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Medicare Advantage Enrollment Update 2022

Edmer Lazaro, DPT, MSHCA; Fred Ullrich, BA; and Keith Mueller, PhD

Background and Purpose

This policy brief continues the RUPRI Center's annual series of Medicare Advantage (MA) enrollment updates. In addition to tracking overall and nonmetropolitan/metropolitan enrollment, this brief also reports on changes in enrollment in types of MA plans. The Center's ongoing line of inquiry also considers policy changes from previous years that may have impacted MA plan enrollment.

Key Findings

- Overall MA enrollment grew by 8.7 percent (2.3 million) from 2021 to 2022; the rate of growth was higher in nonmetropolitan counties (13.4 percent) than in metropolitan counties (7.9 percent).
- Overall, more than half of MA enrollees (57.9 percent) were in Health Maintenance Organization (HMO) plans. The largest proportion of nonmetropolitan enrollees (51.5 percent) were in Local Preferred Provider Organization (PPO) plans, whereas the largest proportion of metropolitan enrollees (61.4 percent) were in HMO plans.
- The percentage of nonmetropolitan MA enrollees in HMO plans increased from 36.8 percent in 2021 to 37.8 percent in 2022. However, there was a decrease in metropolitan enrollees in HMO plans (63.0 percent in 2021 to 61.4 percent in 2022).
- Enrollment in Local PPO plans increased in both nonmetropolitan (from 48.9 percent to 51.5 percent) and metropolitan counties (from 33.2 percent to 35.6 percent) between 2021 and 2022.

Methods

Monthly MA enrollment data for March 2022 were downloaded from Centers for Medicare & Medicaid Services (CMS) websites.[1] 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. CMS identified an issue in previous data releases where beneficiaries with multiple addresses were double counted. Corrected data dating back to 2017 were released and have been incorporated into this report. As a result, some of the numbers reported in this brief may not align with numbers reported in previous updates. Nonmetropolitan/metropolitan designations (based on Urban Influence Code) were used because data were reported by county.

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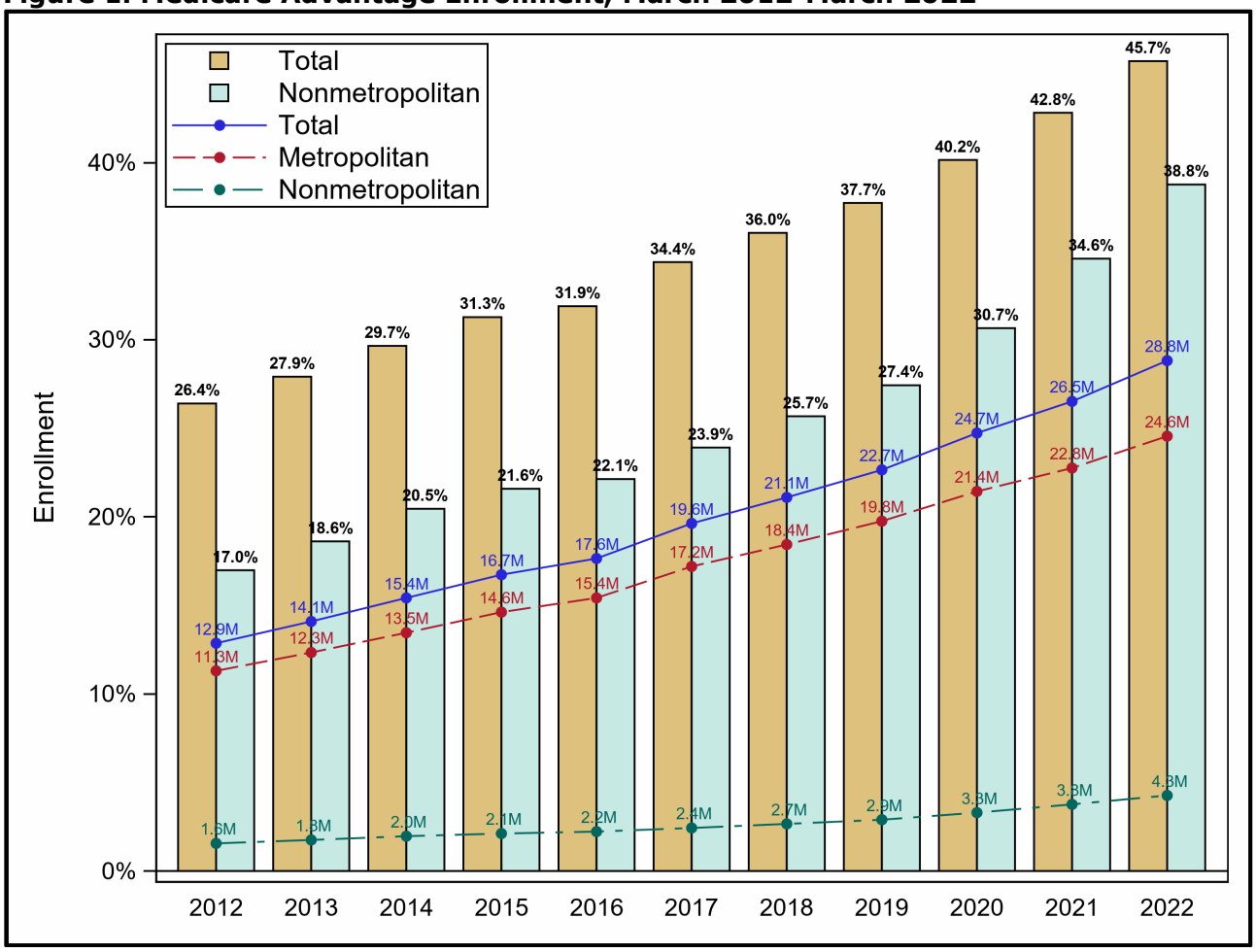
RUPRI RURAL POLICY RESEARCH INSTITUTE

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

Figure 1. Medicare Advantage Enrollment, March 2012-March 2022



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

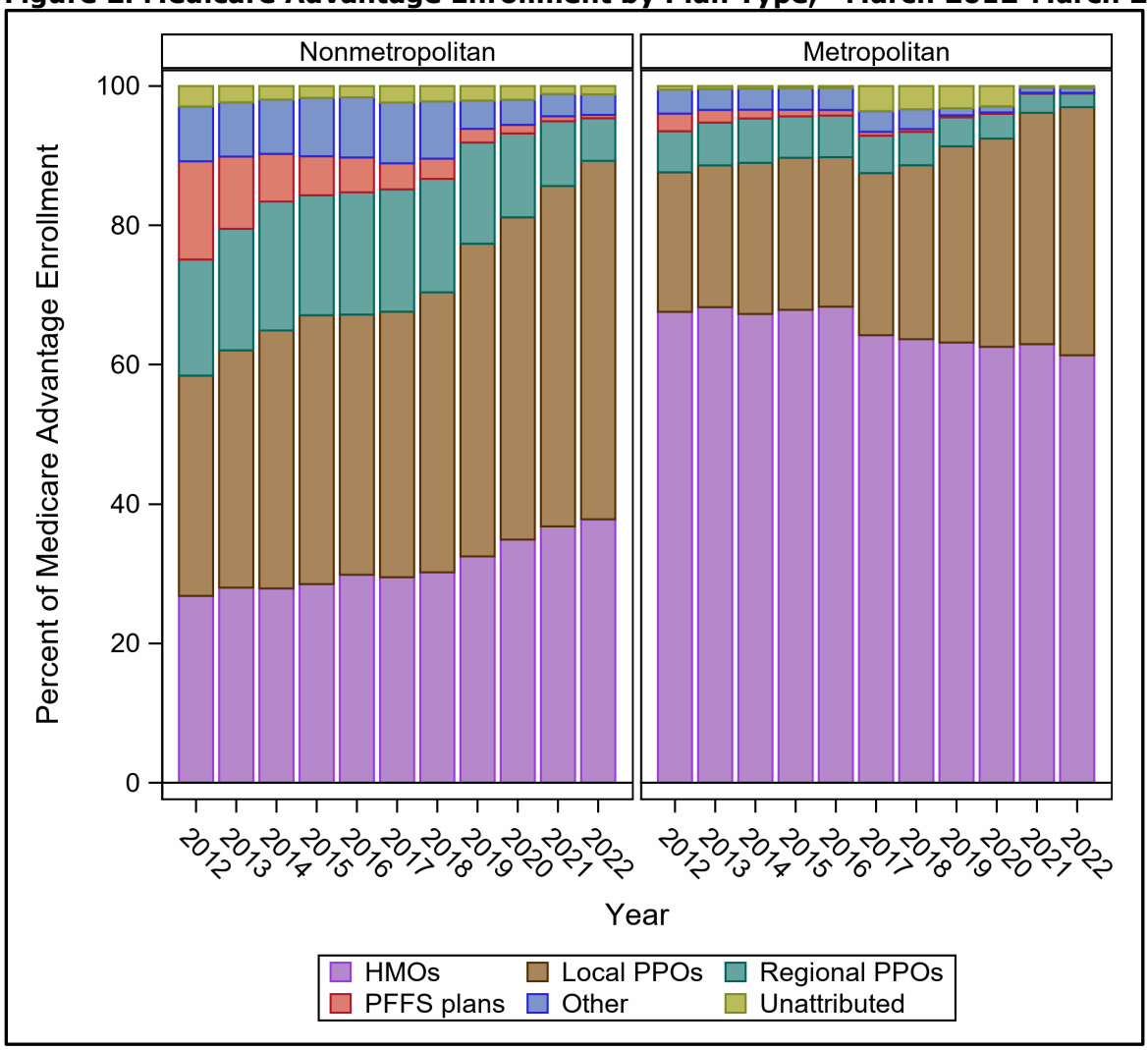
Results/Findings

As of March 2022, 28.8 million Medicare beneficiaries were enrolled in MA plans, which is 45.7 percent of all beneficiaries* (Figure 1, Table 1a). The total number of MA beneficiaries increased by 8.7 percent (2.3 million) between 2021 and 2022. While nonmetropolitan counties had a lower rate of participation than metropolitan counties (38.8 percent and 47.2 percent, respectively), the rate of enrollment growth was higher for nonmetropolitan counties (13.4 percent and 7.9 percent, respectively). The enrollment patterns in MA plan types differed between nonmetropolitan and metropolitan counties (Tables 1a, 1b, 1c). The two dominant plan types discussed in this brief are Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO). HMO plans generally require a beneficiary to choose contracted providers that are in-network (except emergency, urgent, or dialysis care) and require beneficiaries to first see a primary care provider when seeking services. PPOs differ from HMOs in that they generally allow beneficiaries to see any type of provider (i.e. specialist) in- or out-of-network. However, choosing out-of-network providers results in higher cost-sharing for beneficiaries. PPO plans are further divided into Local or Regional plans. Regional PPO plan networks serve a single or a multi-state area as determine by Medicare and Local PPO plans are more localized to a single county or a group of counties chosen by the plan and approved by Medicare.

* CMS reports total enrollment counts using a person-year methodology. For each calendar year, total person-year counts are determined by summing the total number of months that each beneficiary is enrolled in Parts A and/or B during the year and dividing by 12. The person-year method more closely represents true enrollment and is a method generally used by the insurance industry. Total MA enrollment is based on the sum of beneficiaries enrolled in plans from any of the following organization types: Local coordinated care plan (CCP), Regional CCP, Medical Savings Account (MSA), private fee-for-services (PFFS), Demonstrations, National Programs of All-inclusive Care for the Elderly (PACE), 1976 Cost, Health Care Prepayment Plan (HCPP) - 1933 Cost, Employer Direct PFFS. Enrollees are counted by their legal state and county of residence.

More than half (61.4 percent) of metropolitan MA enrollees were in HMO plans, whereas the largest portion (51.5 percent) of nonmetropolitan MA enrollees were in Local PPO plans. Metropolitan HMO plan enrollment has been slowly decreasing since 2017 but was largely flat before that year. Nonmetropolitan HMO plan enrollment increased in 10 of the last 11 years, from 26.8 percent in 2012 to 37.8 percent in 2022. Local PPO plan enrollment grew almost every year since 2009 for both metropolitan and nonmetropolitan areas. Continuing earlier trends, metropolitan and nonmetropolitan enrollment in Regional PPO, Private Fee-For-Service (PFFS), and other plan types continued to decline in 2022. National and state-specific maps and tables of MA enrollment can be found at http://ruprihealth.org/maupdates/nstablesmaps.html

Figure 2. Medicare Advantage Enrollment by Plan Type,* March 2012-March 2022



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

* 'Other' plans include 1876 Cost, HCPP - 1833 Cost, and National PACE plans. 'Unattributed' refers to beneficiaries that could not be assigned to a plan type because of CMS reporting restrictions on county/plans with 10 or fewer enrollees.

Table 1a. Overall Medicare Advantage Enrollment by Plan Type, March 2012-March 2022

Year	Total MA Enrollees	% Total Enrolled	HMO	Local PPO	Regional PPO	PFFS Plan	Other*	Unatt.
2022	28,821,699	45.7%	57.9%	38.0%	2.6%	0.2%	1.1%	0.4%
2021	26,520,298	42.8%	59.2%	35.4%	3.7%	0.2%	1.1%	0.3%
2020	24,732,198	40.2%	58.9%	32.1%	4.7%	0.3%	1.2%	2.8%
2019	22,651,489	37.7%	59.3%	30.3%	5.5%	0.5%	1.4%	3.0%
2018	21,097,238	36.0%	59.4%	26.9%	6.2%	0.7%	3.5%	3.2%
2017	19,628,723	34.4%	59.9%	25.1%	6.9%	1.0%	3.7%	3.4%
2016	17,647,860	31.9%	63.5%	23.5%	7.4%	1.3%	3.8%	0.5%
2015	16,733,384	31.3%	62.9%	23.9%	7.4%	1.5%	3.8%	0.5%
2014	15,421,808	29.7%	62.3%	23.6%	7.9%	2.0%	3.6%	0.6%
2013	14,092,553	27.9%	63.2%	22.1%	7.5%	2.9%	3.6%	0.6%
2012	12,863,257	26.4%	62.6%	21.4%	7.2%	3.9%	4.0%	0.8%

Table 1b. Nonmetropolitan Medicare Advantage Enrollment by Plan Type, March 2009-2022

Year	Total MA Enrollees	% Total Enrolled	HMO	Local PPO	Regional PPO	PFFS Plan	Other*	Unatt.
2022	4,266,542	38.8%	37.8%	51.5%	6.1%	0.5%	3.0%	1.2%
2021	3,762,577	34.6%	36.8%	48.9%	9.3%	0.7%	3.2%	1.1%
2020	3,295,215	30.7%	34.9%	46.3%	12.0%	1.2%	3.6%	2.0%
2019	2,895,620	27.4%	32.5%	44.9%	14.5%	2.0%	4.1%	2.1%
2018	2,660,053	25.7%	30.2%	40.2%	16.3%	2.9%	8.2%	2.2%
2017	2,430,666	23.9%	29.5%	38.1%	17.6%	3.7%	8.7%	2.4%
2016	2,225,321	22.1%	29.9%	37.3%	17.5%	5.0%	8.6%	1.6%
2015	2,114,836	21.6%	28.5%	38.6%	17.2%	5.6%	8.4%	1.7%
2014	1,966,261	20.5%	27.9%	37.0%	18.5%	6.8%	7.8%	1.9%
2013	1,753,427	18.6%	28.0%	34.1%	17.4%	10.4%	7.8%	2.3%
2012	1,559,261	17.0%	26.8%	31.6%	16.7%	14.1%	7.9%	2.9%

Table 1c. Metropolitan Medicare Advantage Enrollment by Plan Type, March 2009-2022

Year	Total MA Enrollees	% Total Enrolled	HMO	Local PPO	Regional PPO	PFFS Plan	Other*	Unatt.
2022	24,555,157	47.2%	61.4%	35.6%	2.0%	0.1%	0.7%	0.3%
2021	22,757,721	44.6%	63.0%	33.2%	2.7%	0.1%	0.8%	0.2%
2020	21,436,742	42.2%	62.6%	29.9%	3.5%	0.2%	0.9%	2.9%
2019	19,755,615	39.9%	63.2%	28.2%	4.2%	0.3%	1.0%	3.2%
2018	18,436,974	38.3%	63.7%	25.0%	4.8%	0.4%	2.8%	3.3%
2017	17,197,848	36.7%	64.2%	23.3%	5.4%	0.6%	3.0%	3.6%
2016	15,422,539	34.1%	68.3%	21.5%	6.0%	0.8%	3.1%	0.3%
2015	14,618,548	33.5%	67.9%	21.8%	5.9%	0.9%	3.1%	0.3%
2014	13,455,547	31.7%	67.3%	21.7%	6.4%	1.3%	3.0%	0.4%
2013	12,339,126	30.0%	68.3%	20.4%	6.1%	1.8%	3.0%	0.4%
2012	11,303,996	28.6%	67.6%	20.0%	5.9%	2.5%	3.4%	0.5%

* 'Other' plans include 1876 Cost, HCPP - 1833 Cost, and National PACE plans. 'Unattributed' refers to beneficiaries that could not be assigned to a plan type because of CMS reporting restrictions on county/plans with 10 or fewer enrollees.

Discussion

Overall, enrollment in MA plans continued to increase between 2021 and 2022. Enrollment in HMO plans continues to increase in nonmetropolitan areas while metropolitan areas show a decrease in the rate of HMO enrollment. Both areas show increased enrollment in local PPO plans. As in previous years, a larger proportion of nonmetropolitan areas are enrolled in local PPO plans while metropolitan areas are enrolled in HMO plans. The overall growth in Medicare Advantage (MA) enrollment continues to raise interest in health policy and health services research, especially as the issue of looming Medicare Part A insolvency threatens program funding. Furthermore, the growth in MA enrollment highlights the need for more complete and comparable data to investigate the value MA plans offer their beneficiaries.

In 2022, there were a total of 3,834 MA plans nationwide available to Medicare beneficiaries. This is about an 8 percent increase from the previous year. An average of 39 plans are accessible to each beneficiary.[2] Supplemental benefits such as dental, vision, and/or hearing services, no or low monthly payments, and annual out-of-pocket limits make MA plans more attractive than traditional Medicare, including Medicare-covered services via telehealth during the COVID-19 pandemic.[3,4,5] Beneficiaries in metropolitan areas can choose from twice as many plans as beneficiaries living in non-metropolitan areas. Certain counties in Ohio, Pennsylvania, California, Texas, and Michigan have over 50 plans while most counties throughout the US have between 11-50 plans with an average of 9 firms offering these plans.[2]

Medicare Advantage plans include more than those serving the general Medicare population. There has been a sharp increase in both the number of special need plans (SNP) and in SNP enrollment over the past five years for beneficiaries requiring institutional-level care, dually eligible beneficiaries, and for beneficiaries with chronic conditions.[2,6] Plans for dually eligible beneficiaries have nearly doubled (373 in 2017 to 700 in 2022) and have more than doubled for those requiring institutional-level care (83 in 2017 to 184 in 2022) and those with chronic conditions (122 in 2017 to 272 in 2022), suggesting insurers' continued interest in providing managed care for these groups.[2,6] Aggregate enrollment in SNPs more than doubled from 2.3million in 2017 to 4.8 million as of June 2022.[2,7] Interestingly, the characteristics of enrollees in MA plans are shared with those in traditional Medicare plans only when people in SNP are excluded from analysis, and most studies exclude those in SNP. When SNP enrollees are included, MA enrollees are more likely to be Black or Hispanic and to have at least one chronic condition.[6,8] Studying the characteristics of beneficiaries in SNP, including any metropolitan vs. nonmetropolitan differences, may better inform future Medicare program design.

Generally, MA programs outperform traditional Medicare in the use of more preventive care visits, reductions in hospitalizations, and fewer emergency department visits. In contrast, quality-of-care metrics on readmission rates, mortality, and surveys of patient experiences indicate poorer performance by MA plans. Studies evaluating racial and ethnic disparities in MA program quality metrics have shown mixed results with some showing better performance by MA plans (in mammography rates, preventable admissions) and others lower performance in readmission rates and immunization for influenza.[9,10] Increases in the number of plan options, increased enrollment, and new firm market entry continue to signal growth for MA programs.[6] The Congressional Budget Office projects about half of Medicare beneficiaries will enroll in MA plans by 2030.[11] In April 2022, The Office of the Inspector General issued a report exposing Medicare Advantage Organizations that delayed or denied MA beneficiaries' access to services.[12] While recommendations have been made to address those issues, the report generally highlights the continued need for more health services research that inform inclusive policies, program re-design, and improve the value of MA programs. RUPRI will continue to monitor MA enrollment trends and policy changes.

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