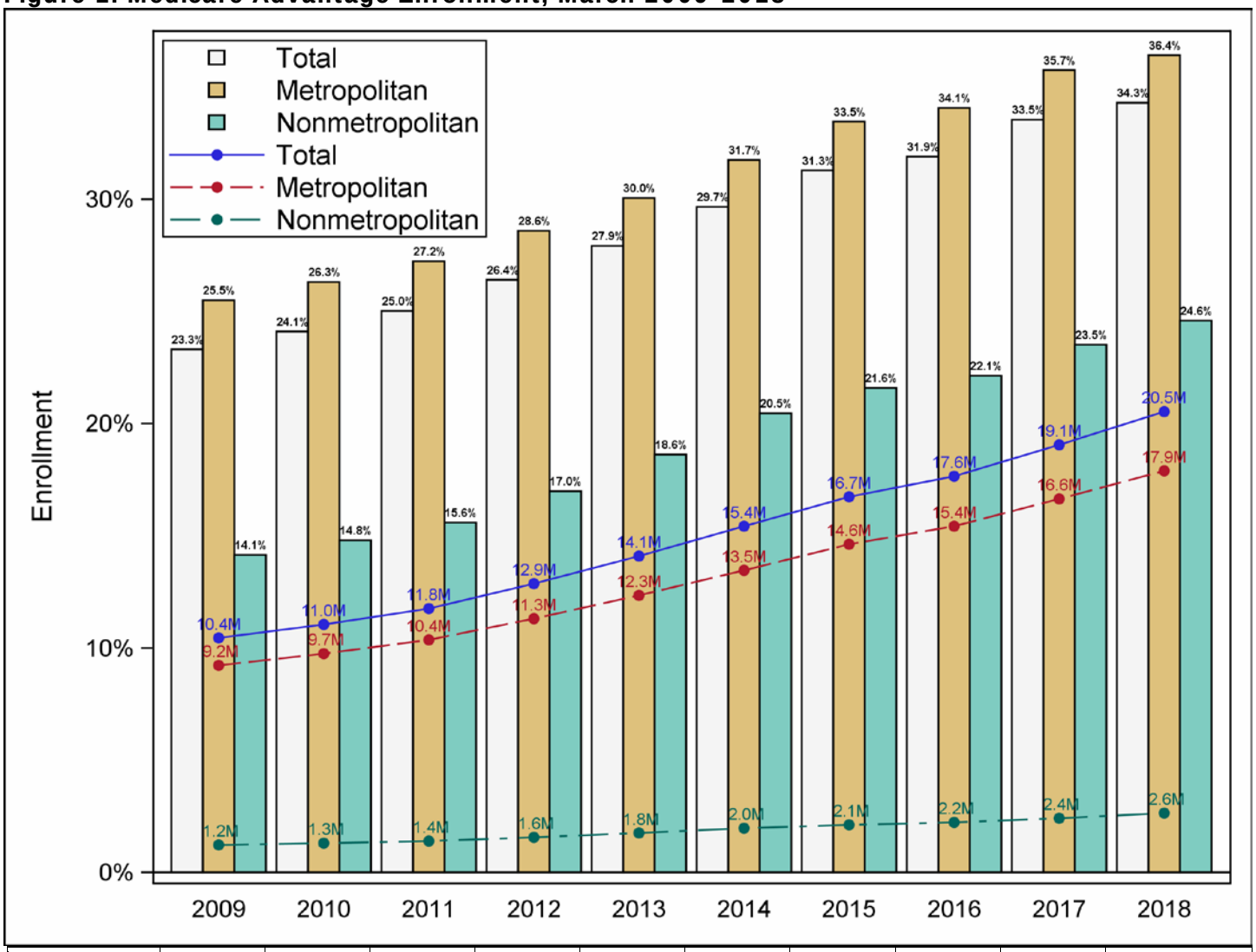
Figure 1. Medicare Advantage Enrollment, March 2009-2018



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
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%	17,889,222 36.4%
Nonmetropolitan	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%	2,639,354 24.6%
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%	20,528,576 34.3%

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

There was little evidence of changes in previously observed enrollment trends in MA plan types between 2017 and 2018. HMO plans (Table 1 and Figure 2) have accounted for around 61 percent of all MA enrollees since 2009, with a considerably lower, but growing percent of nonmetropolitan MA enrollment in HMOs (21 percent in 2009 to 30.4 percent in 2018). Continuing the trends seen in previous years, 2018 saw a slight increase in the proportion of rural MA enrollees in local PPOs and a slight decrease in the proportion of enrollees in regional PPOs. This trend was seen in both metropolitan and in nonmetropolitan areas. However, the nonmetropolitan pattern shows an initial high percent enrollment in PFFS plans shifting largely to PPOs, and most dramatically to local PPOs, which now account for over 40 percent of nonmetropolitan enrollment.

Table 1. Medicare Advantage Enrollment by Plan Type, 2009-2018

Overall

Year	Total MA Enrollees	% Total Eligible	HMO	Local PPO	Regional 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%
2018	20,528,576	34.3%	61.1%	27.6%	6.4%	0.7%	3.6%	0.5%

Metropolitan

Year	Total MA Enrollees	% Total Eligible	HMO	Local PPO	Regional 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%
2018	17,889,222	36.4%	65.6%	25.7%	4.9%	0.4%	2.9%	0.4%

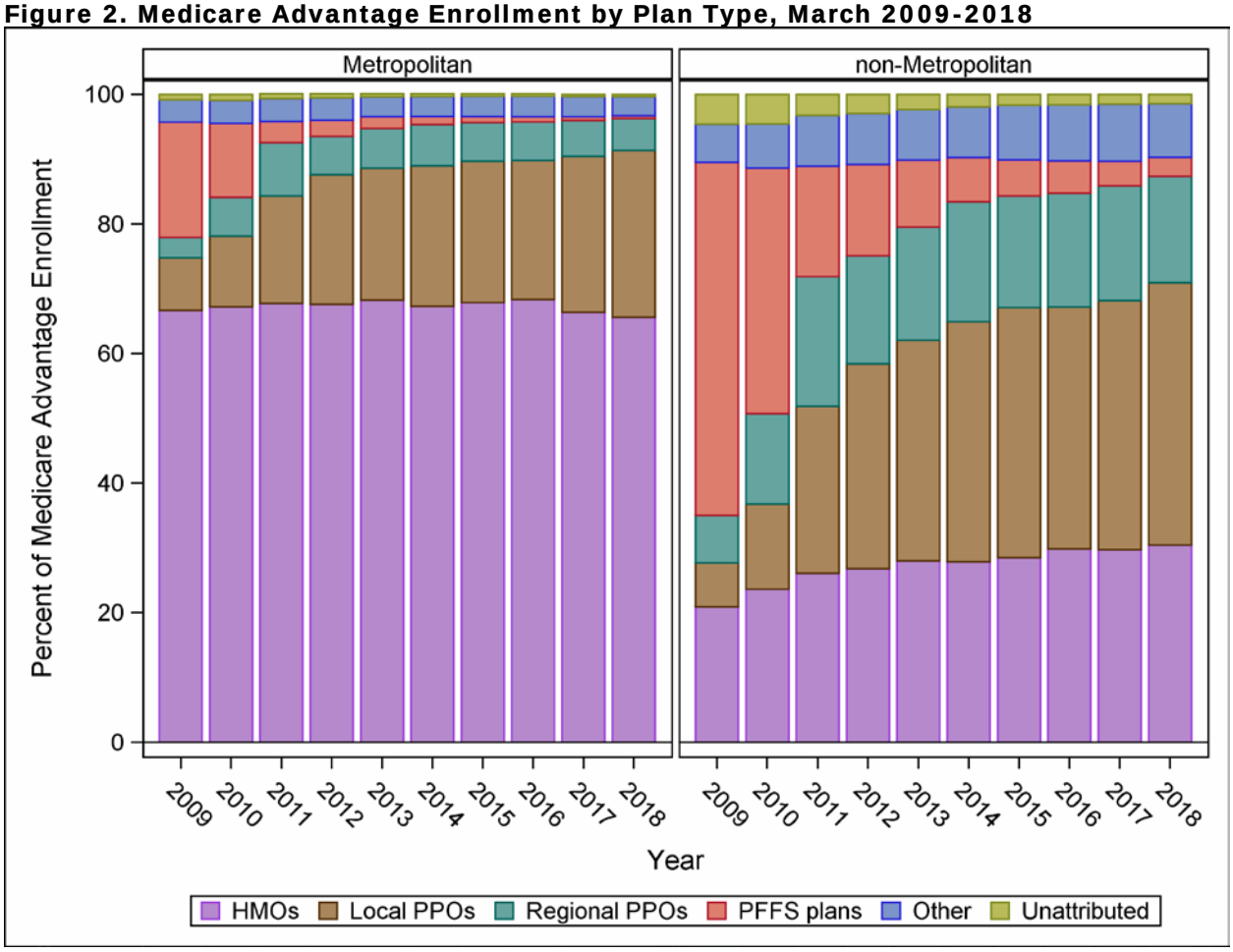
Nonmetropolitan

Year	Total MA Enrollees	% Total Eligible	HMO	Local PPO	Regional 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%
2018	2,639,354	24.6%	30.4%	40.5%	16.4%	2.9%	8.3%	1.4%

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

[1]Unattributed: 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. Medicare Advantage Enrollment by Plan Type, March 2009-2018



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

Discussion

MA enrollment continues to grow in both metropolitan and nonmetropolitan areas across the nation. Total MA enrollment grew by 7.8 percent, which could be the result of several factors. Enrollment growth could be attributed to the "added benefits provided to MA plan beneficiaries over and above the traditional Medicare plans that are not funded through member premiums and lower premium amount offered in MA plans" (Friedman & Swanson, 2018). Additional growth may be attributed to the increase in the number of MA plans available to beneficiaries. A Milliman report indicated that "400 plans that were offered in 2017 are no longer being offered in 2018. However, approximately 700 new MA plans became available in 2018" (Friedman & Swanson).

A Kaiser Family Foundation report observed that "MA plans are not available in 149 counties across 15 states and most of these counties are nonmetropolitan areas" (Jacobson et al., 2017). The reason for the decline and lack of insurer presence in these areas could be because insurers have less negotiation power and smaller operating margins, which makes these areas less attractive and less profitable (Jacobson et al., 2017). However, our research shows that enrollment grew at a faster rate for nonmetropolitan beneficiaries than metropolitan beneficiaries (9.5 percent versus 7.5 percent).

The Centers for Medicare & Medicaid Services (CMS) has recently announced several policy changes set to go into effect in 2019 that could increase enrollment in MA plans. These changes include eliminating the meaningful difference requirement, which will allow MA plans to improve plan options available to beneficiaries. CMS will also allow for flexibility in the MA uniformity requirement, which will "give MA organizations new tools to improve care and outcomes for the most vulnerable enrollees by allowing MA organizations the ability to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer different deductibles for beneficiaries that meet specific medical criteria" (CMS, 2018). Our continued annual reports of rural enrollment will detect any resulting changes in rural participation in MA plans.

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[i] National and state-specific maps and tables of MA enrollment can be found at http://ruprihealth.org/maupdates/nstablesmaps.html