

Background

Beginning in the 1970s, as an alternative to the traditional fee-for-service (FFS) Medicare program,¹ Medicare beneficiaries had the option to receive their benefits through private health maintenance organizations (HMOs).² HMOs could offer benefits on a county-specific basis,² and the government reimbursed plans using a capitation arrangement, which varied by county. Due to this variation, HMOs began, and continue, to dominate the urban and suburban private Medicare markets, where reimbursement rates are most attractive. The inclusion of these private Medicare plans into the traditional Medicare program evolved through a series of legislative decisions, but they were not officially incorporated into the program until the passage of the Balanced Budget Act of 1997 (BBA), in which the private program was renamed Medicare+Choice.¹

The delivery system evolved and expanded from exclusively HMOs to include preferred provider organizations (PPOs), point-of-service (POS) plans, a hybrid of HMOs and PPOs, provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs).² Plans were required to cover at least the benefit levels covered by original Medicare Part A (primarily hospitalization) and Part B (outpatient services), but could now offer enhanced benefits (hearing aids, vision needs, prescription drugs, etc.)² and charge an out-of-pocket premium for whatever benefits they offered.⁵ At first, payments to Medicare+Choice plans were based on traditional Medicare FFS costs in the same area,³ but payments were later adjusted so that county-specific rates increased by 2% annually (despite FFS costs increasing more slowly and even decreasing due to the cuts in the BBA).² Consequently, a trend emerged where beneficiaries in urban counties (more so than in rural counties) typically enjoyed access to additional benefits⁶ without incurring more financial burden.⁴ However, even the 2% minimum increase was insufficient to keep pace with increases in medical expenditures, so plans reduced benefits, which predictably resulted in disenrollment.² Succeeding legislation, such as the Benefits Improvement and Protection Act of 2000 (BIPA), which attempted to balance the Medicare formula to reimburse plans, did not resolve the disenrollment trend until the Medicare Modernization Act (MMA) was enacted in 2003.²

Under the MMA, Medicare+Choice was re-named Medicare Advantage (MA),¹ and outpatient prescription drug benefits (Medicare Part D) were provided for the first time. MA plans that did not already cover prescription drugs typically added this coverage. In 2004, \$1.3 billion in funding was added to Medicare reimbursements to encourage plan participation.² New types of plans such as local HMOs, PFFS, special needs plans (SNPs), regional PPOs, and other types of private plans (e.g., cost plans, health care prepayment plans, Program of All-Inclusive Care for the Elderly plans, medical savings accounts, demonstrations, and pilots),¹ were added, which enabled plans to compete more effectively in the Medicare marketplace. The reimbursement pricing structure was changed once again: (1) Plan payments in all counties increased, and plans could be paid no less than 100% of traditional FFS Medicare expenditures for the county; (2) Benchmarks, the county rating system on which plan payments are based, also increased, resulting in benchmarks that were, on average, 118% of traditional FFS costs in 2008.⁵ MedPAC

estimations show that, on average, MA plans were paid 109% of traditional FFS costs per enrollee in 2010. Until the passage of the MMA, the vast majority of rural areas had never attracted insurers,⁶ which some experts believe was the intent of the legislation—increase private plan participation in underserved areas to make plans available nationwide.

Key Legislation Impacting Medicare Advantage

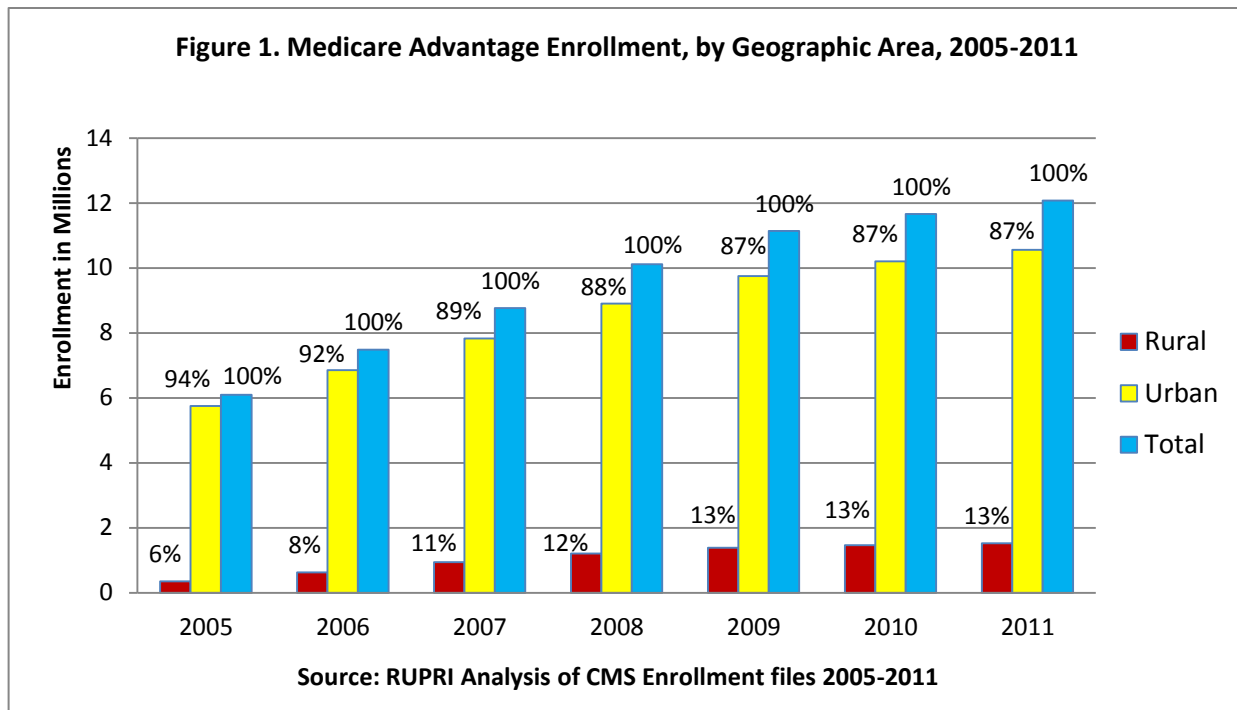
- **Balanced Budget Act of 1997**
 - Renamed the Medicare private plan options “Medicare+Choice”
 - Allowed Medicare to contract with local preferred provider organizations, private fee-for-service plans, and medical savings account plans
 - Established a payment floor, primarily applicable to rural counties
- **Benefits Improvement and Protection Act of 2000**
 - Improved payments to firms by creating payment floors for urban areas and increasing the floor for rural areas
- **Medicare Modernization Act of 2003**
 - “Medicare+Choice” renamed “Medicare Advantage” (MA)
 - Certified two additional plan types—regional preferred provider organization plans and special needs plans
 - Increased federal payments to plans to promote plan participation
- **Medicare Improvements for Patients and Providers Act of 2008**
 - Changed payments to plans
 - Added beneficiary protections, focusing on marketing practices
 - Created network requirements for private-fee-for-service plans
- **Patient Protection and Affordable Care Act of 2010**
 - 2012: Provides new quality bonus payments to plans
 - 2014:
 - Decreases federal payments to MA plans to more closely align to the average costs of care under the traditional fee-for-service Medicare program
 - Requires MA plans to maintain a medical loss ratio of at least 85%, which will restrict the share of premiums that firms can use for expenses and profits

Source: Centers for Medicare and Medicaid Services

Rural Medicare Advantage Enrollment Trends

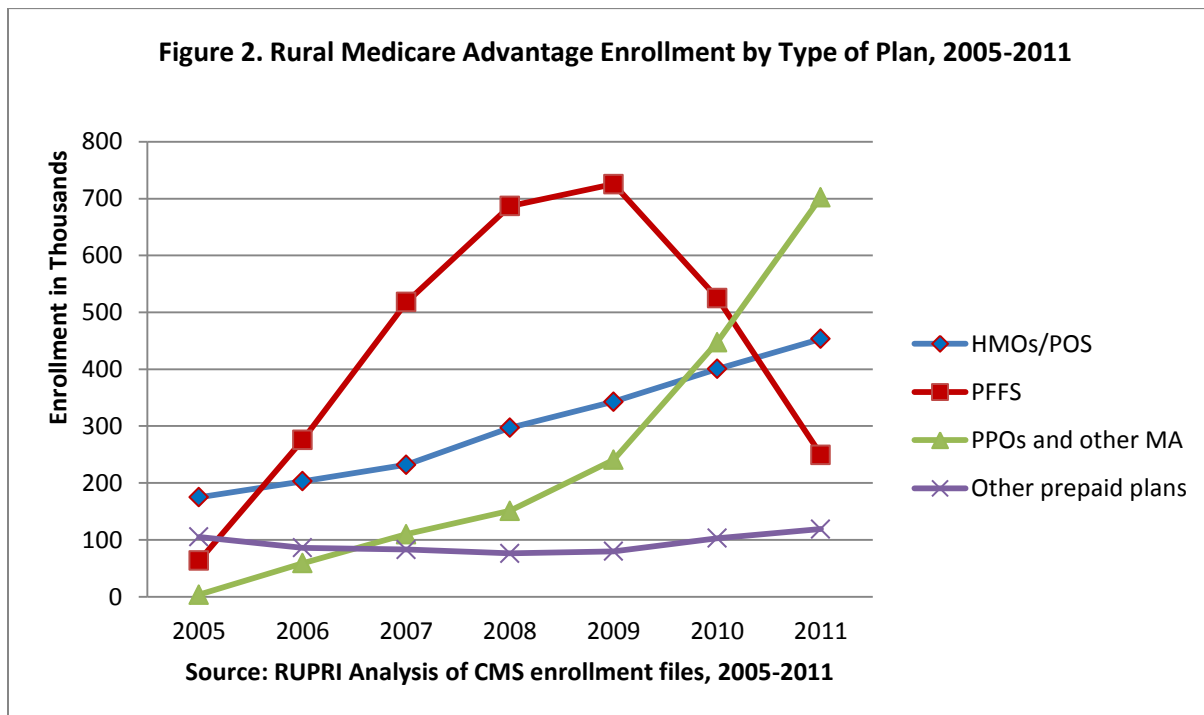
As a result of the changes that were established by the MMA and went into effect in 2005, the MA program experienced significant growth in rural areas, an area where enrollment was previously limited. In particular, through 2008, PFFS plans saw a significant increase in rural enrollment. Enrollment in MA plans in rural areas in December 2005 was 346,000 beneficiaries, with a total of 63,000 beneficiaries in PFFS plans. Over a period of three years, enrollment in rural areas tripled, increasing to over 1.2 million MA enrollees, with over 700,000 enrolled in PFFS plans. PFFS plans (versus other types of plan coverage options) were appealing to insurers wanting to offer MA coverage in rural areas since little overhead was necessary to enter the market, including the expense of negotiating with dominant providers to convince them to accept payment as part of a panel of providers. As established through legislation, PFFS plans were not required to create provider networks within their plans, which simplified the process and eased the costs associated with offering coverage; historically, PFFS plans are the only type of private Medicare plan not required to form provider networks. In addition, PFFS plans were paid at a higher payment rate than the average MA plan. For example, in 2008, estimates show that PFFS plans were paid on average 117% of traditional Medicare FFS costs, while the average among MA plans was 113% of FFS costs.⁵

Rural Enrollment in MA plans has more than tripled over the last five years, with an enrollment of over 1.5 million beneficiaries in March 2011, while program enrollment nationwide has nearly doubled, to a total of over 12.1 million beneficiaries (Figure 1). As of March 2011, about 16% of rural Medicare beneficiaries were enrolled in the MA program, while 26% of Medicare beneficiaries were enrolled nationally. Although traditional FFS Medicare continues to have the largest share of Medicare beneficiaries, the percentage of Medicare beneficiaries enrolled nationally in MA has grown significantly over the last five years, from 13% to 26%.



The rapid growth of rural MA enrollment since the MA program began in 2005 was driven by enrollment in PFFS plans. Rural enrollment in PFFS plans grew from 63,000 enrollees in 2005 to over 725,000 enrollees in early 2009, a 1,050% increase in enrollment; however, PFFS plans have experienced a drop in their enrollment in rural areas in 2010 and 2011, falling from the peak enrollment of 725,000 in 2009 to approximately 530,000 in 2010, and down to 250,000 in 2011 (Figure 2). These changes were driven largely by the following factors:

1. Changes established by legislation—the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required PFFS plans to form provider networks by 2011 in the majority of their locations where they had previously not been required to establish a provider network;⁷
2. Consolidation and elimination of plans by CMS to reduce the number of “low enrollment and duplicative” plans available to beneficiaries;⁸
3. Slow growth in payment rates (as CMS increased reimbursements to MA plans by 0.8% in 2010 compared to 3.6% in 2009);⁹ and
4. Increased beneficiary premiums for MA plans (PFFS plans premiums increased by 78% from 2009 to 2010).¹⁰ In 2011, PFFS plan premiums rose an average of 15% over 2010.¹¹



The aforementioned factors caused some plans to leave the market; the number of plans available to rural beneficiaries dropped, on average, from 36 plans in 2009, to 24 plans in 2010 (a decline of 33%), and down to 16 plans in 2011 (down by 33% from 2010).¹¹ In addition, the overall number of PFFS plans offered across the nation fell from 696 plans in 2009, to 413 plans in 2010 (a decline of 41%), and down to 220 plans in 2011 (down by 47% from 2010).

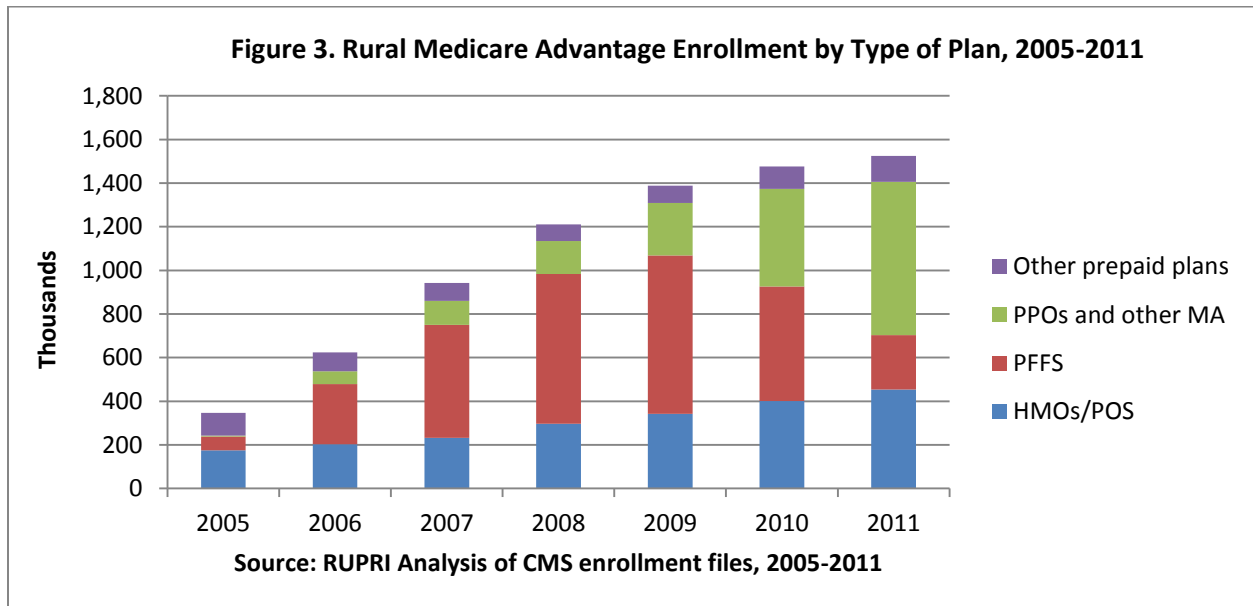
Although many rural counties (461 total) are exempted from the new provider network requirement^a for PFFS plans, the majority of rural counties have been affected. Despite the exemption, only seven of the 220 PFFS plans offering coverage in 2010 served only counties exempted from the MIPPA requirements.¹¹ Therefore, the vast majority of PFFS plans serving MA enrollees in 2011 have been required to establish provider networks. Some plans discontinued PFFS coverage in lieu of establishing networks in some of these rural markets. Due to the historical provision that PFFS plans were able to operate without a provider network and offer MA coverage in areas in which it is difficult to establish provider networks, we can deduce that at least some of the decline in PFFS enrollment can be attributed to the new provider network requirements.

On the other hand, in conjunction with the decline in PFFS enrollment, the MA market has seen an increase in PPO enrollment. Total PPO enrollment in rural areas has increased from 3,500 enrollees in 2005 to over 702,000 enrollees in March 2011. Local PPOs have an enrollment of approximately 396,000 beneficiaries, while regional PPOs have an enrollment of 306,000. Enrollment in local PPOs has been growing more quickly than in regional PPOs in rural and urban areas, which can likely be attributed to the payment structure of these coordinated care plans. Regional PPOs have difficulty competing in areas in which local plans are offered due to the ability of the local plans to set their rates at the county level, while the regional PPOs have to maintain their regional rates and benefits.¹² Enrollment in HMO plans in rural areas has more than doubled over the last five years, with an enrollment of over 450,000 enrollees in March 2011.

^a MIPPA required non-employer PFFS plans to develop networks with providers by 2011 unless they operate in a county with fewer than two network-based plans, including HMOs, local PPOs, cost plans, or network-based regional PPO or MSA plans.

Composition of the Medicare Advantage Market

The composition of the rural MA market has changed dramatically since the program began in 2005, as shown in Figure 3. HMO plans dominated the market in 2005, and PFFS plans quickly grew to dominate the market by June 2007. PFFS plans maintained over 50% of the rural MA market share through 2009. In 2010, PPOs gained significant market share at 30%, and PFFS plans fell to only 36% of the rural MA market. This trend has continued into 2011, as the MIPPA requirements have gone into effect, with PPO plans garnering 46% of the market share and PFFS plan market share falling to only 16% of rural MA enrollees. A similar shift in market share from PFFS plans to PPO plans is happening in the urban MA markets, however, on a reduced scale, as the bulk of enrollment in urban markets has been concentrated in HMO plans consistently over the last five years.

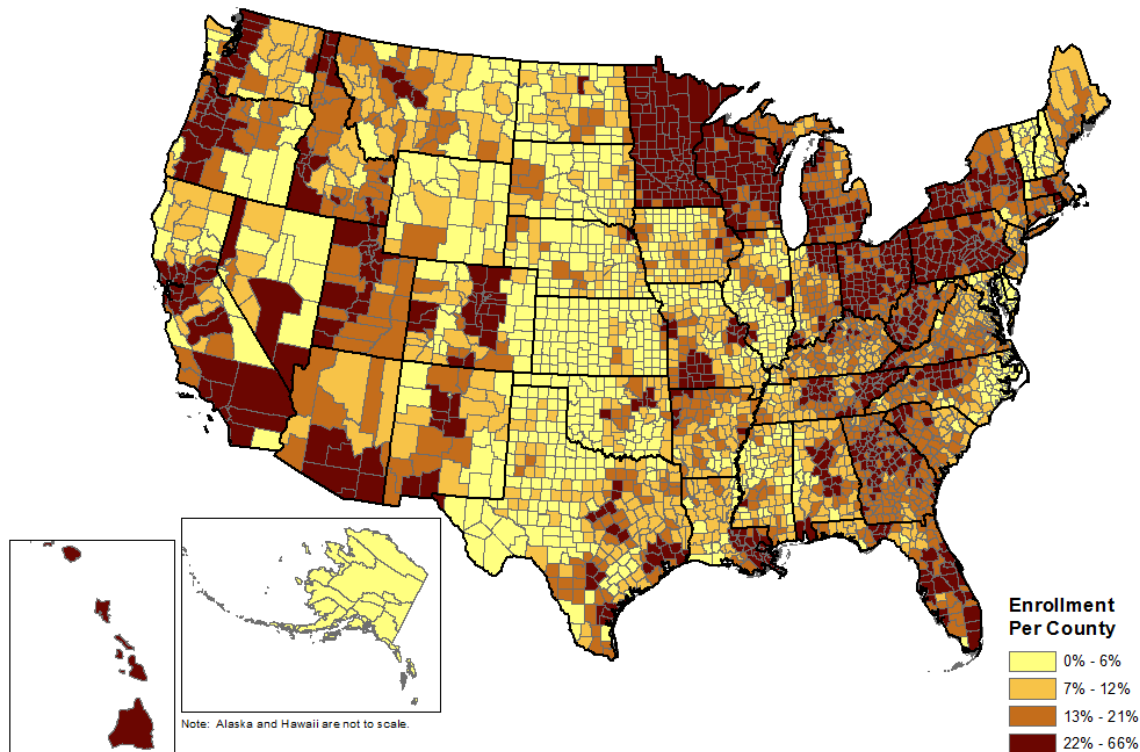


Geographic Variation in Medicare Advantage Enrollment

Current rural enrollment in the MA program varies dramatically among states, with the highest percentage of enrollment at 39.2% of eligible Medicare beneficiaries in Hawaii and the lowest percentage of enrollment at 0.2% in Alaska. Ten states have over 20% of their rural Medicare beneficiaries enrolled in MA plans (see Appendix), including Arizona, Hawaii, Minnesota, New York, Ohio, Oregon, Pennsylvania, Utah, Wisconsin, and West Virginia. The states with the highest percentage of eligible Medicare beneficiaries enrolled in MA plans tend to be on the West Coast, in the Great Lakes and Northeast regions, and in some southern states (Figure 4). The majority of Midwestern states do not have high enrollment in MA plans.

In addition, MA enrollment varies by county, as micropolitan^b counties have higher enrollment on average (16.3%) than non-micropolitan counties (13.2%). Enrollment within a state can vary significantly, as it does in Arizona, with 20.3% of rural Medicare-eligible beneficiaries enrolled in an MA plan, including 21.2% of beneficiaries living in rural micropolitan counties and 12.4% of eligible beneficiaries living in non-micropolitan counties.

Figure 4. Percent of Eligible Medicare Beneficiaries Enrolled in Medicare Advantage by County, March 2011



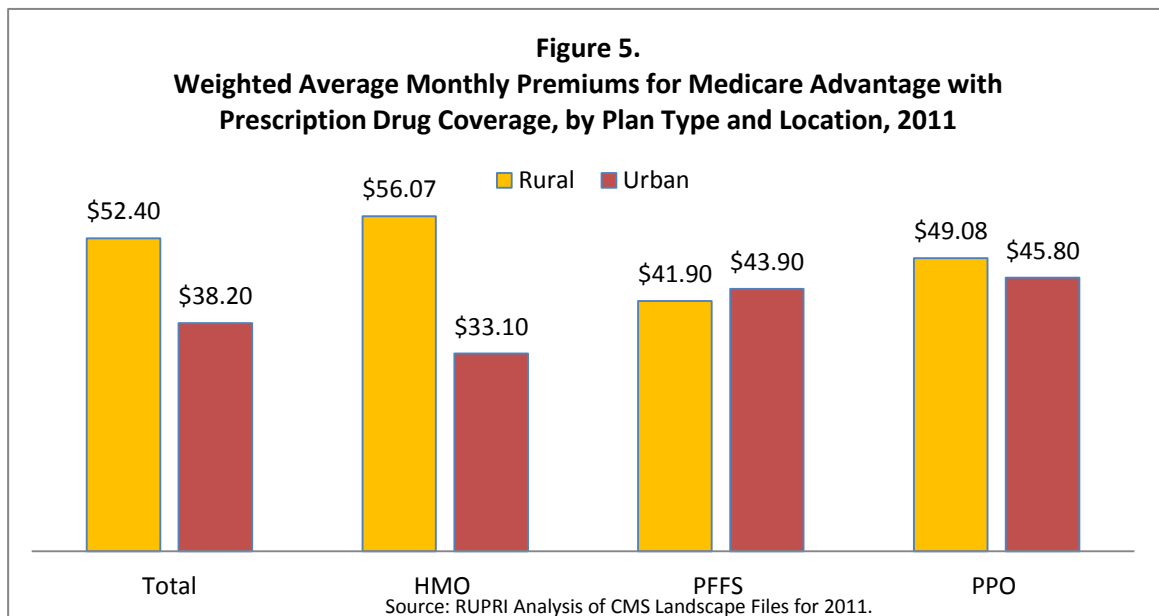
Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of March 2011
Produced by: RUPRI Center for Rural Health Policy Analysis, 2011.

^b Micropolitan counties are identified as areas based around a core city or town with a population of 10,000 to 49,999 residents.

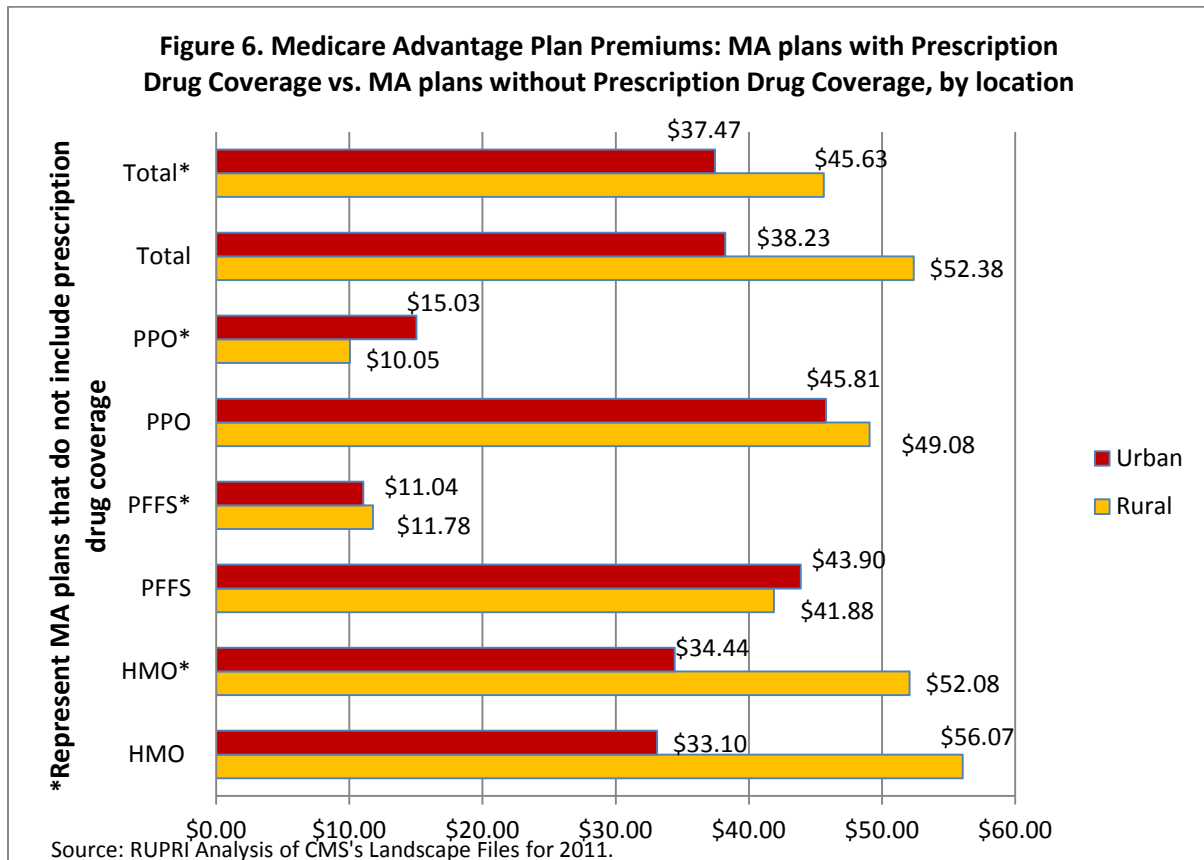
Premiums in Medicare Advantage Plans

The average national premium for MA plans that include prescription drug coverage in 2011 is approximately \$40 per month. The average MA premium in rural areas is much higher, at \$52.40 per month, than in urban areas, with an average premium of \$38.20 per month (Figure 5). Premiums vary significantly by type of plan in rural areas, (Figure 6), as HMOs have the highest premiums in rural areas at \$56.07, followed by PPOs at \$49.08, and PFFS plans at \$41.90. In addition, approximately 54.5% (3,398,690) of MA enrollees in urban areas are enrolled in zero premium MA plans, compared to only 29.6% (264,655) of rural MA enrollees. MA plans with zero premiums are available in 53% of rural counties, representing 73% of the rural Medicare-eligible population, whereas zero premium MA plans are available in 83% of urban counties, which represents 95% of the urban MA-eligible population. Monthly premiums in rural areas range from zero premium plans to premiums of \$291 a month for the Humana Gold Choice PFFS plan.

The higher premiums of HMO and PPO plans in rural areas than in urban areas are likely due to the elevated costs incurred by plans when establishing provider networks in rural areas. HMO and PPO plans have struggled to establish provider networks in many rural areas due to low population density (diseconomies of scale), small numbers of providers, and provider resistance to MA contracting.¹² As a result of these elevated costs, rural HMO and PPO plans may not be able to cover as much of their costs with the contracted MA payment rate, and then must pass these additional costs on to the beneficiaries in the form of higher premiums. Plans that are able to cover their costs with the MA payment rate alone are able to charge a zero premium to their beneficiaries. Zero premium plans, as mentioned earlier, are more prevalent in urban areas (54.5% of beneficiaries) than in rural areas (29.6%) and bring down the average premium for all beneficiaries in urban areas. Nationwide, over 75% of zero premium plan enrollment is in HMO plans, and nearly 20% of zero premium enrollment is in PPO plans.



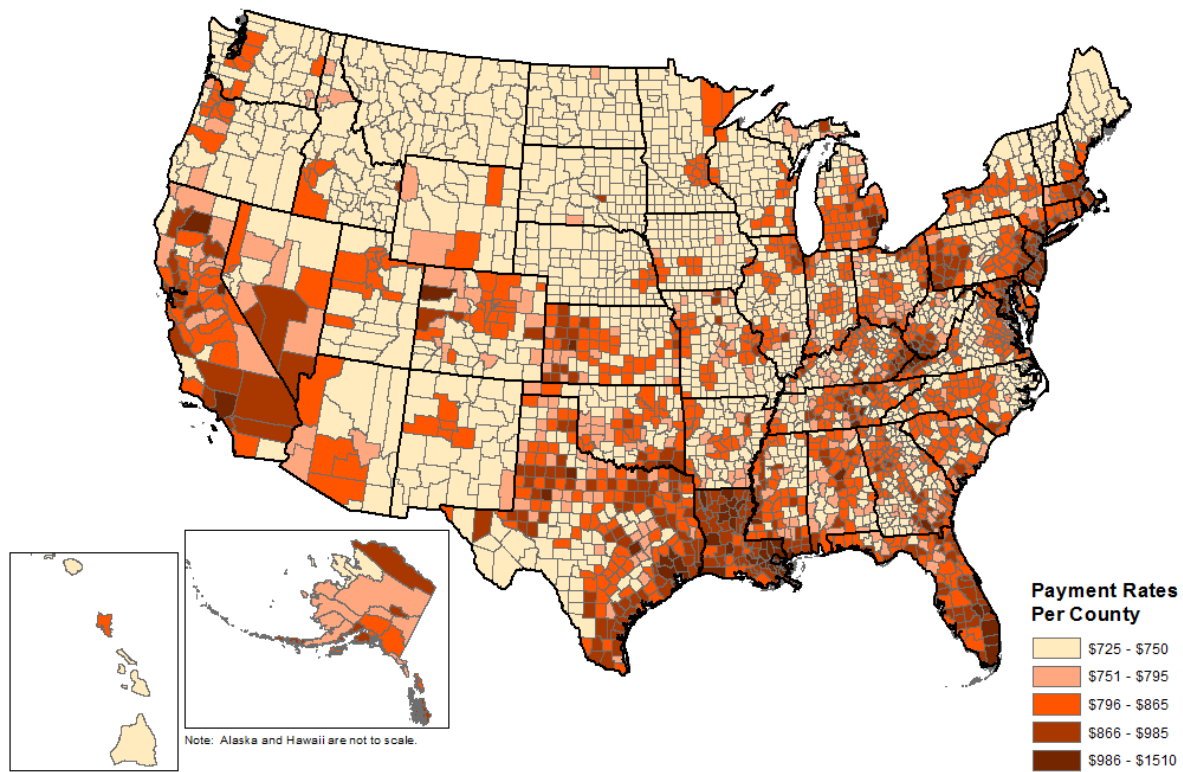
In addition, analysis of the MA premium data including the MA plans that do not offer prescription coverage shows that the premiums for these plans are lower than for the MA plans that offer prescription drug coverage in rural areas. In total, the average premium for MA plans that offer prescription drug coverage in rural areas is \$52.40, while for plans that do not offer prescription drug coverage the average is \$45.63 (Figure 6). The PPO and PFFS MA plans that do not offer prescription drug coverage have significantly lower premiums in rural and urban areas than their counterpart plans that do offer prescription drug coverage. However, HMO plans offering prescription drug coverage in rural areas are only slightly more costly than the HMO plans that do not offer prescription drug coverage.



Payment Rates in Medicare Advantage Plans

There is significant variation in the county-level payment rates within the MA program, which is the result of a number of legislative changes that have been made to the program in recent years. This variation leads to fluctuations in enrollment and premiums as the plans react to the higher or lower payment rates at the county level. A map (Figure 7) illustrates the variation in payment rates across the country and displays the concentration of counties that receive the rural and urban floor payment rates.

Figure 7. Medicare Advantage Payment Rates by County, March 2011



Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of March 2011
Produced by: RUPRI Center for Rural Health Policy Analysis, 2011.

The categories on the map were chosen to reflect the natural breaks in the distribution of payments that arise due to the existence of rural and urban floor payments mandated by the BBA and subsequent legislation. Thus, nearly one-half of all counties belong in the first category due to their adherence to the rural floor.^c About one-quarter of the counties belong to the middle category, which encompasses the urban floor. The RUPRI Center for Rural Health Policy

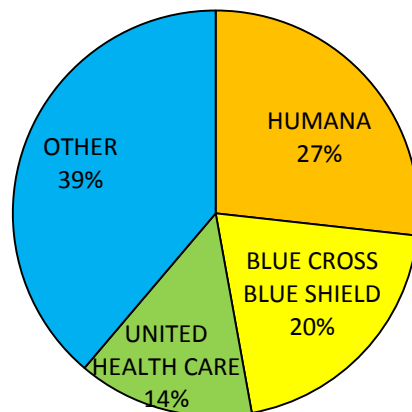
^c Rural floor payment rates were created by the BBA and have been modified over time by subsequent legislation. The rural floor payments vary slightly among counties due to adjustments to the payments that have been put into place by BIPA and the MMA.

Analysis is currently researching the effects of the payment rates on enrollment as well as the effects of the interaction of payment rates and per capita costs within a county as a function of enrollment. The results from this research will be forthcoming and will describe the role that payment rates and the ratio of payment rates to per capita costs play in the MA market in detail.

Medicare Advantage Enrollment by Firm

A few firms continue to dominate the rural MA market (Figure 8). Nearly half of all rural MA enrollees in 2011 are in plans affiliated with two firms—Humana (27%) and Blue Cross/Blue Shield (BCBS) affiliates (20%), which are multiple independent firms sharing the BCBS trademark; United Health Care accounts for the next largest share of the market (14%). The remainder of enrollment is in a grouping of other national and more locally based firms (such as Aetna, Care Improvement Plus, Coventry, Geisinger, Medica, Pyramid, Sterling, Unicare, and United Mine Workers of America).

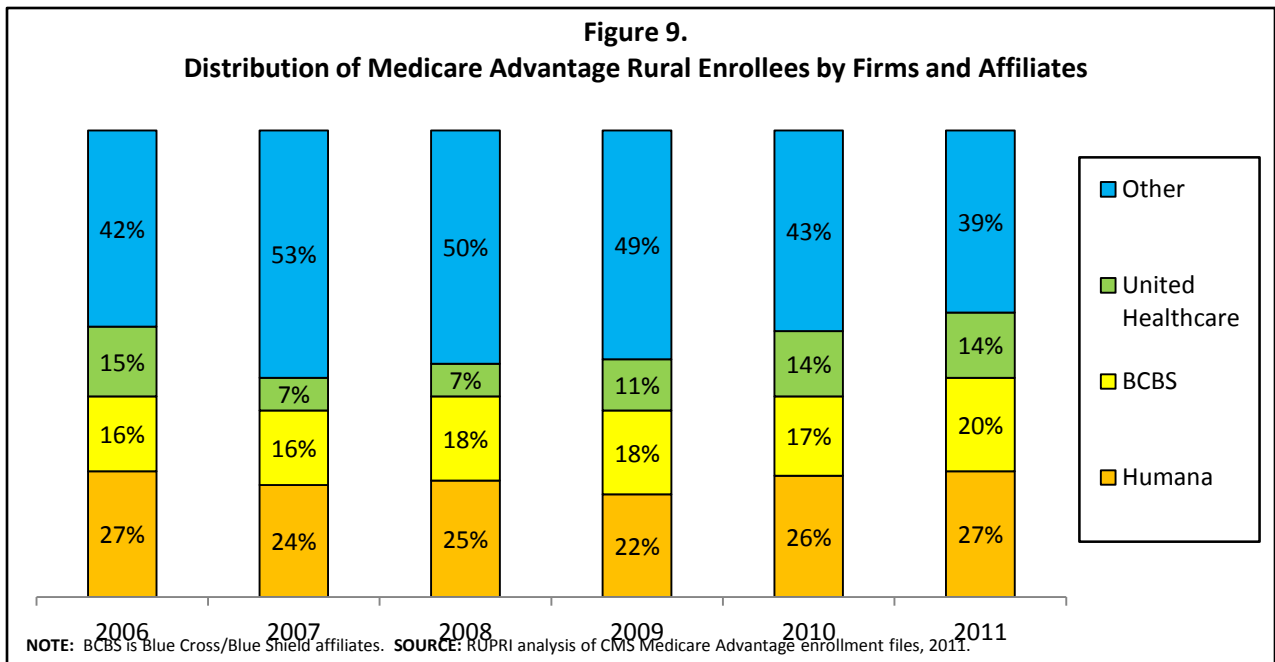
Figure 8. Rural Medicare Advantage Enrollment, by Firm or Affiliate, 2011



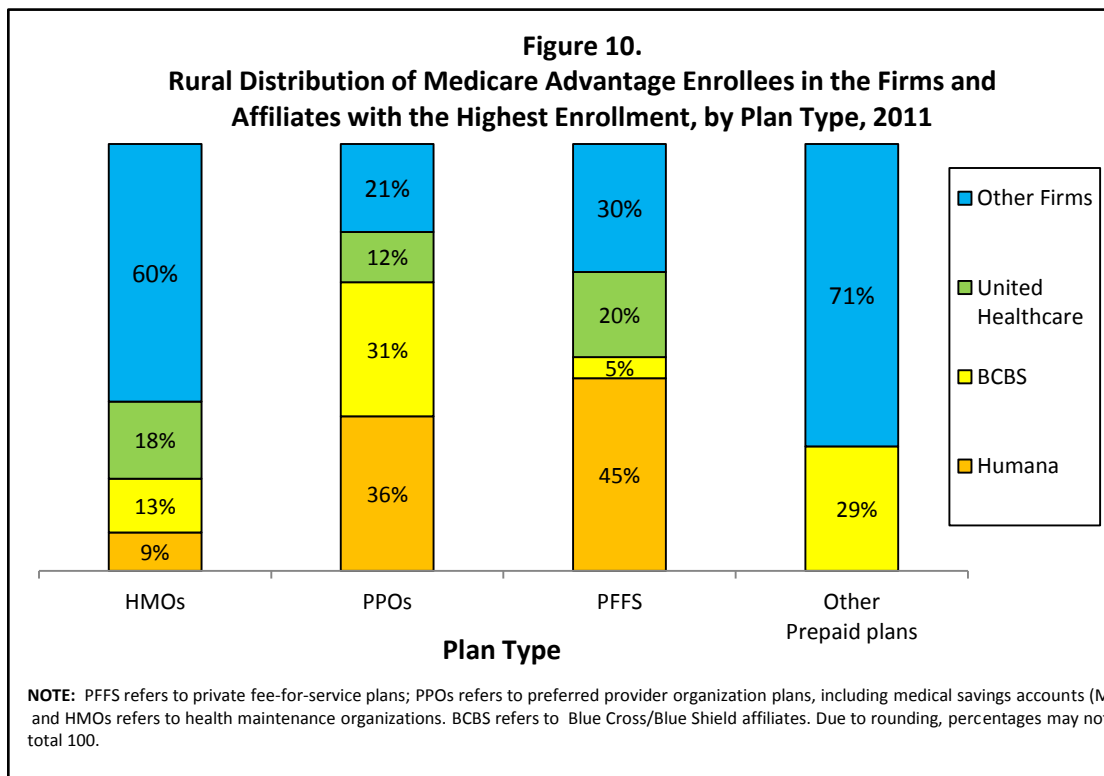
NOTE: Other includes firms with 3% or less of total enrollment. BCBS are Blue Cross/Blue Shield affiliates.

SOURCE: RUPRI analysis of CMS enrollment files, 2011.

Humana, BCBS, and United Health Care are the three largest firms that have dominated the rural MA market from 2006 to today (Figure 9). While other firms, such as Unicare, United Mine Workers of America, Coventry, and Pyramid, have gradually increased their market share over the years, they comprise much less of the market than the top three dominant firms.



Firms in rural areas differ in their dependence on different types of plans (Figure 10). PPOs are the most popular plan type among the top three firms with the highest enrollment, and PFFS plans also play a significant role. HMOs are less popular among the top three firms: 60% of all enrollment in HMOs is composed of other, less dominant, firms. Humana is a leading force in the rural MA market, encompassing almost half of all enrollment in PFFS plans; on the other hand, BCBS affiliates rely very little on PFFS plans. Other prepaid plans include enrollment from BCBS affiliates and other less dominant firms.



The Future of Medicare Advantage in Rural Areas

In the coming years, the rural MA market may experience some change as health reform is implemented. Several provisions were included in the Patient Protection and Affordable Care Act of 2010 (ACA) that could have an impact on the MA program and in turn impact rural MA enrollment in the future. These changes include:

- A change in the reimbursement structure of MA plans to make the payments commensurate with the traditional FFS Medicare costs incurred within the county.¹³ As payment rates are reduced, changes in enrollment in MA plans throughout the nation can be anticipated.
- A plan to provide quality-based payments to plans that receive four or more out of five stars in their quality ranking on Medicare.gov starting in 2012. Rural plans may not receive these bonus payments as readily as their urban counterparts due to the fact that HMO plans and those with greater enrollment are more likely to have a quality rating of four or more.¹⁴ The vast majority of HMO plans and enrollment are in metropolitan areas, and they tend to have a greater number of Medicare beneficiaries enrolled. Therefore, plans offering MA coverage in rural areas are less likely to receive the bonus payments, and MA firms may choose to focus their efforts on the plans where they are likely to receive the quality payments.
- A reduction in the risk adjustments scores of MA enrollees relative to similar beneficiaries in traditional FFS Medicare. CMS reduced the risk scores for the 2010 plan year and reduced the risk scores for 2011 by 3.41%.¹³

The future of MA remains uncertain, particularly in rural areas, given the recent dramatic shift in enrollment from PFFS to PPO plans and the changes to come in the future as a result of the ACA. Many rural MA beneficiaries are likely to realize some changes to their benefits and the cost sharing associated with their plans, while others may need to choose an alternative plan or move to traditional FFS Medicare due to their plan leaving the market. For now, the MA market in rural America remains strong and continues to grow in enrollment. However, the effects of the decline in PFFS enrollment and the rapid growth of PPO plans, along with the effects of health reform, need to be monitored to ensure that rural MA beneficiaries are able to obtain the health insurance coverage that they need.

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- ⁷The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), P.L.110-275.
- ⁸See Centers for Medicare and Medicaid Services press release, “Robust Medicare Health and Drug Plans Coverage Continues in 2010; Beneficiary Protections Strengthened,” October 1, 2009.
- ⁹See Centers for Medicare and Medicaid Services press release, “Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies,” April 6, 2009.
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Appendix

| RURAL Enrollment in Medicare Advantage and other Prepaid Plans, by State, March 2011 ⁽¹⁾ | | | | | | | | | | | |
|---|--|--------------|-------------|-------------|--|---|---------|---------|-----------------------------|-------------------------------|--------------------------|
| STATE ⁽²⁾ | Percent of Medicare eligibles enrolled in: | | | | TOTAL Enrolled in MA and Prepaid Plans | Enrollment in Medicare Advantage Plans: | | | | Enrolled in Prepaid plans (4) | TOTAL Medicare Eligibles |
| | MA and Prepaid plans | MA Plans | PFFS Plans | PPO Plans | | TOTAL in MA Plans | HMO/POS | PFFS | PPOs and Other MA plans (3) | | |
| UNITED STATES | 15.7% | 14.5% | 2.6% | 7.3% | 1,524,239 | 1,405,358 | 453,544 | 249,499 | 702,315 | 118,881 | 9,679,466 |
| AK | 0.1% | 0.1% | 0.0% | 0.1% | 30 | 30 | 0 | 0 | 30 | 0 | 22,635 |
| AL | 13.6% | 13.5% | 0.6% | 8.1% | 37,087 | 37,008 | 13,251 | 1,508 | 22,249 | 79 | 273,254 |
| AR | 12.7% | 12.6% | 6.0% | 4.3% | 31,464 | 31,390 | 5,959 | 14,823 | 10,608 | 74 | 248,169 |
| AZ | 20.3% | 20.2% | 2.3% | 4.3% | 26,137 | 25,994 | 17,496 | 2,998 | 5,500 | 143 | 128,888 |
| CA | 8.6% | 8.5% | 1.0% | 4.0% | 14,337 | 14,176 | 5,775 | 1,700 | 6,701 | 161 | 166,220 |
| CO | 12.6% | 4.6% | 1.7% | 1.4% | 12,754 | 4,645 | 1,530 | 1,734 | 1,381 | 8,109 | 100,897 |
| CT | 14.1% | 14.1% | 0.0% | 3.6% | 7,269 | 7,269 | 5,395 | 0 | 1,874 | 0 | 51,682 |
| DE | 2.1% | 2.1% | 0.0% | 1.3% | 943 | 925 | 341 | 0 | 584 | 18 | 44,133 |
| FL | 17.0% | 17.0% | 0.4% | 10.4% | 47,023 | 47,003 | 17,191 | 1,067 | 28,745 | 20 | 276,932 |
| GA | 19.7% | 19.7% | 6.3% | 13.1% | 61,650 | 61,650 | 655 | 19,833 | 41,162 | 0 | 313,025 |
| HI | 41.8% | 34.4% | 0.1% | 20.5% | 24,541 | 20,211 | 8,125 | 41 | 12,045 | 4,330 | 58,736 |
| IA | 7.7% | 7.2% | 1.0% | 3.6% | 20,373 | 19,044 | 6,863 | 2,586 | 9,595 | 1,329 | 266,089 |
| ID | 19.0% | 18.8% | 6.8% | 9.0% | 16,109 | 15,956 | 2,563 | 5,765 | 7,628 | 153 | 84,926 |
| IL | 6.5% | 5.7% | 0.7% | 3.9% | 21,413 | 18,624 | 3,397 | 2,427 | 12,800 | 2,789 | 327,794 |
| IN | 18.2% | 18.0% | 3.5% | 14.3% | 45,461 | 45,006 | 374 | 8,804 | 35,828 | 455 | 249,840 |
| KS | 4.0% | 3.8% | 2.8% | 1.0% | 7,272 | 6,801 | 0 | 4,968 | 1,833 | 471 | 180,448 |
| KY | 13.1% | 12.1% | 1.4% | 10.4% | 48,203 | 44,707 | 1,522 | 5,019 | 38,166 | 3,496 | 368,560 |
| LA | 11.0% | 11.0% | 2.5% | 2.4% | 21,093 | 21,093 | 11,800 | 4,737 | 4,556 | 0 | 192,617 |
| MA | 0.3% | 0.3% | 0.0% | 0.3% | 13 | 13 | 0 | 0 | 13 | 0 | 4,477 |
| MD | 1.6% | 1.5% | 1.0% | 0.5% | 895 | 864 | 23 | 578 | 263 | 31 | 55,899 |
| ME | 12.3% | 12.3% | 1.0% | 5.8% | 14,844 | 14,844 | 6,716 | 1,162 | 6,966 | 0 | 120,567 |
| MI | 19.2% | 19.2% | 1.2% | 14.0% | 71,818 | 71,818 | 14,844 | 4,462 | 52,512 | 0 | 373,858 |
| MN | 41.5% | 19.1% | 0.9% | 6.9% | 114,384 | 52,696 | 31,149 | 2,436 | 19,111 | 61,688 | 275,598 |
| MO | 11.5% | 11.4% | 5.4% | 2.9% | 37,359 | 36,956 | 10,242 | 17,451 | 9,263 | 403 | 323,875 |
| MS | 6.8% | 6.8% | 1.8% | 2.9% | 20,444 | 20,444 | 6,383 | 5,513 | 8,548 | 0 | 299,217 |
| MT | 12.9% | 12.9% | 6.4% | 6.5% | 14,391 | 14,391 | 0 | 7,157 | 7,234 | 0 | 111,736 |
| NC | 13.1% | 13.1% | 4.8% | 2.6% | 69,303 | 69,228 | 29,823 | 25,534 | 13,871 | 75 | 529,763 |
| ND | 7.1% | 3.8% | 3.3% | 0.5% | 4,753 | 2,514 | 0 | 2,201 | 313 | 2,239 | 66,604 |
| NE | 7.3% | 6.5% | 5.0% | 1.2% | 10,482 | 9,430 | 600 | 7,169 | 1,661 | 1,052 | 144,147 |
| NH | 5.2% | 5.2% | 4.7% | 0.5% | 4,910 | 4,910 | 20 | 4,389 | 501 | 0 | 94,105 |
| NM | 9.8% | 9.7% | 1.3% | 7.6% | 11,448 | 11,251 | 973 | 1,475 | 8,803 | 197 | 116,580 |
| NV | 17.7% | 17.6% | 0.7% | 5.1% | 8,645 | 8,589 | 5,794 | 322 | 2,473 | 56 | 48,756 |
| NY | 25.1% | 25.0% | 3.3% | 11.8% | 72,527 | 72,355 | 28,815 | 9,522 | 34,018 | 172 | 289,084 |
| OH | 25.7% | 25.5% | 0.7% | 21.5% | 100,321 | 99,865 | 13,107 | 2,728 | 84,030 | 456 | 391,007 |
| OK | 5.9% | 5.9% | 2.9% | 1.9% | 14,802 | 14,676 | 2,606 | 7,315 | 4,755 | 126 | 250,836 |
| OR | 22.3% | 22.1% | 0.0% | 12.8% | 40,329 | 40,048 | 16,828 | 0 | 23,220 | 281 | 181,065 |
| PA | 30.9% | 30.4% | 1.6% | 12.6% | 122,367 | 120,604 | 64,459 | 6,279 | 49,866 | 1,763 | 396,080 |
| SC | 14.1% | 14.1% | 1.8% | 11.4% | 29,444 | 29,362 | 1,840 | 3,811 | 23,711 | 82 | 208,530 |
| SD | 6.6% | 5.0% | 2.7% | 2.4% | 5,361 | 4,076 | 0 | 2,148 | 1,928 | 1,285 | 80,876 |
| TN | 17.4% | 17.3% | 1.7% | 3.8% | 59,954 | 59,751 | 40,744 | 5,748 | 13,259 | 203 | 345,278 |
| TX | 9.4% | 8.5% | 2.0% | 4.2% | 52,154 | 46,849 | 12,542 | 11,227 | 23,080 | 5,305 | 552,265 |
| UT | 23.8% | 22.9% | 1.4% | 16.2% | 9,751 | 9,371 | 2,181 | 557 | 6,633 | 380 | 40,919 |
| VA | 15.5% | 14.5% | 9.4% | 2.5% | 38,027 | 35,672 | 6,457 | 23,004 | 6,211 | 2,355 | 245,645 |
| VT | 5.0% | 5.0% | 2.6% | 2.2% | 3,992 | 3,946 | 150 | 2,074 | 1,722 | 46 | 79,713 |
| WA | 11.8% | 11.7% | 1.5% | 2.3% | 19,102 | 19,007 | 12,810 | 2,487 | 3,710 | 95 | 162,314 |
| WI | 29.6% | 26.3% | 3.2% | 9.4% | 88,174 | 78,489 | 40,871 | 9,518 | 28,100 | 9,685 | 298,032 |
| WV | 21.0% | 16.2% | 2.0% | 13.5% | 38,592 | 29,641 | 1,195 | 3,600 | 24,846 | 8,951 | 183,401 |
| WY | 4.6% | 4.0% | 3.0% | 0.8% | 2,494 | 2,166 | 135 | 1,622 | 409 | 328 | 54,394 |

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

Note: HMO = health maintenance organization; MA = Medicare Advantage; PFFS = private fee for service; POS = point of service; PPO = preferred provider organization

(1) 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).

(2) Some states not shown because either they have no rural areas or because the CMS data show no enrollees in rural areas (DC, NJ).

(3) Includes demonstration plans, MSA plans, and other types of CCP plans.

(4) Includes Cost and PACE plans.

| Total Enrollment in Medicare Advantage and other Prepaid Plans, by State, March 2011 ⁽¹⁾ | | | | | | | | | | | |
|---|--|--------------|-------------|-------------|--|---|-----------|---------|-----------------------------|-------------------------------|--------------------------|
| STATE | Percent of Medicare eligibles enrolled in: | | | | TOTAL Enrolled in MA and Prepaid Plans | Enrollment in Medicare Advantage Plans: | | | | Enrolled in Prepaid plans (3) | TOTAL Medicare Eligibles |
| | MA and Prepaid plans | MA Plans | PFFS Plans | PPO Plans | | TOTAL in MA Plans | HMO/POS | PFFS | PPOs and Other MA plans (2) | | |
| UNITED STATES | 25.6% | 24.7% | 1.2% | 7.0% | 12,080,778 | 11,648,988 | 7,776,353 | 587,692 | 3,284,943 | 427,348 | 47,112,035 |
| AK | 0.2% | 0.2% | 0.0% | 0.2% | 120 | 120 | 0 | 0 | 120 | 0 | 65,356 |
| AL | 20.5% | 20.4% | 0.4% | 7.5% | 175,052 | 174,202 | 107,096 | 3,179 | 63,927 | 850 | 852,740 |
| AR | 14.2% | 14.1% | 4.7% | 4.3% | 76,368 | 75,645 | 27,036 | 25,283 | 23,326 | 723 | 536,817 |
| AZ | 36.8% | 36.8% | 0.8% | 3.3% | 343,555 | 343,124 | 305,153 | 7,566 | 30,405 | 431 | 933,435 |
| CA | 46.4% | 46.2% | 0.1% | 3.1% | 1,738,149 | 1,731,330 | 1,609,877 | 4,372 | 117,081 | 7,295 | 3,749,296 |
| CO | 33.1% | 28.9% | 1.5% | 2.7% | 209,020 | 182,175 | 155,705 | 9,416 | 17,054 | 26,845 | 631,387 |
| CT | 19.0% | 19.0% | 0.1% | 4.0% | 108,766 | 108,766 | 85,415 | 501 | 22,850 | 0 | 571,020 |
| DC | 9.6% | 3.2% | 0.0% | 1.1% | 7,567 | 2,485 | 1,653 | 0 | 832 | 5,082 | 78,860 |
| DE | 3.4% | 3.4% | 0.0% | 1.2% | 5,149 | 5,131 | 3,342 | 0 | 1,789 | 18 | 151,077 |
| FL | 31.7% | 31.5% | 0.2% | 8.7% | 1,073,238 | 1,067,383 | 766,417 | 7,040 | 293,926 | 798 | 3,390,801 |
| GA | 21.5% | 21.5% | 4.5% | 12.1% | 269,592 | 269,592 | 61,859 | 56,043 | 151,690 | 0 | 1,256,047 |
| HI | 42.4% | 35.5% | 0.1% | 22.0% | 89,111 | 74,646 | 28,250 | 278 | 46,118 | 14,465 | 210,009 |
| IA | 12.6% | 11.0% | 0.6% | 5.7% | 65,256 | 57,420 | 24,949 | 3,029 | 29,442 | 7,836 | 519,726 |
| ID | 28.2% | 27.6% | 4.5% | 13.5% | 65,460 | 64,260 | 22,385 | 10,499 | 31,376 | 1,200 | 232,471 |
| IL | 9.1% | 8.7% | 0.4% | 3.2% | 168,604 | 161,919 | 95,996 | 6,940 | 58,983 | 6,685 | 1,854,402 |
| IN | 17.1% | 16.9% | 2.2% | 13.4% | 173,229 | 171,904 | 14,144 | 21,876 | 135,884 | 1,325 | 1,014,432 |
| KS | 10.9% | 10.5% | 2.0% | 5.1% | 47,650 | 50,960 | 14,835 | 8,528 | 22,197 | 2,090 | 435,802 |
| KY | 16.4% | 15.8% | 1.1% | 11.3% | 125,951 | 121,486 | 26,218 | 8,496 | 86,772 | 4,465 | 767,801 |
| LA | 23.9% | 23.8% | 1.5% | 1.7% | 165,247 | 164,979 | 142,758 | 10,506 | 11,715 | 268 | 692,718 |
| MA | 17.6% | 17.4% | 0.0% | 2.7% | 188,109 | 185,692 | 156,722 | 27 | 28,943 | 2,417 | 1,067,929 |
| MD | 7.8% | 4.9% | 0.3% | 1.4% | 62,018 | 38,887 | 25,843 | 2,261 | 10,783 | 24,099 | 794,039 |
| ME | 13.3% | 13.3% | 0.6% | 5.7% | 35,414 | 35,414 | 18,504 | 1,708 | 15,202 | 0 | 267,012 |
| MI | 23.4% | 23.4% | 0.7% | 13.1% | 390,668 | 389,983 | 159,667 | 10,949 | 219,367 | 685 | 1,669,386 |
| MN | 44.2% | 21.3% | 0.4% | 5.8% | 349,715 | 168,304 | 119,509 | 3,074 | 45,721 | 181,411 | 791,566 |
| MO | 21.2% | 21.1% | 2.6% | 5.2% | 214,527 | 213,298 | 135,148 | 26,038 | 52,112 | 1,229 | 1,009,613 |
| MS | 9.3% | 9.3% | 1.7% | 3.9% | 46,704 | 46,676 | 18,344 | 8,661 | 19,671 | 28 | 501,142 |
| MT | 14.2% | 14.2% | 7.0% | 7.2% | 24,392 | 24,349 | 0 | 12,037 | 12,312 | 43 | 171,499 |
| NC | 17.5% | 17.5% | 3.6% | 4.0% | 263,268 | 262,974 | 147,568 | 54,518 | 60,888 | 294 | 1,505,942 |
| ND | 8.7% | 4.3% | 3.1% | 1.2% | 9,525 | 4,686 | 0 | 3,360 | 1,326 | 4,839 | 108,878 |
| NE | 10.9% | 10.3% | 2.9% | 2.5% | 30,625 | 28,771 | 13,508 | 8,257 | 7,006 | 1,854 | 280,441 |
| NH | 5.7% | 5.7% | 5.0% | 0.6% | 12,593 | 12,593 | 178 | 10,988 | 1,427 | 0 | 221,168 |
| NJ | 12.7% | 12.6% | 0.0% | 1.1% | 169,580 | 169,125 | 154,018 | 67 | 15,040 | 455 | 1,336,988 |
| NM | 25.8% | 25.6% | 0.9% | 7.2% | 81,756 | 81,106 | 55,385 | 2,842 | 22,879 | 650 | 316,973 |
| NV | 30.6% | 30.5% | 0.5% | 3.9% | 110,026 | 109,829 | 94,083 | 1,745 | 14,001 | 197 | 359,968 |
| NY | 30.7% | 30.4% | 0.8% | 7.1% | 925,264 | 915,655 | 676,607 | 24,233 | 214,815 | 9,528 | 3,009,756 |
| OH | 33.6% | 32.5% | 0.5% | 17.9% | 642,243 | 621,092 | 269,227 | 9,779 | 342,086 | 21,151 | 1,909,462 |
| OK | 14.8% | 14.8% | 1.7% | 2.8% | 89,883 | 89,678 | 61,913 | 10,570 | 17,195 | 205 | 607,465 |
| OR | 40.8% | 40.6% | 0.1% | 19.1% | 255,439 | 254,089 | 133,877 | 812 | 119,400 | 1,350 | 625,594 |
| PA | 38.1% | 37.7% | 0.9% | 12.7% | 873,686 | 864,452 | 554,431 | 20,185 | 289,836 | 8,486 | 2,290,509 |
| RI | 34.7% | 34.6% | 0.0% | 7.4% | 63,737 | 63,553 | 50,020 | 0 | 13,533 | 184 | 183,433 |
| SC | 15.9% | 15.8% | 3.5% | 10.1% | 124,407 | 123,989 | 17,115 | 27,503 | 79,371 | 418 | 783,904 |
| SD | 8.5% | 6.9% | 3.0% | 3.9% | 11,663 | 9,522 | 45 | 4,056 | 5,421 | 2,141 | 137,314 |
| TN | 25.0% | 24.9% | 0.8% | 4.7% | 266,662 | 265,842 | 206,747 | 9,046 | 50,049 | 820 | 1,067,534 |
| TX | 19.8% | 18.9% | 1.1% | 3.9% | 602,557 | 576,021 | 422,573 | 34,649 | 118,799 | 26,536 | 3,044,936 |
| UT | 34.2% | 33.6% | 4.4% | 13.2% | 97,942 | 96,397 | 46,044 | 12,607 | 37,746 | 1,545 | 286,630 |
| VA | 13.8% | 12.3% | 5.0% | 4.9% | 159,256 | 142,484 | 27,506 | 58,161 | 56,817 | 16,772 | 1,155,428 |
| VT | 4.9% | 4.8% | 2.2% | 2.5% | 5,497 | 5,407 | 150 | 2,469 | 2,788 | 90 | 112,831 |
| WA | 25.2% | 25.2% | 1.2% | 5.2% | 247,985 | 247,335 | 184,721 | 11,893 | 50,721 | 650 | 983,167 |
| WI | 29.9% | 26.9% | 2.2% | 10.8% | 274,273 | 247,407 | 128,659 | 19,790 | 98,958 | 26,866 | 918,344 |
| WV | 22.0% | 19.1% | 1.9% | 15.8% | 84,410 | 73,222 | 5,187 | 7,405 | 60,630 | 11,188 | 383,035 |
| WY | 5.0% | 3.9% | 3.0% | 0.8% | 4,021 | 3,180 | 135 | 2,437 | 608 | 841 | 80,994 |

SOURCE: RUPRI Center for Rural Health Policy Analysis, based on Centers for Medicare and Medicaid Services (CMS) data, as of March 2011.
Note: HMO = health maintenance organization; MA = Medicare Advantage; PFFS = private fee for service; POS = point of service; PPO = preferred provider organization
(1) 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).
(2) Includes demonstration plans, MSA plans, and other types of CCP plans.
(3) Includes Cost and PACE plans.
(4) Total enrollment numbers include enrollment in US territories