RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

Brief No. 2025-1 January 2025 http://www.public-health.uiowa.edu/rupri/

Medicare Advantage Enrollment Update 2024

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 (rural/urban) MA 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

- Medicare Advantage (MA) enrollment now exceeds 50 percent of eligible beneficiaries (enrolled in both Part A and Part B) in metropolitan counties (56.1 percent); at the current rate of growth, nonmetropolitan enrollment is expected to exceed 50 percent (currently 48.1 percent) next year, in 2025.
- While the annual rate of MA growth continues to exceed the rate of growth in total Medicare eligible beneficiaries, it has moderated somewhat from previous years.
- Much of the growth in nonmetropolitan MA enrollment has been in plans using local preferred provider organizations (PPOs), accounting for a majority of MA enrollees in nonmetropolitan counties since 2022.

Methods

Monthly MA plan enrollment data[1] and total monthly Medicare enrollment[2] for March 2024 were downloaded from Centers for Medicare & Medicaid Services (CMS) websites. March enrollment data are used in this series of annual updates on plan type enrollment because it is the first month after open enrollment closes each year and reflects net enrollment each year[1]. CMS suppresses enrollment counts in any county and/or plan if the county or plan has fewer than 10 enrollees. Therefore, plan type enrollment figures derived from that data will be slight undercounts. The resulting data provided enrollment information from 3,138 counties[2] in the 50 United States and the District of Columbia. Beneficiaries were classified as

RHRC Rural Health Research & Policy Centers
Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org

This project was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement/grant #1U1GRH07633. The information, conclusions and opinions expressed in this policy brief are those of the authors and no endorsement by FORHP, HRSA, HHS is intended or should be inferred.

RUPRI RURAL POLICY RESEARCH INSTITUTE

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

[1] 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.

[2] The term "county" is used throughout this report, but in some cases, these are actually "county equivalents": places that are comparable to counties for administrative purposes but referred to by a different name. For example, Louisiana has parishes, Alaska has organized boroughs and census areas, and Connecticut has planning regions.

nonmetropolitan/metropolitan based on the county of their primary residence using 2023 Rural-Urban Continuum Codes (metropolitan: 1,2,3; nonmetropolitan: 4-9).

There are MA enrollees in all 50 states and the District of Columbia, but there are 14 counties with no MA enrollees reported. All of those counties are classified as nonmetropolitan, with the largest number of them (12) being in the most remote classification (i.e., Urban population of fewer than 5,000, not adjacent to a metro area). Twelve of these 14 counties are in Alaska.

Medicare Advantage Plan Types[3]

Most MA plans can be classified into three types:

HMO (Health Maintenance Organization): These plans have a narrow network of contracted doctors, hospitals, and other health-care professionals who agree to provide services to the plan's members at a discounted rate. Beneficiaries must use network providers for medical care, although there are exceptions for emergency care or out-of-area dialysis. HMO plans require that enrollees select a primary care physician who will coordinate patient care and provide necessary referrals for specialty care.

PPO (Preferred Provider Organization): PPOs also have networks of contracted health care providers, but these plans typically do not require beneficiaries to select a primary care provider. PPOs will typically provide benefits outside the plan's network, although beneficiaries may have to pay higher coinsurance or copayments. PPOs are generally more flexible than MA HMO plans, but they are also generally more expensive. PPOs are classified as "local" (serving one or more counties, or partial counties) or "regional" (serving a single state or multi-state areas).

PFFS (Private Fee-For-Service): These plans allow beneficiaries to see any provider who agrees to accept the plan's rules and payment terms. Some PFFS plans have networks of contracted providers, but the beneficiary is responsible for making sure that the provider will accept the plan's terms.

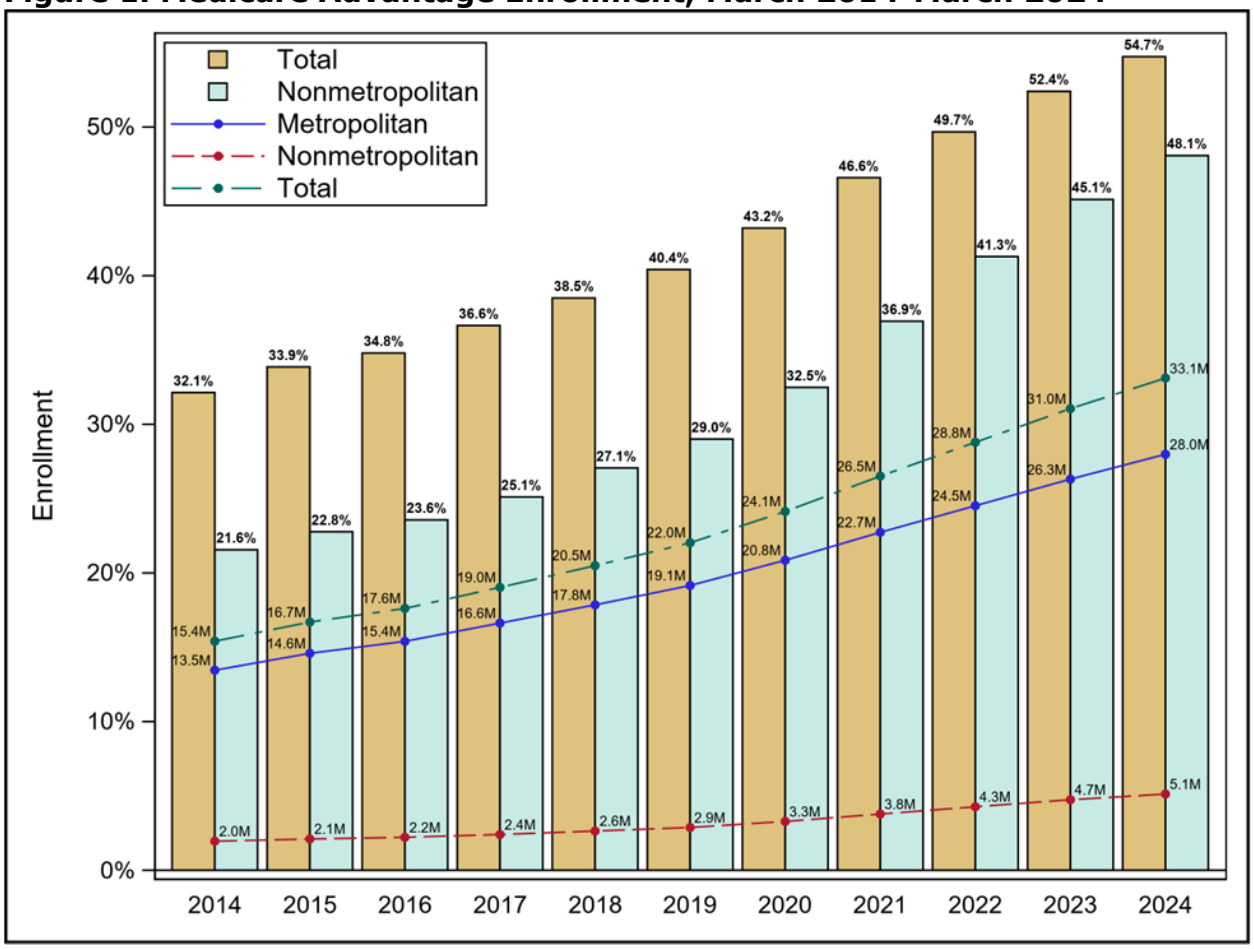
There are a number of other, much less common, plan types, such as MSAs (Medical Savings Accounts) that are similar to the Health Savings Accounts (HSAs) that many employers sponsor, and SNPs (Special Needs Plans) that are limited to beneficiaries with specific chronic diseases or disabling conditions, those requiring institutional or nursing home care, and those with both Medicare and Medicaid coverage.

Findings

In March 2024, 33.1 million Medicare beneficiaries (54.7 percent of those eligible) were enrolled in an MA plan. This represents an enrollment increase of 6.6 percent over the previous year, which is the lowest annual percent increase since 2016. As we have seen and reported in previous years, the rate of growth was higher in nonmetropolitan counties (8.0 percent) than in metropolitan counties (6.6 percent) with both of those increases also representing the slowest rate of growth since 2015. As of March 2024, 48.1 percent of nonmetropolitan and 56.1 percent of metropolitan eligible beneficiaries are enrolled in an MA plan (Figure 1 and Tables 1a-c).

The majority of eligible metropolitan beneficiaries are now enrolled in MA plans. At the current rate of growth, the majority of nonmetropolitan enrollees will be enrolled in MA in 2025.

Figure 1. Medicare Advantage Enrollment, March 2014-March 2024



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

Tables 1a-c and Figure 2 show that there has been a gradual increase in the proportion of nonmetropolitan MA enrollees in HMO plans (37.5 percent in 2024) continuing a trend that has been nearly constant since 2017. Since 2016, there has been a nearly constant decrease in the proportion of metropolitan MA enrollees in such plans (57.1 percent in 2024). The proportion of MA enrollees in local PPO plans has grown steadily in both geographies but is significantly higher in nonmetropolitan counties (55.9 percent nonmetropolitan and 40.4 percent metropolitan).

Table 1a. Overall Medicare Advantage Enrollment by Plan Type[i], March 2014-March 2024

Year	Total[ii] Medicare Enrolled	Total MA Enrollees	% Total Enrolled	MA Enrollment Percentage					
				HMO	Local PPO	Regional PPO	PFFS Plan	Other	Unatt. Other Prepaid
2024	60,490,145	33,100,490	54.7%	54.0%	42.8%	1.1%	0.1%	0.1%	1.9%
2023	59,266,360	31,048,119	52.4%	55.4%	40.6%	1.7%	0.1%	0.0%	2.2%
2022	57,962,863	28,783,678	49.7%	56.5%	38.0%	2.6%	0.2%	0.0%	2.7%
2021	56,905,974	26,505,919	46.6%	57.8%	35.4%	3.7%	0.2%	0.0%	2.8%
2020	55,869,512	24,130,852	43.2%	58.8%	32.9%	4.8%	0.3%	0.0%	3.2%
2019	54,513,003	22,025,463	40.4%	59.2%	31.2%	5.6%	0.5%	0.0%	3.4%
2018	53,230,019	20,486,377	38.5%	59.4%	27.7%	6.4%	0.7%	0.0%	5.7%
2017	51,930,454	19,025,912	36.6%	59.8%	25.9%	7.1%	1.0%	0.0%	6.2%
2016	50,622,845	17,609,527	34.8%	61.5%	23.5%	7.4%	1.3%	0.0%	6.2%
2015	49,306,404	16,692,180	33.9%	61.2%	24.0%	7.4%	1.5%	0.1%	5.8%
2014	47,946,526	15,404,771	32.1%	62.3%	23.7%	7.9%	2.0%	0.1%	4.1%

Table 1b. Nonmetropolitan Medicare Advantage Enrollment by Plan Type[i], March 2014-2024

Year	Total[ii] Medicare Enrolled	Total MA Enrollees	% Total Enrolled	MA Enrollment Percentage					
				HMO	Local PPO	Regional PPO	PFFS Plan	Other	Unatt. Other Prepaid
2024	10,659,055	5,123,458	48.1%	37.5%	55.9%	2.4%	0.3%	0.0%	3.9%
2023	10,511,831	4,742,594	45.1%	36.9%	54.3%	3.6%	0.3%	0.0%	4.8%
2022	10,342,613	4,268,697	41.3%	36.6%	51.3%	6.2%	0.5%	0.1%	5.3%
2021	10,234,892	3,779,215	36.9%	35.9%	48.4%	9.3%	0.7%	0.1%	5.7%
2020	10,106,265	3,282,156	32.5%	34.3%	46.1%	12.1%	1.2%	0.1%	6.3%
2019	9,916,241	2,876,107	29.0%	32.1%	44.8%	14.5%	2.0%	0.1%	6.5%
2018	9,749,877	2,638,238	27.1%	29.9%	40.1%	16.3%	2.9%	0.1%	10.7%
2017	9,575,795	2,404,218	25.1%	29.1%	38.1%	17.6%	3.8%	0.1%	11.4%
2016	9,400,449	2,215,156	23.6%	29.4%	37.2%	17.4%	5.0%	0.0%	11.0%
2015	9,228,098	2,100,903	22.8%	28.4%	38.4%	17.1%	5.7%	0.2%	10.4%
2014	9,059,536	1,952,904	21.6%	28.2%	36.8%	18.3%	6.9%	0.2%	9.6%

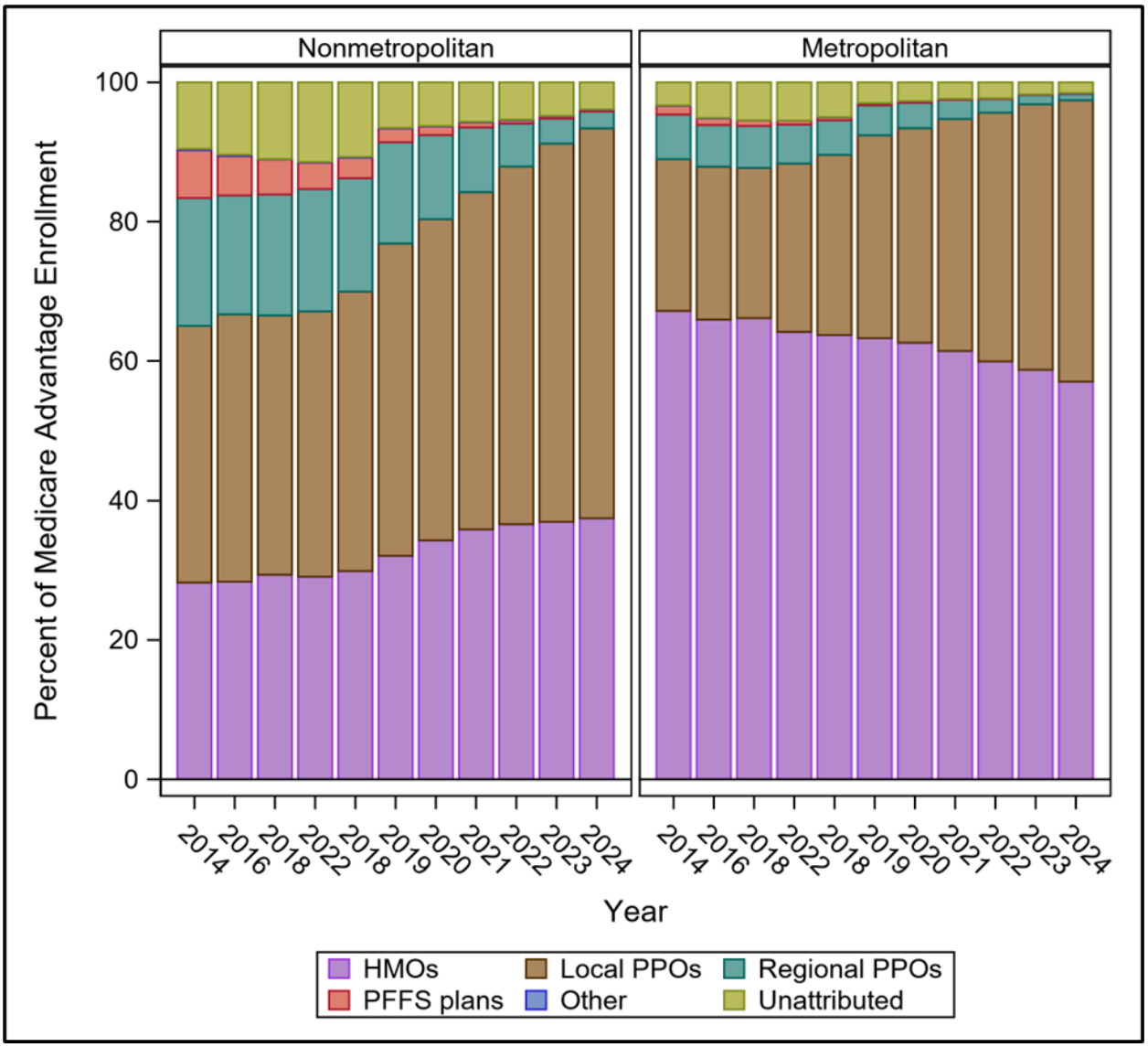
Table 1c. Metropolitan Medicare Advantage Enrollment by Plan Type[i], March 2014-2024

Year	Total[ii] Medicare Enrolled	Total MA Enrollees	% Total Enrolled	MA Enrollment Percentage					
				HMO	Local PPO	Regional PPO	PFFS Plan	Other	Unatt. Other Prepaid
2024	49,831,090	27,977,032	56.1%	57.1%	40.4%	0.9%	0.1%	0.1%	1.5%
2023	48,754,529	26,305,525	54.0%	58.8%	38.1%	1.3%	0.1%	0.0%	1.7%
2022	47,620,250	24,514,981	51.5%	60.0%	35.7%	2.0%	0.1%	0.0%	2.3%
2021	46,671,082	22,726,704	48.7%	61.5%	33.3%	2.7%	0.1%	0.0%	2.4%
2020	45,763,247	20,848,696	45.6%	62.6%	30.8%	3.7%	0.2%	0.0%	2.7%
2019	44,596,762	19,149,356	42.9%	63.3%	29.1%	4.3%	0.3%	0.0%	3.0%
2018	43,480,142	17,848,139	41.0%	63.7%	25.9%	5.0%	0.4%	0.0%	5.0%
2017	42,354,659	16,621,694	39.2%	64.2%	24.1%	5.6%	0.6%	0.0%	5.5%
2016	41,222,396	15,394,371	37.3%	66.2%	21.5%	6.0%	0.8%	0.0%	5.5%
2015	40,078,306	14,591,277	36.4%	66.0%	21.9%	6.0%	0.9%	0.1%	5.1%
2014	38,886,990	13,451,867	34.6%	67.2%	21.8%	6.4%	1.3%	0.1%	3.3%

i. 'Other' plans include 1876 Cost, HCPP - 1833 Cost, National PACE plans, MSA plans, and Limited Income Newly Eligible Transition (LI NET) 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.

ii. Count of Medicare beneficiaries enrolled in Hospital Insurance (or Part A) and Supplementary Medical Insurance (or Part B).

Figure 2. Medicare Advantage Enrollment by Plan Type*, March 2014-March 2024



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, National PACE plans, MSA plans, and Limited Income Newly Eligible Transition (LI NET) plans. 'Unattributed' refers to beneficiaries who could not be assigned to a plan type because of CMS reporting restrictions on county/plans with 10 or fewer enrollees.

Table 2 shows the shift to local PPOs in nonmetropolitan counties; the number of enrollees increased by a factor of 3.4 from 2014 to 2024 as compared to 2.9 for HMO enrollment and a decrease of 70.0 percent enrollment in regional PPO plans (calculations not included in the table). The decline in regional PPO enrollees is particularly dramatic between 2019 and 2024. By 2024, they are a non-factor, with only 1.2 percent of nonmetropolitan Medicare eligible beneficiaries enrolled in them. The decline in enrollment is not paralleled by a similar decline in the number of plans offered. The number of regional PPOs in nonmetropolitan counties was nearly constant (n~50) from 2019 to 2024. The number of local PPO plans in nonmetropolitan counties increased in those same years, from 539 to 1,221 (figures not shown).

Table 2. Enrollment in Medicare Advantage and Other Prepaid Plans, by Location of Residence and by Type of Plan, 2014-2024

Type of Plan	March 2014		March 2019		March 2024	
	Rural	Total	Rural	Total	Rural	Total
Medicare Advantage*	**1,766,374**	**14,774,651**	**2,688,225**	**21,268,854**	**4,924,388**	**32,469,618**
HMOs/POS	551,389	9,592,439	922,335	13,042,852	1,918,737	17,880,142
PFFS	134,262	303,965	57,089	114,178	13,510	30,423
Local PPO	719,173	3,646,964	1,288,586	6,862,658	2,866,441	14,162,821
Regional PPO	358,252	1,220,359	417,939	1,243,553	124,309	373,613
Other MA plans**	3,298	10,924	2,306	5,613	1,391	22,619
Not attributable***	**186,530**	**630,120**	**187,852**	**756,609**	**199,070**	**630,872**
TOTAL	**1,952,904**	**15,404,771**	**2,876,107**	**22,025,463**	**5,123,458**	**33,100,490**
	Percent of Total Medicare Population		**Percent of Total Medicare Population**		**Percent of Total Medicare Population**	
Medicare Advantage*	**19.5%**	**30.8%**	**27.1%**	**39.0%**	**46.2%**	**53.7%**
HMOs/POS	6.1%	20.0%	9.3%	23.9%	18.0%	29.6%
PFFS	1.5%	0.6%	0.6%	0.2%	0.1%	0.1%
Local PPO	7.9%	7.6%	13.0%	12.6%	26.9%	23.4%
Regional PPO	4.0%	2.5%	4.2%	2.3%	1.2%	0.6%
Other MA plans**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not attributable***	**2.1%**	**1.3%**	**1.9%**	**1.4%**	**1.9%**	**1.0%**
TOTAL	**21.6%**	**32.1%**	**29.0%**	**40.4%**	**48.1%**	**54.7%**

Source: RUPRI Center for RURAL Health Policy Analysis, based on Centers for Medicare and Medicaid Services (CMS) data as of March 2024

*HMO = health maintenance organization; POS = point of service; PFFS = private fee-for-service; PPO = preferred provider organization.

**Other prepaid plans include 1876 Cost, HCPP-1833 Cost, National PACE plans, MSA plans, Limited Income Newly Eligible Transition (LI NET) plans.

***CMS censors enrollment counts in any county/plan if the plan enrolls 10 or fewer beneficiaries in that county. "Not attributable" includes beneficiaries that have been censored.

Table 3 shows average MA enrollment (penetration) and the average number of MA plans available in nonmetropolitan and metropolitan counties by Census region. MA enrollment in nonmetropolitan counties is lower than that in metropolitan counties in the Midwest region and much lower in the West region. However, nonmetropolitan enrollment is slightly higher in the Northeast region, where the average number of MA plans in nonmetropolitan counties is nearly as high as those in metropolitan counties. The lowest average enrollment is in West nonmetropolitan counties, which also have the lowest average number of plans.

Table 3. Nonmetropolitan and Metropolitan Medicare Advantage Enrollment and Plans March 2024, by U.S. Census Region*

	Nonmetropolitan		Metropolitan	
Region	MA Enrollment	Avg. # MA Plans	MA Enrollment	Avg. # MA Plans
Midwest	48.0%	24.2	57.9%	39.4
Northeast	53.3%	43.6	53.1%	45.6
South	52.5%	26.7	55.9%	35.2
West	33.3%	9.7	58.0%	28.3

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

* Excludes Cost plans.

Discussion

Consistent with other reports of national enrollment in MA plans[4], we report continued growth in MA plan enrollment. We add the rural-urban comparison to existing reports of national and state data, showing that the percent of rural eligible beneficiaries continues to lag the urban percent; however, it will soon be more than 50 percent in both populations. The rate of enrollment growth slowed in 2024, and there are reasons to suspect the pace may continue to slow. Increased scrutiny by CMS of marketing and enrollment practices, as well as increased awareness of treatment and payment abuses (e.g., prior authorization and payment delays) by some MA plans may slow enrollment. Pressures on the federal budget may lead to reduced payment to MA plans, which could precipitate health plan decisions that change benefits and out-of-pocket costs, although perhaps only modestly.[5] Some plans, including United and Humana, took actions in 2024 to increase cost-sharing; others reduced some benefits.[6] The impact of these changes include plan switching and lower plan enrollment growth. Another reason to expect a change in the pace of increased enrollment is that there may be a plateau in the percent of beneficiaries switching from Traditional Medicare (TM) into MA plans. A significant source of growth in MA enrollment has been such switching, representing a net gain in MA enrollment (switching into MA minus switching into TM) between 61 percent and 90 percent from 2006 to 2022.[7] This resulted in fewer TM enrollees in 2022 than in 2006.[8] Finally, because MA plan offerings are a function of what private insurance companies believe will lead to their financial success, enrollment growth is subject (in part) to the somewhat unpredictable behavior of private firms.

Much of the growth in rural beneficiary enrollment into MA plans has been in local PPOs, which have grown more rapidly than any other plan type, while enrollment into regional PPOs has declined. This pattern has implications for provider choices available to enrollees as a result of plan networks having a local (as opposed to a regional) focus. This will need to be explored with further research. Additionally, to the extent MA plans need to include local healthcare organizations and clinics in local PPO networks, rural providers may be in stronger negotiation positions. Further research is needed to understand all the dynamics of local PPO offerings in MA. Questions to address include: How many of these plans are single-county or multiple-county but exclusively rural? Are they more likely to be offered by national, state-based, or local MA firms? Is the experience of local providers different compared with how they negotiate with regional PPOs or HMOs?

Another set of variables that may be affecting enrollment into MA plans is the availability of supplemental benefits (as compared to TM) at little or no cost to beneficiaries. Three types of supplemental benefits may attract enrollees: traditional health-related benefits (such as vision, hearing, fitness, and dental) established prior to 2019; expanded health-related supplemental benefits (such as in-home support services and support for caregivers) added through the CHRONIC Care Act, 2018; and special supplemental benefits for the chronically ill (including food and produce, meals, and transportation) that started in 2020. Growth in enrollment from 2020 through 2024 may be influenced by those benefits. However, adjustments to benchmarks used to set MA payment may affect decisions by health plans to include those benefits, which could in turn affect enrollment. For an analysis of the percent of nonmetropolitan counties in which the benefits are currently offered, see earlier RUPRI Center work.[9]

The market activities of MA plans and subsequent enrollment decisions by Medicare eligible beneficiaries continue to evolve. Implications for rural beneficiaries and rural healthcare providers need to be studied and considered in further policy development. The interaction of Medicare program payment to MA plans and plan decisions regarding benefits and out-of-pocket costs has received some attention nationally, but should be studied particularly in a rural context. Rural beneficiaries should have choices among plans offering a full array of benefits, comparable to urban choices. The effect of plan benefit addition or withdrawal on enrollment needs to be assessed. Policy makers can then consider the importance of beneficiary access to those choices and what that might require in setting benchmarks. Providers need to understand the structure of the market in their service area and what that means for negotiations with health plans.

Other questions about market dynamics should be explored. We have documented the increasing share of rural enrollment attributable to local PPOs. We will explore the role of local, state, and regional MA plans in affecting rural enrollment. We also continue to monitor rates by counties and states (detailed numbers by counties within states are available on the RUPRI web site: https://rupri.public-health.uiowa.edu/maupdates/nstablesmaps.html). Researchers have begun to examine explanations for beneficiary choices[7]. Future research should continue to explore reasons for those choices, including differentiating rural beneficiaries.

References

[1] Centers for Medicare and Medicaid Services. "Monthly MA Enrollment by State/County/Contract." 2024. Accessed 4/11/2024. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract.

[2] Centers for Medicare and Medicaid Services. "Medicare Monthly Enrollment Data." 2024. Accessed 4/11/2024. https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data.

[3] Porretta A. "The Different Types of Medicare Advantage Plans." 2022. Accessed 5/30/2024. https://www.ehealthinsurance.com/medicare/parts/the-different-types-of-medicare-advantage-plans/.

[4] ATI Advisory. "Medicare Advantage Enrollment Trends." 2024. Accessed 7/2/2024. https://atiadvisory.com/resources/wp-content/uploads/2024/03/2024-Medicare-Advantage-Enrollment-Databook.pdf

[5] Chernew ME, Miller K, Petrin A and Town RJ. "Reducing Medicare Advantage Benchmarks Will Decrease Plan Generosity, But Those Effects Will Likely Be Modest." *Health Affairs* 42:4 (2023). 10.137/hlthaff.2022.01031.

[6] Tepper N and Eastabrook D. "Layoffs, benefit cuts follow Medicare Advantage pay reductions". *Modern Healthcare A.M.* (October 25, 2023). Accessed October 30, 2023. https://www.modernhealthcare.com/insurance/centene-unitedhealth-layoffs-medicare-advantage-pay-cuts-star-ratings-cms.

[7] Xu L, Welch WP, Sheingold S, De Lew N, and Sommers BD. "Medicare Switching: Patterns of Enrollment Growth in Medicare Advantage, 2006-22." *Health Affairs* 42:9 (2023). 10.1377/hlthaff.2023.00224.

[8] Trish E, Valdez S, Ginsburg PB, Randall S, and Liberman SM. "Substantial Growth in Medicare Advantage and Implications For Reform." *Health Affairs* 42:2 (2023). 10.1377/hlthaff.2022.00668.

[9] Lazaro E, Shane DLM, Ullrich F, and Mueller K. "Medicare Advantage Plan Growth in Rural America: Availability of Supplemental Benefits." *Rural Policy Brief* (2024). RUPRI Center for Rural Health Policy Analysis. Retrieved 7/17/2024. https://rupri.public-health.uiowa.edu/publications/policybriefs/2024/MA_Plan_Growth.pdf.

Preferred Citation: Lazaro, E; Ullrich, F; and Mueller K. **Medicare Advantage Enrollment Update 2024**, RUPRI Center for Rural Health Policy Analysis; Brief No. 2025-1.