Stand-Alone Prescription Drug Plans Dominated the Rural Market in 2011

Growth Driven by Medicare Advantage Prescription Drug Plan Enrollment

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Introduction

In May 2011, over 28 million Medicare-eligible beneficiaries, representing 60.3% of the eligible population, had prescription drug coverage through Medicare Part D, the federal program designed to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. In rural areas,[1] 59.1% of eligible Medicare beneficiaries (5.8 million) had prescription drug coverage through Medicare Part D drug plans, a slightly smaller proportion than the 60.6% of urban beneficiaries (22.5 million) who were covered. Overall in 2010, the latest year for which such data are available, a total of 90% of Medicare-eligible beneficiaries had prescription drug coverage through the Medicare Part D program or other creditable coverage (with 59.5% in Part D).[2] Rural beneficiaries are more likely to enroll in stand-alone prescription drug plans (PDPs), while urban beneficiaries are more likely to enroll in Medicare Advantage (MA) plans that offer prescription drug coverage (MA-PD plans) in addition to all other health care services. Although stand-alone PDPs are dominant in rural areas, the overall growth in Part D coverage from 2008 to 2011 was due to growth in MA-PD enrollment in rural areas. As a result of the difference in the types of Part D coverage most prevalent in rural and urban areas, Medicare Part D beneficiaries may be impacted differently by the changes in MA payment rates mandated by the ACA or any additional policy changes to the Part D program.

Key Findings

- While almost half of rural Medicare beneficiaries (47.6%) were enrolled in a stand-alone PDP and 11.5% of rural beneficiaries were enrolled in an MA-PD plan in 2011, only about a third of urban beneficiaries (36.3%) were enrolled in a stand-alone PDP, while 24.3% were enrolled in an MA-PD plan (Table 1).
- The percentage of rural Medicare beneficiaries enrolled in Part D plans grew from 54.8% in 2008 to 59.1% in 2011. Enrollment in Medicare Part D plans in urban areas has been similar, growing from 56.0% of eligible beneficiaries in 2008 to 60.6% in 2011. These numbers do not include Medicare beneficiaries with other creditable coverage.
- The recent increase in rural enrollment in Part D can be attributed MA-PD plan enrollment growth, from 709,000 (7.6% of eligible Medicare beneficiaries) in 2008 to over 1.13 million (11.5% of eligible Medicare beneficiaries) in 2011.
- Average monthly premiums for stand-alone PDPs in rural areas grew from $31.34 in 2008 to $37.77 in 2011 (in 2011 dollars), a 20.5% increase. Similarly, average monthly premiums for stand-alone PDPs in urban areas increased 23.3%, from $31.08 in 2008 to $38.31 in 2011 (in 2011 dollars).
- The weighted average monthly MA-PD premium for rural enrollees in 2011 was significantly higher than for urban enrollees ($52.38 compared to $38.23). Rural beneficiaries enrolled in health maintenance organization (HMO) plans had the highest premiums; those enrolled in preferred provider organization (PPO) plans and private fee-for-service (PFFS) plans had premiums roughly comparable to those of urban beneficiaries.
- The percentage of rural beneficiaries in Part D plans varied considerably across the US. In many states, over 60% of rural beneficiaries were enrolled in Part D plans in 2011; enrollment rates were highest in Iowa (68.8%), Hawaii (67.8%), North Dakota (66.4%), and Nebraska (65.7%). In contrast, Part D enrollment rates among rural beneficiaries were below 50% in seven states: Alaska, Delaware, Maryland, Massachusetts, Michigan, Nevada, and New Hampshire.

Enrollment in Part D Plans

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173) (MMA) allowed Medicare beneficiaries to add prescription drug coverage to their Medicare coverage, beginning in January 2006, by enrolling in a private plan either through a stand-alone PDP or an MA-PD plan.

Medicare beneficiaries (rural and urban) may have prescription drug coverage from other sources described as "creditable coverage" (actuarially equivalent to Part D coverage), such as veterans' benefits or a private insurance plan (e.g., employer health plan). For this reason, the coverage rates listed here underestimate the overall prescription drug coverage rates in the population. The Centers for Medicare and Medicaid Services (CMS) no longer reports creditable coverage rates by county. However, in 2010, CMS reported that 7.79 million (16.8%) eligible Medicare beneficiaries nationwide had other "creditable" prescription drug coverage, 6.36 million (13.7%) had coverage through the Medicare Retiree Drug Subsidy, 27.65 million (59.5%) had coverage through Medicare Part D, and in total 89.9% of persons eligible for Medicare Part D had some form of creditable coverage.[3]

As of May 2011, nearly 5.8 million rural Medicare beneficiaries (59.1%) had prescription drug coverage through Medicare Part D (Table 1). The number of rural enrollees in Part D grew by over 13.6% from 2008 through 2011, more than double the growth rate of the Medicare eligible population. Urban enrollment grew by over three million enrollees during the same time, rising from 56% of eligible beneficiaries to 60.6%. Nearly 60% of the increase in enrollment in Part D coverage in rural areas can be attributed to MA-PD plan enrollment growth. Urban enrollment in Part D plans followed a similar pattern, with the majority of enrollment growth in MA-PD plans.

Table 1. Enrollment in Medicare Part D

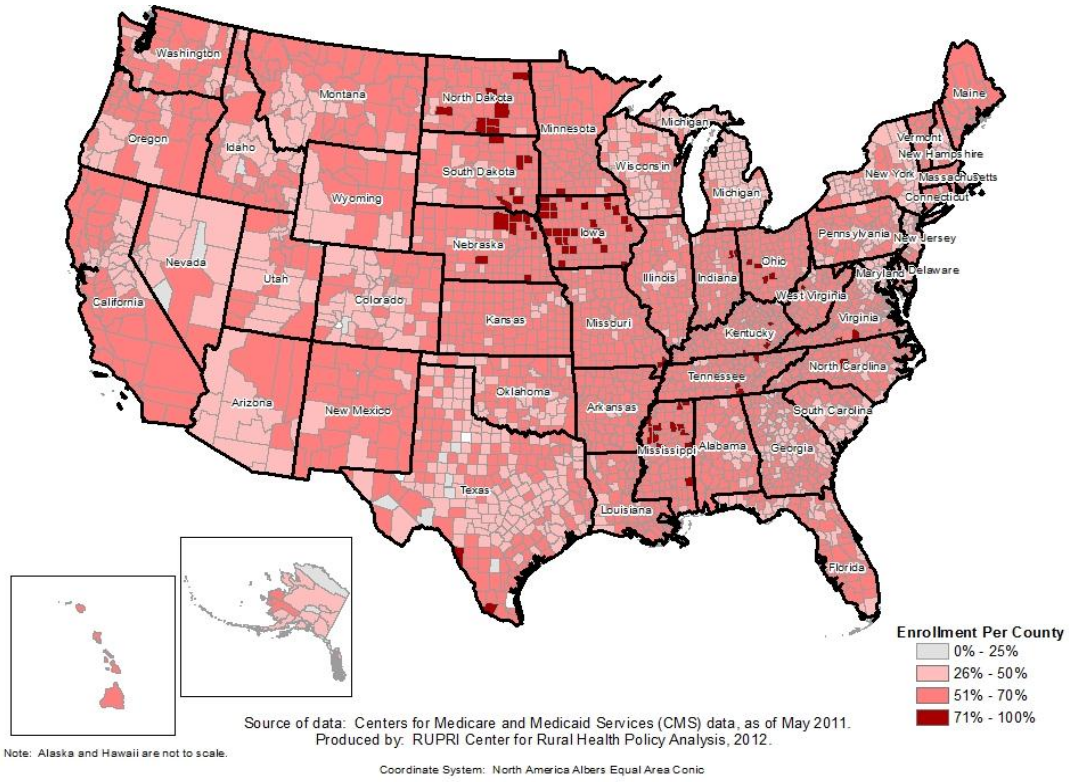
		Enrollment in Medicare Part D						Number of Medicare Eligibles
		Total in Part D		Number in PDPs		Number in MA-PD		
		Numbers in Thousands	Percentage of Medicare Eligibles	Numbers in Thousands	Percentage of Medicare Eligibles	Numbers in Thousands	Percentage of Medicare Eligibles	Numbers in Thousands
May 2008	Rural, Total	5,125	54.8%	4,416	47.2%	709	7.6%	9,349
	Urban, Total	19,362	56.0%	12,332	35.7%	7,029	20.3%	34,558
	U.S., Total	24,487	55.8%	16,748	38.1%	7,738	17.6%	43,906
May 2009	Rural, Total	5,293	55.5%	4,391	46.0%	901	9.4%	9,543
	Urban, Total	20,269	57.2%	12,398	35.0%	7,871	22.2%	35,449
	U.S., Total	25,562	56.8%	16,790	37.3%	8,772	19.5%	44,992
May 2010	Rural, Total	5,426	55.9%	4,410	45.4%	1,016	10.5%	9,707
	Urban, Total	21,039	58.1%	12,597	34.8%	8,442	23.3%	36,212
	U.S., Total	26,465	57.6%	17,006	37.0%	9,459	20.6%	45,919
May 2011	Rural, Total	5,825	59.1%	4,692	47.6%	1,133	11.5%	9,855
	Urban, Total	22,499	60.6%	13,485	36.3%	9,014	24.3%	37,113
	U.S., Total	28,324	60.3%	18,177	38.7%	10,147	21.6%	46,968

Notes: 1) Some elderly persons (rural and urban) have prescription drug coverage from other sources such as private insurance plans (e.g., employer health plans), which are described as "creditable" coverage. Although no longer publishing such data by county, CMS reports that in 2010, 7.79 million Medicare eligible beneficiaries nationwide had other "creditable" prescription drug coverage. 2) Excludes enrollment in any county and plan if the plan enrolls 10 or fewer enrollees in that county (due to restrictions on data release by Centers for Medicare and Medicaid Services).

Patterns of Enrollment in Medicare Part D

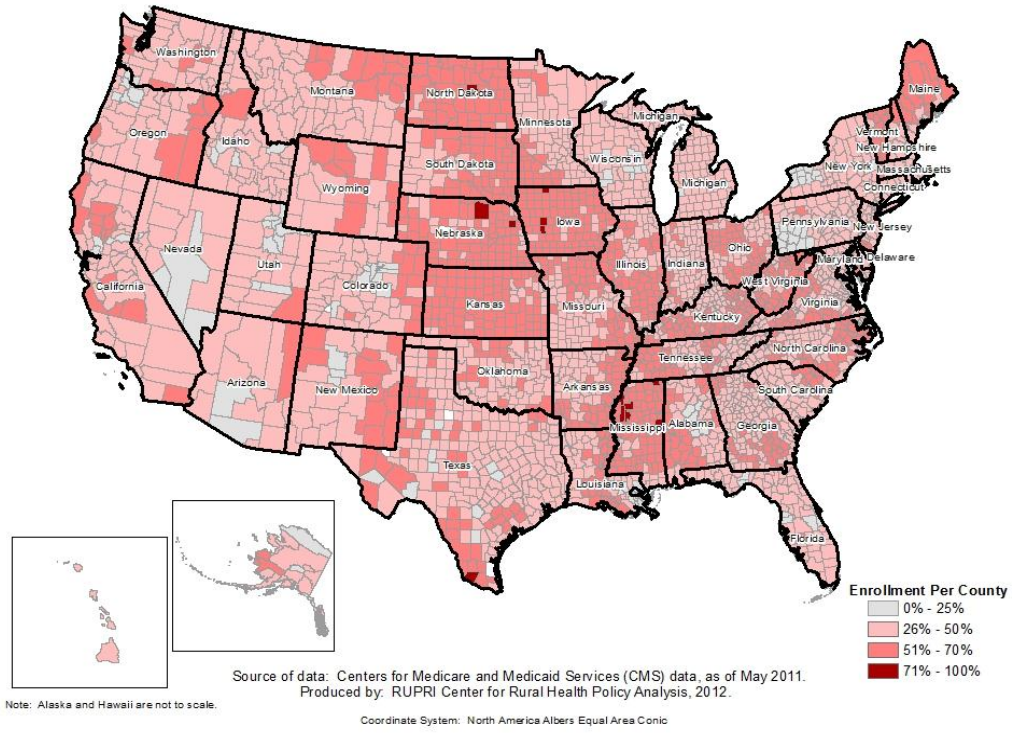
More than 50% of eligible Medicare beneficiaries are enrolled in Medicare Part D in the majority (72%) of counties in the United States (Figure 1); however, there are still a significant number of counties with enrollment of fewer than 50% of eligible beneficiaries. Midwestern states have the highest concentrations of enrollment in Part D plans; however, Part D enrollment is widely distributed across the country.

Figure 1. Percent of Eligible Medicare Beneficiaries Enrolled in Medicare Part D by County, May 2011



In 37% of counties, more than half of the eligible Medicare beneficiaries enroll in stand-alone PDPs (Figure 2). These counties are concentrated in Midwestern and southern states. While lower stand-alone PDP enrollment may reflect individuals going without drug coverage in some counties, it can also correlate with greater enrollment in MA-PD plans or better access to other creditable coverage outside of the Medicare Part D program; thorough analysis of individual-level data would need to be done to disentangle these possible explanations.

Figure 2. Percent of Eligible Medicare Beneficiaries Enrolled in Stand-Alone Prescription Drug Plans by County, May 2011



Part D Enrollment by State

Rural enrollment in Medicare Part D plans varies across states (Table 2), with the highest percentage of (68.8%) of eligible rural beneficiaries enrolled in Iowa, and the lowest percentage (38.8%) enrolled in Alaska. In all but seven states, over half of the rural Medicare beneficiaries in the state were enrolled in either a stand-alone PDP or an MA-PD plan in 2011. The states with enrollment below half of eligible rural beneficiaries are Alaska, Delaware, Maryland, Massachusetts, Michigan, Nevada, and New Hampshire. States that have higher enrollment in MA-PD plans typically have lower enrollment in stand-alone PDPs, suggesting that in areas where both are available, Medicare beneficiaries tend to enroll in MA coverage that includes prescription drug coverage in lieu of traditional Medicare and stand-alone Part D coverage. States with a larger rural population are more likely to have higher stand-alone PDP enrollment than more urban states, which are likely to have a higher concentration of Medicare beneficiaries in MA-PD plans.

Table 2. Enrollment in Medicare Part D Prescription Drug Coverage, May 2011

	Rural Counties				Urban Counties			
STATE	Eligible Medicare Beneficiaries	Percent in Part D	Percent in PDPs	Percent in MA-PDPs[1]	Eligible Medicare Beneficiaries	Percent in Part D	Percent in PDPs	Percent in MA-PDPs[1]
UNITED STATES	**9,855,093**	**59.10%**	**47.60%**	**11.50%**	**46,968,272**	**60.30%**	**38.70%**	**21.60%**
AK	22,346	38.30%	38.30%	0.00%	65,542	36.50%	36.50%	0.00%
AL	278,548	59.30%	46.60%	12.70%	852,251	56.70%	36.90%	19.80%
AR	250,977	61.70%	50.60%	11.10%	536,237	60.10%	47.40%	12.70%
AZ	131,542	55.10%	37.10%	18.00%	933,120	62.60%	27.10%	35.50%
CA	170,408	54.50%	47.00%	7.50%	4,809,875	69.90%	34.70%	35.10%
CO	103,908	50.50%	42.50%	8.00%	632,530	58.20%	27.70%	30.50%
CT	52,995	55.20%	41.80%	13.40%	570,301	56.80%	38.70%	18.10%
DC	No Rural Counties				78,769	48.80%	39.50%	9.20%
DE	46261	49.20%	47.80%	1.40%	151,031	50.90%	47.90%	3.10%
FL	284,280	53.60%	38.90%	14.60%	3,389,670	62.30%	31.90%	30.40%
GA	321,581	63.60%	46.20%	17.40%	1,256,645	60.30%	40.30%	20.00%
HI	61,762	67.80%	30.90%	36.90%	209,936	66.70%	27.30%	39.40%
IA	265,899	68.80%	62.00%	6.70%	518,395	66.10%	55.70%	10.30%
ID	86,729	53.30%	39.60%	13.70%	232,564	57.00%	34.20%	22.80%
IL	329,645	57.60%	53.30%	4.30%	1,852,674	55.80%	48.30%	7.50%
IN	254,196	60.50%	45.70%	14.90%	1,013,773	58.60%	44.10%	14.60%
KS	180,748	61.40%	58.20%	3.20%	435,099	61.10%	51.20%	9.90%
KY	376,918	66.30%	58.50%	7.80%	767,364	64.80%	53.30%	11.50%
LA	195,364	59.30%	50.30%	9.00%	692,195	61.80%	39.00%	22.80%
MA	4,630	45.70%	45.40%	0.30%	1,067,801	58.60%	42.00%	16.70%
MD	57,109	46.50%	45.70%	0.80%	794,252	45.80%	38.70%	7.20%
ME	123,163	64.30%	53.20%	11.10%	266,916	63.00%	50.60%	12.40%
MI	382,587	46.30%	37.50%	8.80%	1,668,838	48.30%	34.90%	13.40%
MN	278,810	68.40%	44.70%	23.70%	791,350	68.20%	37.00%	31.20%
MO	327,827	61.20%	51.00%	10.20%	1,008,378	62.30%	42.10%	20.20%
MS	303,493	67.00%	61.40%	5.60%	500,653	63.90%	55.70%	8.20%
MT	115,055	53.10%	42.70%	10.40%	171,325	54.70%	43.40%	11.30%
NC	541,024	60.20%	49.10%	11.10%	1,505,767	59.30%	43.70%	15.60%
ND	66,367	66.40%	62.90%	3.50%	108,826	65.50%	61.00%	4.50%
NE	143,961	65.70%	60.00%	5.70%	279,826	62.70%	53.20%	9.40%
NH	97,010	47.20%	43.90%	3.40%	221,092	48.00%	44.10%	4.00%
NJ	No Rural Counties				1,336,519	53.80%	43.20%	10.60%
NM	118,726	58.40%	49.40%	9.00%	317,082	62.50%	37.70%	24.80%
NV	50,211	46.10%	29.60%	16.50%	360,215	55.60%	26.00%	29.60%
NY	293,145	54.40%	34.20%	20.20%	3,008,351	60.90%	32.90%	28.00%
OH	398,220	64.60%	53.10%	11.50%	1,907,400	65.70%	44.00%	21.70%
OK	252,919	58.90%	54.50%	4.40%	606,218	58.90%	45.90%	13.00%
OR	185,012	58.60%	40.10%	18.40%	625,693	65.30%	30.00%	35.30%
PA	405,711	61.70%	39.40%	22.40%	2,285,785	64.50%	32.70%	31.80%
RI	No Rural Counties				183,240	68.70%	35.20%	33.50%
SC	215,111	56.90%	44.30%	12.70%	784,205	54.50%	39.80%	14.60%
SD	81,237	62.70%	58.00%	4.70%	137,286	61.00%	54.60%	6.40%
TN	354,802	64.80%	49.30%	15.60%	1,067,438	64.20%	40.80%	23.40%
TX	560,630	53.30%	46.10%	7.20%	3,046,421	56.50%	38.40%	18.10%
UT	41,713	54.40%	34.60%	19.80%	287,012	56.30%	27.50%	28.80%
VA	249,999	62.10%	50.00%	12.10%	1,155,055	52.40%	40.60%	11.80%
VT	82,230	58.10%	54.10%	4.00%	112,873	56.80%	52.80%	3.90%
WA	166,571	52.30%	44.00%	8.30%	984,128	56.40%	36.10%	20.30%
WI	302,895	52.10%	33.00%	19.00%	917,587	55.20%	33.10%	22.00%
WV	184,935	59.10%	53.00%	6.10%	381,945	60.10%	50.90%	9.10%
WY	55,883	51.00%	48.00%	3.00%	80,824	51.10%	47.80%	3.20%

SOURCE: RUPRI Center for Rural Health Policy Analysis, based on Centers for Medicare and Medicaid Services (CMS) data, as of May 2011.

Note: Excludes enrollment in any county and plan if the plan enrolls 10 or fewer enrollees in that county (due to restrictions on data release by CMS), and enrollees in Alaska and US territories (due to data incompatibilities).

(1) Includes, Demo, Cost and PACE plans.

Premiums in Medicare Part D

Stand-Alone PDP Premiums

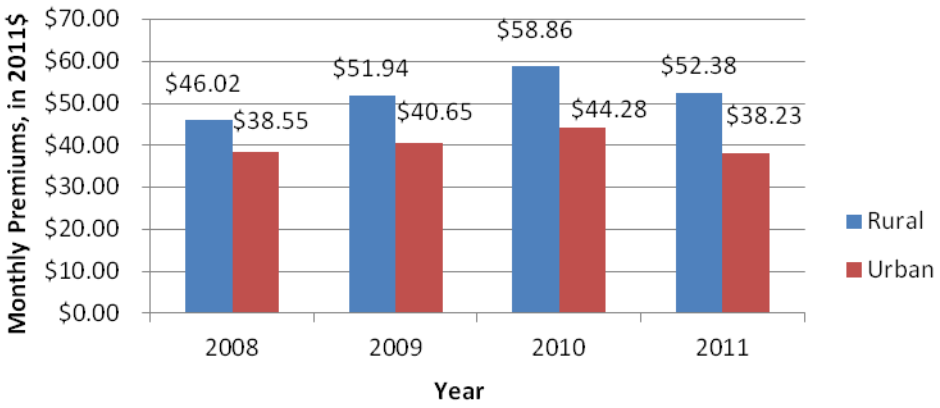
Inflation-adjusted averages of monthly premiums for stand-alone PDPs through Medicare Part D grew by over 20% from 2008 through 2011. The average rural and urban PDP premiums—not factoring in urban/rural cost-of-living or wage differentials—remain close in value and grew at a similar pace. Rural premiums grew from $31.34 in 2008 to $37.77 in 2011 (in 2011 dollars), a 20% increase in four years (Figure 3). Urban premiums grew slightly more rapidly than rural, with a 23% increase in the last four years, growing from an average of $31.08 in 2008 to $38.31 in 2011 (in 2011 dollars). Stand-alone PDP premiums fell slightly in 2011 in both urban and rural areas after adjusting for inflation.

Figure 3. Inflation-Adjusted Monthly Premiums for Stand-Alone Prescription Drug Plans, 2008-2011

MA-PD Plan Premiums

In 2011, the average premium for MA-PD plans in rural areas was $52.38, higher than the average urban premium of $38.23 (Figure 4). The average premium for rural MA-PD plans grew by nearly 14% from 2008 to 2011, while the urban average declined by less than 1% for the same period, after adjusting for inflation. MA-PD plans are comprehensive, meaning that premiums cover the cost of both health care services and prescription drugs.

Figure 4. Inflation-Adjusted Premiums for Medicare Advantage Plans with Prescription Drug Coverage, 2008-2011



Note: Premiums are averaged across HMO, PPO, and PFFS plan types.

Rural-Urban Premium Differential

As shown in Figure 3, average stand-alone premiums do not differ dramatically across rural and urban counties. The same stand-alone PDP plans are typically available to both rural and urban beneficiaries in a particular region or nationally, depending on the coverage area of the plan, which causes the premiums to be similar for beneficiaries regardless of where they live. This helps explain the similar average PDP premiums and premium growth rates for both rural and urban beneficiaries.

In contrast, rural beneficiaries have historically paid higher premiums for MA-PD coverage than urban beneficiaries due to the types of plans into which the beneficiaries enroll. Urban beneficiaries are much more likely than rural beneficiaries to enroll in MA HMO plans with or without prescription drug coverage (69% of urban MA enrollment compared to 30% of rural MA enrollment), and urban HMO plans on average have significantly lower premiums than the PPO, PFFS, or rural HMO plans that rural MA beneficiaries chose in 2011 and have chosen historically.[4] Rural beneficiaries are more limited in the types of MA plans available to them than urban beneficiaries and pay higher premiums, in part because plans incur higher costs when establishing provider networks for health care services in rural areas. Historically, HMO and PPO plans have struggled to establish provider networks in rural areas due to low population density, small numbers of providers, and provider resistance to MA contracting.[5] However, rural MA enrollment has grown significantly in recent years to over 700,000 rural MA enrollees in PPO plans (over 46% of rural enrollment in the MA program), and over 450,000 enrollees in HMO plans (30% of rural MA enrollment).

In 2011, the average premium for an HMO plan in rural areas was $56.07, while the average premium in urban areas was $33.10. PPO plan premiums were only slightly higher in rural areas, with an average premium of $49.08, compared to $45.80 in urban areas. PFFS plans had slightly lower average premiums in rural areas, at $41.90, compared to urban areas at $43.90.

Conclusions

Medicare Part D prescription drug coverage has become a vital component of health coverage for rural and urban Medicare beneficiaries alike. Medicare Part D enrollment has grown slowly and steadily since the program began in 2006. Urban enrollment in Part D plans has slightly outpaced rural enrollment during this time. Rural Medicare beneficiaries continue to enroll in stand-alone PDPs at a higher rate than urban beneficiaries but have much lower enrollment in MA-PD plans than their urban counterparts. Rural and urban beneficiaries in a particular region typically have the same stand-alone PDP options and premiums, since the plans are regional or national, which is advantageous to rural beneficiaries and explains their high enrollment levels in stand-alone PDPs. Conversely, rural beneficiaries historically have not enrolled in MA-PD plans as readily as their urban counterparts due to limited plan availability and elevated premiums; however, rural enrollment in MA-PD plans has grown significantly in recent years and is close to keeping pace with urban MA-PD growth. On average, MA-PD premiums are substantially higher for rural beneficiaries and have risen more rapidly than those of urban beneficiaries, which suggests that other factors, such as non-drug benefits offered through MA plans, may be important in attracting and retaining enrollment in rural areas.

One implication of this analysis is that, under the cost containment measures enacted by the ACA, rural and urban Medicare Part D beneficiaries may be impacted differently. Because the ACA changes MA payment rate-setting dramatically, and research shows that a reduced payment-to-cost ratio encourages HMO enrollment at the expense of other plan types, we can expect to see HMOs gain market share in the MA market.[6] However, since the HMO model is most prevalent and successful in urban areas, the payment changes are likely to reduce MA plan choices – and possibly drive up premiums to some extent – in rural areas.

Future Research

Medicare Part D has helped rural and urban beneficiaries obtain prescription drug coverage; however, the type of coverage they obtain varies by plan, plan type, structure, and benefits. Further analysis might investigate the specific benefits available within the various stand-alone PDPs and MA-PD plans, including drug formularies, use of local pharmacies by plans, and projections of the beneficiaries' out-of-pocket expenses. Such work would allow researchers and policymakers to fully understand the prescription drug coverage options available to rural and urban Medicare beneficiaries.

The different enrollment patterns in MA-PD plans and stand-alone PDPs in urban and rural areas raise a number of questions. As managed care becomes an increasingly important tool for cost containment and quality improvement across the health care industry and for Medicare in particular, will such plans provide more coordinated care, including monitoring the use of multiple prescription drugs? Will rural beneficiary enrollment in Part D plans shift from stand-alone PDPs to MA-PD plans? If not, how will rural beneficiaries realize gains associated with MA-PD plan activities?

The Patient Protection and Affordable Care Act of 2010 (ACA) as passed will bring significant changes to the Part D program over the next several years, including phasing out the coverage gap ("doughnut

hole") by 2020. These changes begin with rebates starting in 2012 for enrollees who reach the coverage gap. Many questions remain regarding Medicare Part D enrollment, including: Are the prescription drug benefits available to rural and urban Medicare beneficiaries equitable? Will the phase-out process impact rural and urban beneficiaries similarly? Since the doughnut-hole closure is accomplished differently for name-brand vs. generic medications, we might consider the potential differential impact for rural and urban beneficiaries, who have different types of coverage and thus may have different use patterns for their medications.

Endnotes

[1]The rural or urban definition of a county was determined using the 2003 Urban Influence Codes produced by the United States Department of Agriculture (USDA), Economic Research Service. Codes 1 and 2 are defined as metropolitan by the USDA, all other codes are designated as non-metropolitan and are considered rural for this analysis.

[2]Centers for Medicare and Medicaid Services, Medicare, Prescription Drug Coverage – General Information, 2010 Enrollment Information (accessed at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html, April 24, 2012).

[3]Centers for Medicare and Medicaid Services, Medicare, Prescription Drug Coverage – General Information, 2010 Enrollment Information (accessed at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html, April 24, 2012).

[4] Kemper, L., L Pollack, A Barker, T McBride, K Mueller. "Rural Medicare Advantage 2011: Enrollment Trends and Plan Characteristics." RUPRI Center for Rural Health Policy Analysis, P2011-9. Available at http://cph.uiowa.edu/rupri/publications/policypapers/NOV.MA%20Overview%20October%202011%20FINAL.pdf

[5]Gold, M. (2009). Medicare's Private Plans: A report card on Medicare Advantage. *Health Affairs*, 28(1), w41-54.

[6] Pollack, L, A Barker, L Kemper, T McBride, K Mueller. "The Effect of Payment Rate Variation on Medicare Advantage Enrollment by Plan Type." Forthcoming.