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 benefits[6] 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

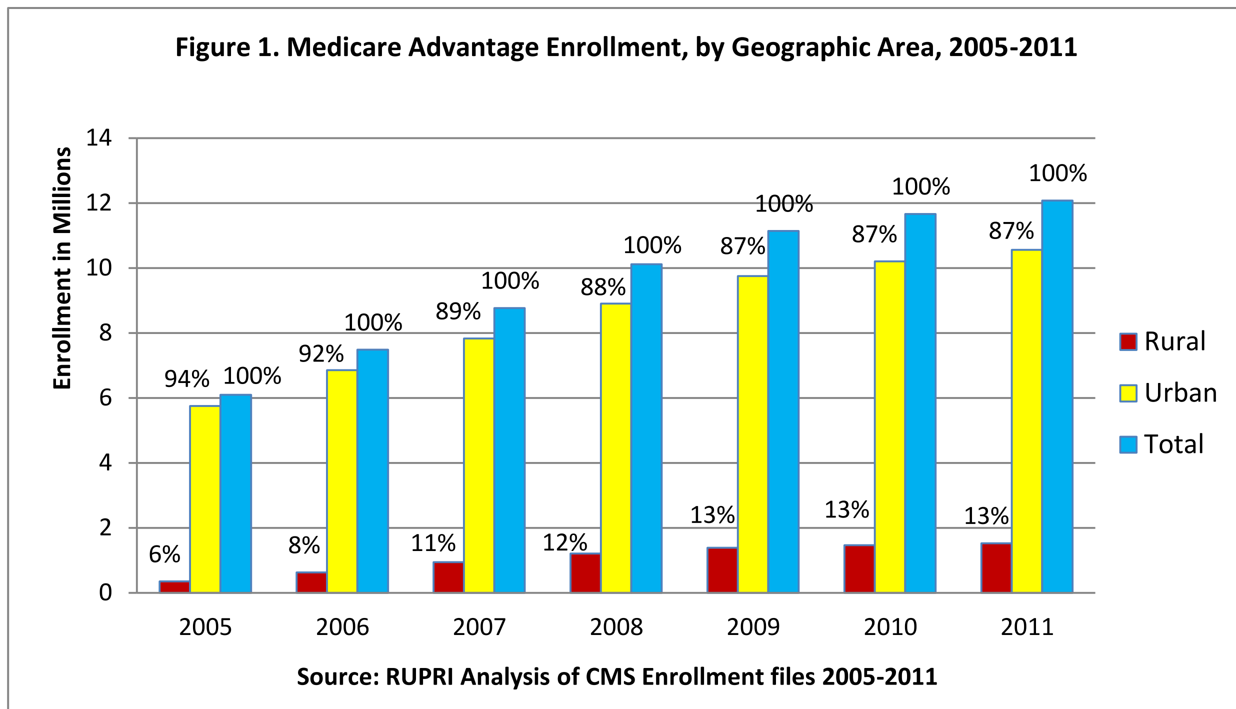
- **Balanced Budget Act of 1997**
  - Renamed the Medicare private plan options “Medicare+Choice”
  - Allowed Medicare to contract with local preferred provider organizations, private fee-for-service plans, and medical savings account plans
  - Established a payment floor, primarily applicable to rural 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]

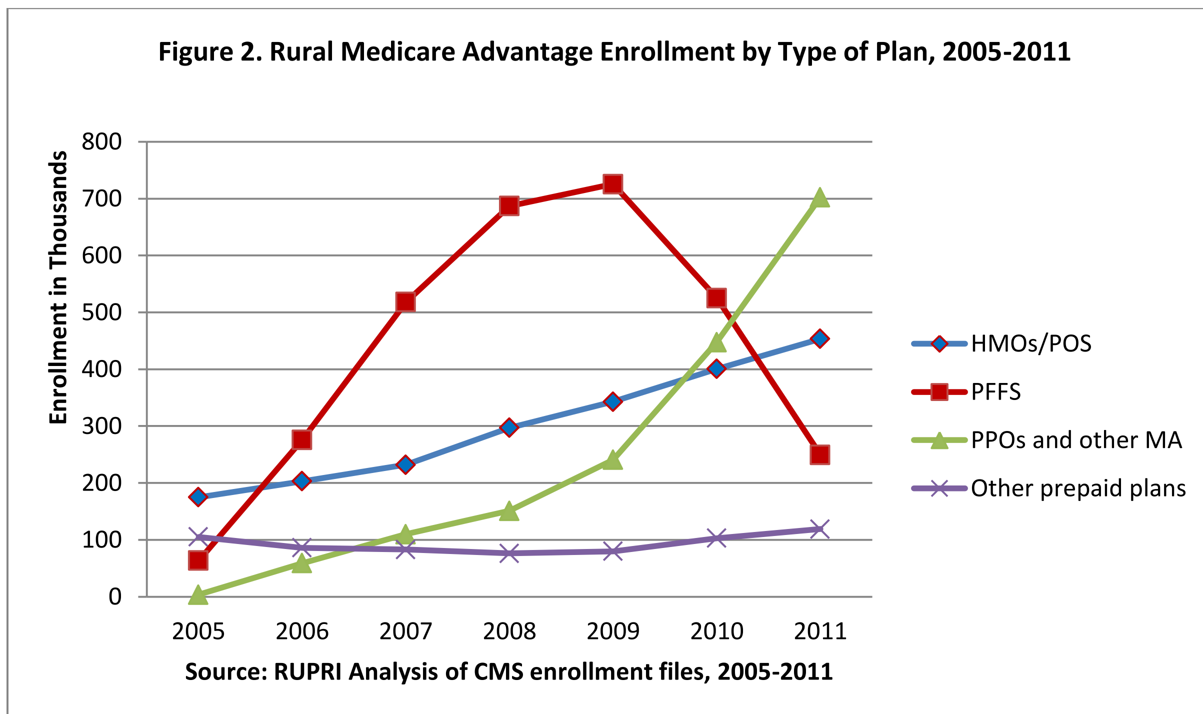
Rural Enrollment in MA plans has more than tripled over the last five years, with an enrollment of over 1.5 million beneficiaries in March 2011, while program enrollment nationwide has nearly doubled, to a total of over 12.1 million beneficiaries (Figure 1). As of March 2011, about 16% of rural Medicare 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]

Figure 2. Rural Medicare Advantage Enrollment by Type of Plan, 2005-2011



Source: RUPRI Analysis of CMS enrollment files, 2005-2011

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).

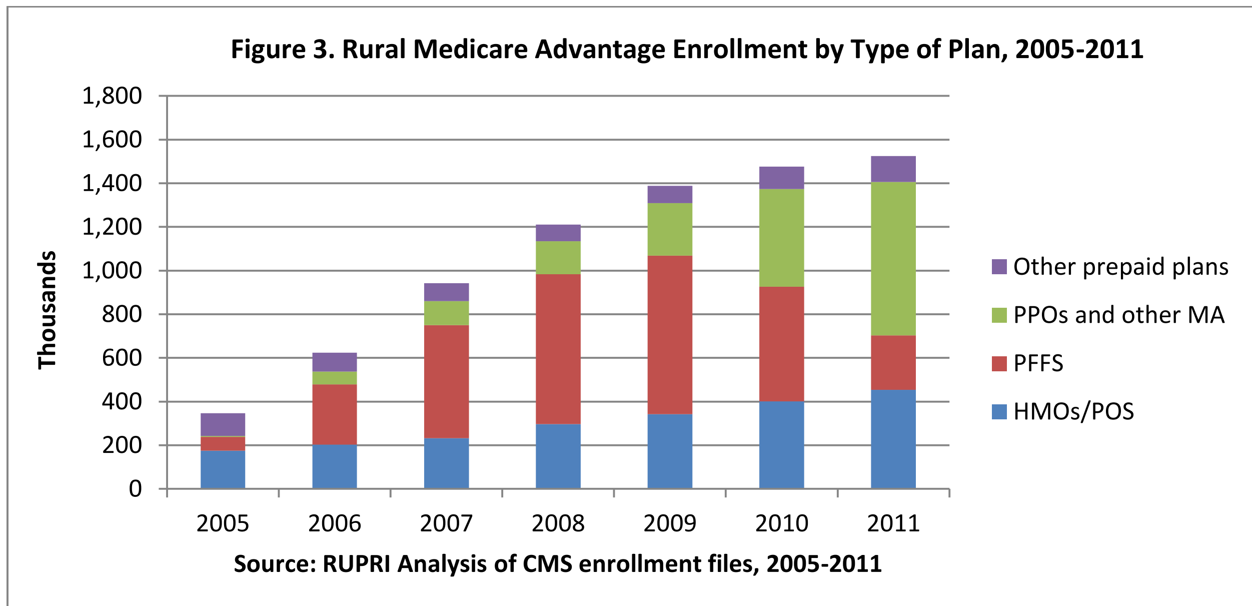
Although many rural counties (461 total) are exempted from the new provider network requirement[a] for PFFS plans, the majority of rural counties have been affected. Despite the exemption, only seven of the 220 PFFS plans offering coverage in 2010 served only counties exempted from the MIPPA requirements.[11] 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.

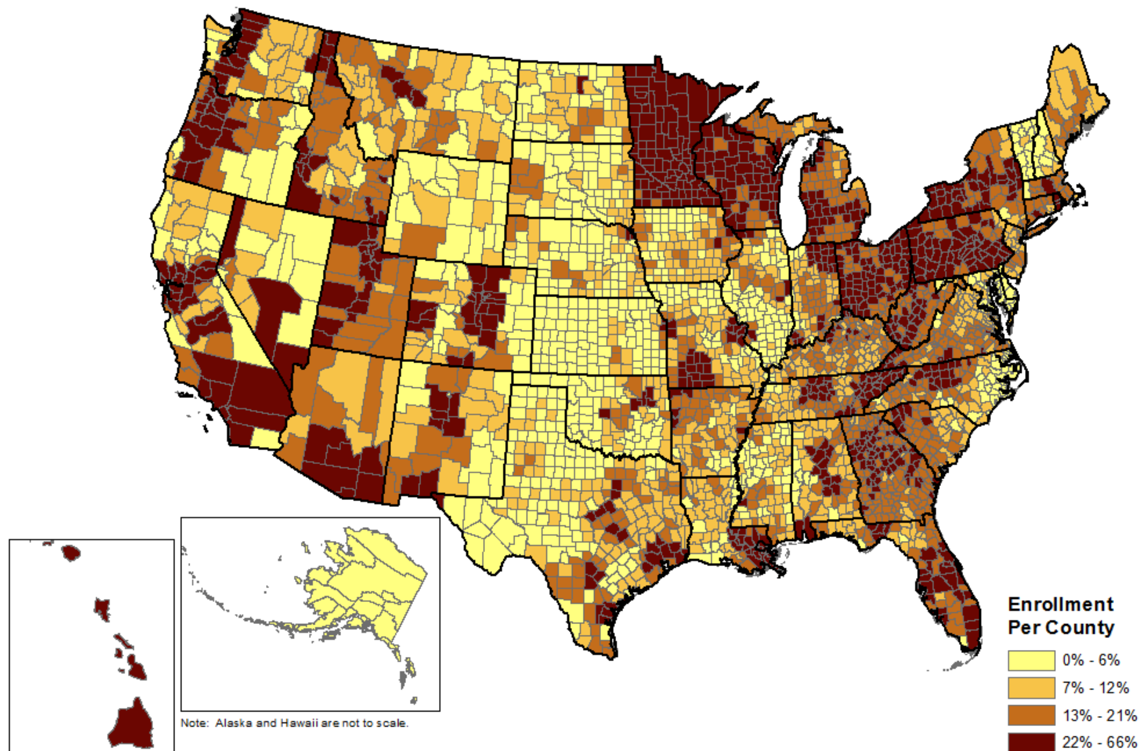


Geographic Variation in Medicare Advantage Enrollment

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



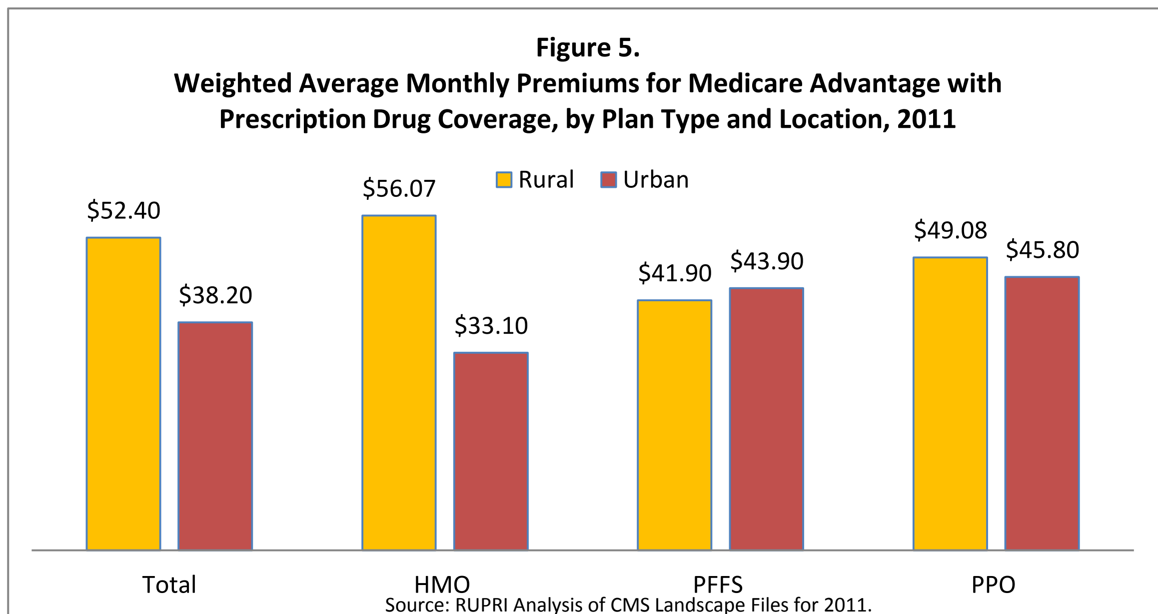
[b] Micropolitan counties are identified as areas based around a core city or town with a population of 10,000 to 49,999 residents.

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.

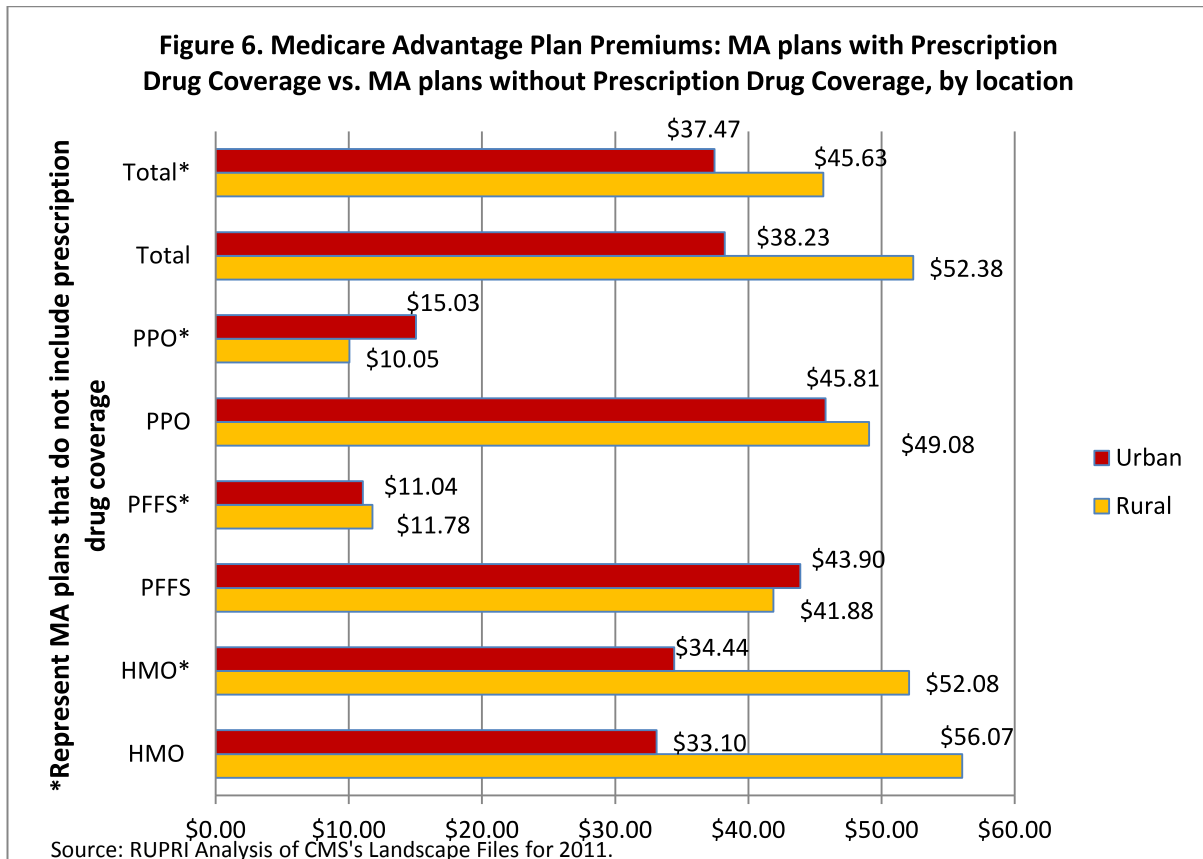
The higher premiums of HMO and PPO plans in rural areas than in urban areas are likely due to the elevated costs incurred by plans when establishing provider networks in rural areas. HMO and PPO plans have struggled to establish provider networks in many rural areas due to low population density (diseconomies 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.

Figure 5.
Weighted Average Monthly Premiums for Medicare Advantage with Prescription Drug Coverage, by Plan Type and Location, 2011



Source: RUPRI Analysis of CMS Landscape Files for 2011.

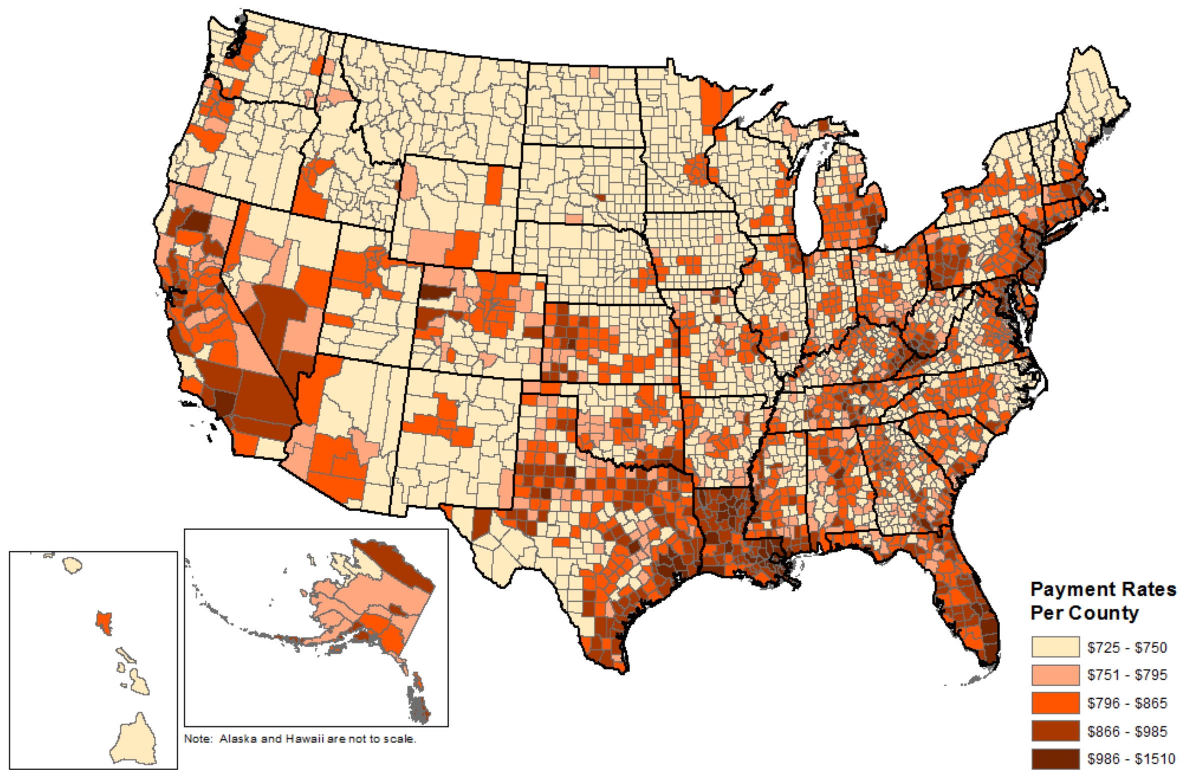
In addition, analysis of the MA premium data including the MA plans that do not offer prescription coverage shows that the premiums for these plans are lower than for the MA plans that offer prescription drug coverage in rural areas. In total, the average premium for MA plans that offer prescription 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

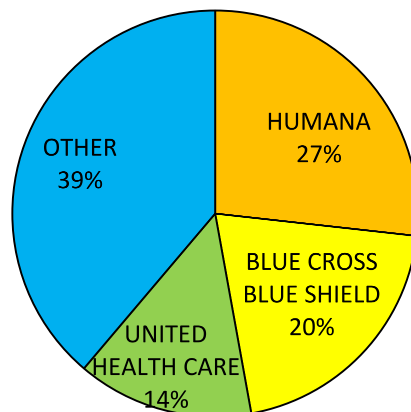
[c] Rural floor payment rates were created by the BBA and have been modified over time by subsequent legislation. The rural floor payments vary slightly among counties due to adjustments to the payments that have been put into place by BIPA and the MMA.

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

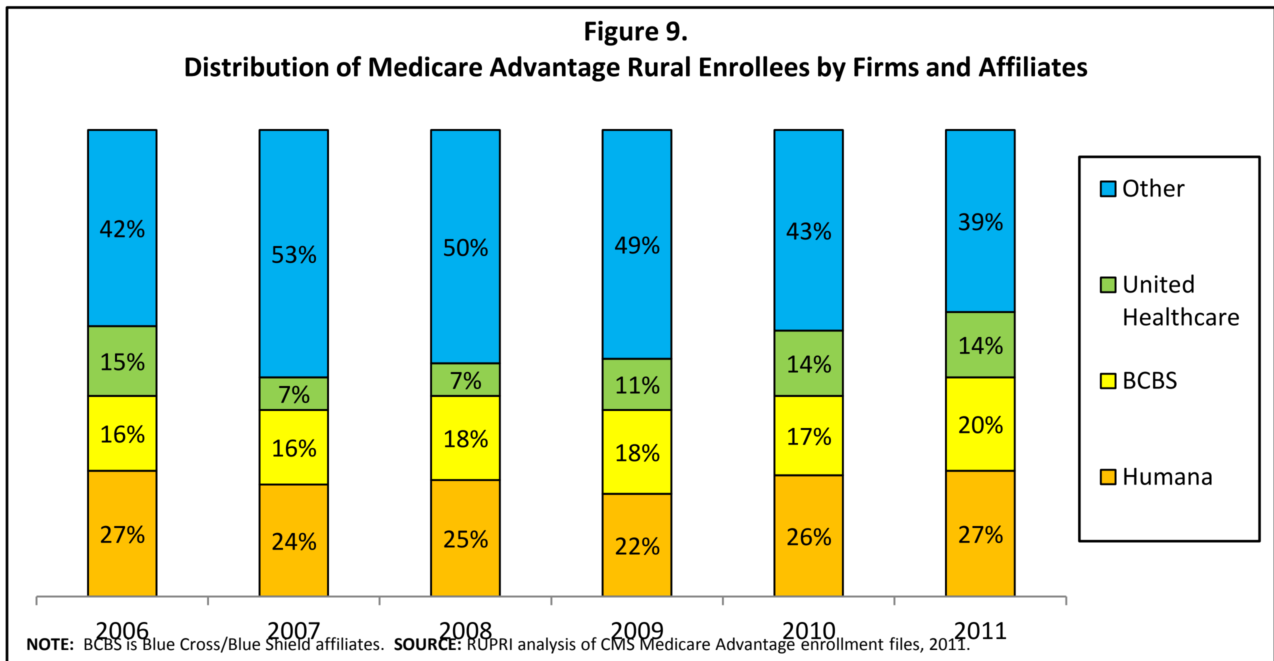
A few firms continue to dominate the rural MA market (Figure 8). Nearly half of all rural MA enrollees in 2011 are in plans affiliated with two firms—Humana (27%) and Blue Cross/Blue Shield (BCBS) affiliates (20%), which are multiple independent firms sharing the BCBS trademark; United Health Care accounts 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

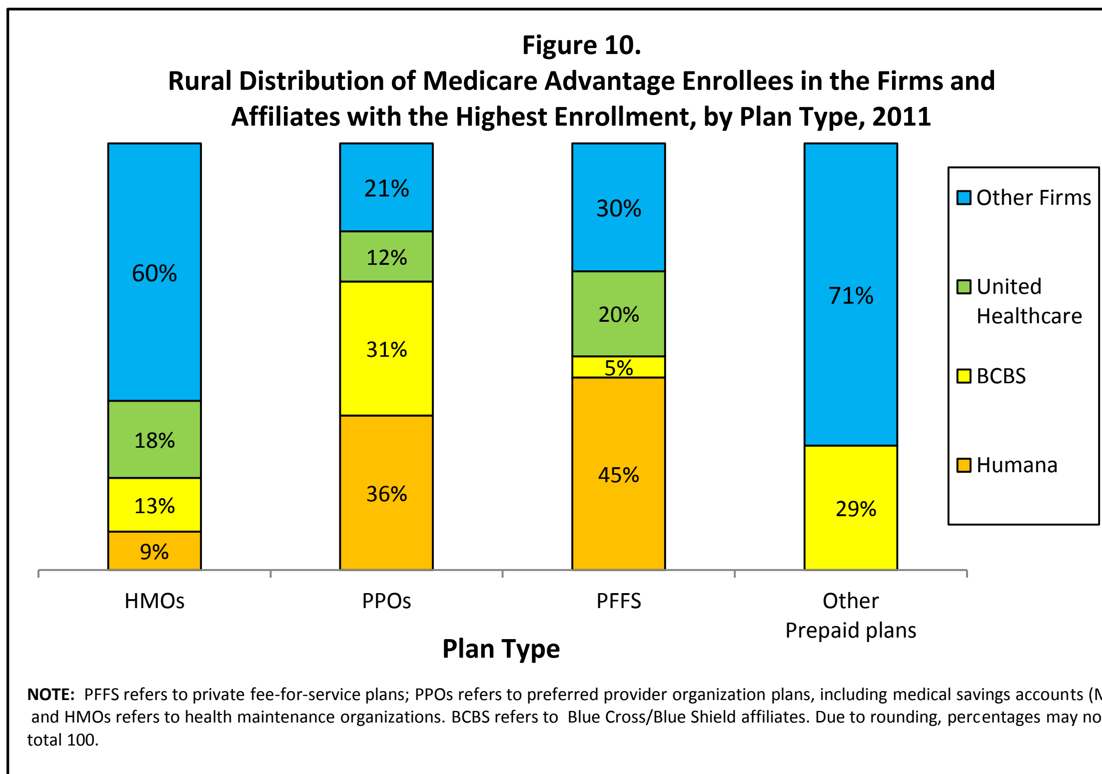


NOTE: Other includes firms with 3% or less of total enrollment. BCBS are Blue Cross/Blue Shield affiliates.
SOURCE: RUPRI analysis of CMS enrollment files, 2011.

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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Appendix

RURAL Enrollment in Medicare Advantage and other Prepaid Plans, by State, March 2011 (1)

	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
STATE (2)	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]											
	Percent of Medicare eligibles enrolled in:				TOTAL Enrolled in	Enrollment in Medicare Advantage Plans:					
STATE	MA and Prepaid plans	MA Plans	PFFS Plans	PPO Plans	MA and Prepaid Plans	TOTAL in MA Plans	HMO/POS	PFFS	PPOs and Other MA plans (2)	Enrolled in Prepaid plans (3)	TOTAL Medicare Eligibles
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	45,560	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