MILLIMAN WHITE PAPER

2023 urban and rural differences in Medicare Advantage: Current landscape and plan considerations

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The Medicare Advantage (MA) market continues to grow each year; over 30 million Americans are enrolled in an MA plan in 2023.[1] Over the last few years, MA plans have expanded to include new plan offerings in rural areas, and more rural Medicare eligibles than ever before have access to plans under the MA program.[2]

This paper provides insight into the current landscape of MA, specifically how the MA landscape differs between rural and urban areas across the country. We highlight key differences in plan offerings in the market today and provide considerations for MA plans when contemplating expansion into rural areas.

Executive Summary

Rural areas currently have a lower proportion of Medicare eligibles enrolled in MA relative to the Medicare eligible population in urban areas. Medicare Advantage organizations (MAOs) should consider the risks and rewards of offering plans in rural areas, such as expected revenue levels and provider network adequacy rules, which are both discussed further below. We also summarized throughout this article some of the differences between urban and rural markets to showcase the current benefit and premium landscape differentials.

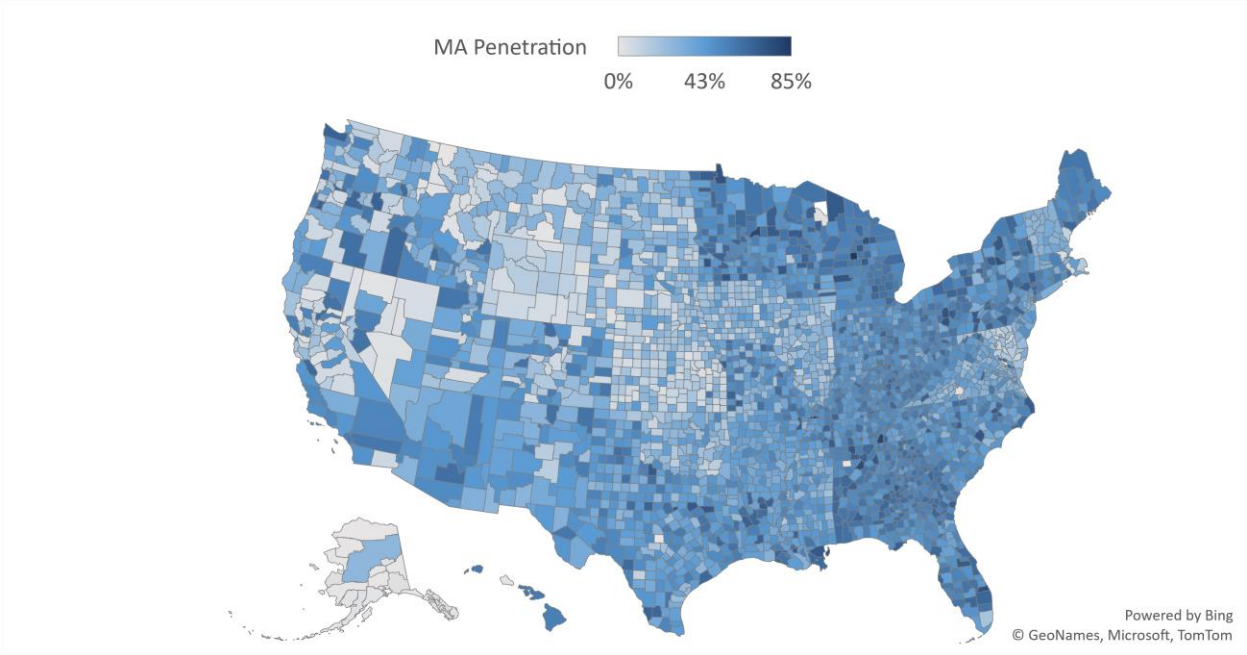
First, we sought to identify whether differences in MA enrollment, plan offerings, or benefits existed between urban and rural areas across the country. We used various publicly available Centers for Medicare and Medicaid Services (CMS) data sources to compare current 2023 MA penetration, payment rates, plan types, premiums, and a few key supplemental benefits between rural and urban markets. We limited our analysis of plan types, premiums, and key supplemental benefits to non-special needs plans (non-SNPs).

MA penetration rates (i.e., the percentage of an eligible population enrolled in an MA plan) vary significantly across the country, as seen in Figure 1, ranging from 0% in Alaska to over 85% in Minnesota. In general, we observed that rural areas tend to have lower MA penetration rates than urban areas. This can be due to a variety of reasons, which we discuss in detail throughout this article.

[1] CMS (January 2023). MA State/County Penetration 2023 01. Retrieved April 4, 2023, from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/ma-state/ma-state/county-penetration-2023-01.

[2] AHIP (November 17, 2022). Market Competition in Medicare Advantage Delivers Lower Costs, More Choices, and Better Access to Benefits. Retrieved April 4, 2023, from https://www.ahip.org/news/articles/market-competition-in-medicare-advantage-delivers-lower-costs-more-choices-and-better-access-to-benefits.

FIGURE 1: MA PENETRATION IN JANUARY 2023



Source: MA State/County Penetration 2023 01 | CMS

We also summarized the 2023 CMS 5% quality bonus payment rates and fee-for-service (FFS) quartiles and observed that, while urban areas have slightly higher payment rates compared to rural areas, rural areas still offer competitive revenue relative to expected medical costs. Due to CMS payment rate mechanics, lower-cost counties, which are typically rural, have payment rates greater than 100% of estimated FFS costs.

When looking at plan designs, we focused on plan types, premiums, and several important supplemental benefits. We observed that beneficiaries in urban and rural areas are offered similar benefit levels at a nationwide level, but they differ at the regional level. Depending on the attribute being analyzed, some regions showed higher or lower coverage levels compared to national averages. We summarize our findings regarding plan design differences as follows:

- **Plan designs**: As of January 2023, enrollment in health maintenance organizations (HMOs) makes up a majority of the total enrollment (41%) in urban areas, compared to enrollment in preferred provider organizations (PPOs) making up a majority of total enrollment (56%) in rural areas. When including HMO-point-of-service (POS) plans, approximately 59% of urban MA beneficiaries are in plans with out-of-network coverage, compared to 78% of rural MA beneficiaries.
- **Premiums**: Nationwide monthly premiums are on average approximately $2.50 per month lower in urban areas than in rural areas. At the regional level, this pattern was consistent for all regions except the Northeast, where monthly premiums in urban areas were higher by about $2 per month compared to rural areas.
- **Dental limits**: The percentage of beneficiaries enrolled in a plan with coverage for both preventive and comprehensive dental coverage was consistent between urban and rural areas nationwide, at around 91%. However, the level of coverage differed, where substantially more beneficiaries in urban areas were enrolled in plans with high dental annual dollar limits (greater than $5,000 annually or approximately 15% of all beneficiaries enrolled in a plan with preventive and comprehensive dental) than beneficiaries in rural areas (approximately 3.5% of all beneficiaries enrolled in a plan with preventive and comprehensive dental).
- **Vision hardware limits**: Annual vision hardware coverage limits across urban and rural areas was consistent, where the most popular coverage limit for beneficiaries was between $101 to $200 annually. In urban areas, the second-most popular coverage limit was between $201 to $300 annually, where in rural areas this was between $1 to $100 annually.

- **Nonemergency medical transportation (NEMT)**: The proportion of beneficiaries in a plan with an NEMT benefit in rural areas is notably lower than in urban areas. However, NEMT coverage in rural areas has increased relative to 2022. In fact, the proportion of beneficiaries in a plan with some level of NEMT increased by 10% in 2023. The most common benefit limit selected for NEMT was between one and 24 one-way trips annually, which held true for all regions.
- **Over-the-counter (OTC) benefit**: The proportion of beneficiaries in a plan with no OTC coverage is approximately 10%, consistent across urban and rural areas nationwide. However, this varies at the regional level, where significantly more beneficiaries (25%) in the Northeast have no OTC, and significantly fewer beneficiaries (5%) have no OTC in the Midwest. The most popular coverage allowance across all regions is between $10 to $20 monthly.

If an MAO offers new plans in a rural area, it should consider the current landscape of benefits offered. As is true with entering any county, the MAO will need to ensure it can set up an adequate provider network, as well as manage overall medical costs to thresholds below the payment rates, to fund supplemental benefits while remaining profitable (or not jeopardizing overall financial solvency). Because rural areas by definition have low population density, the MAO will also need to weigh the cost versus reward of marketing and expanding services to rural beneficiaries compared to the potential revenue.

Background

MEDICARE ADVANTAGE PROGRAM HISTORY

Under the 2003 Medicare Prescription Drug Improvement and Modernization Act (MMA), Medicare began allowing approved health plans to offer private coverage, known as Medicare Advantage (MA).[3] Today, nearly 50% of Medicare-eligible beneficiaries nationwide are enrolled in MA plans.[4] One of the key differentiators of MA plans compared to FFS Medicare (also known as “original” or “traditional” Medicare) is the opportunity to offer benefits that are supplemental (i.e., in addition) to FFS.

The landscape of these supplemental benefits has evolved significantly over time and in 2023 nearly all MA beneficiaries have access to at least one type of supplemental benefit. According to a recent Milliman paper, as of 2023 approximately 99% of Medicare Advantage general enrollment beneficiaries are in a plan with supplemental vision exam coverage and over 90% are in a plan with supplemental dental coverage, vision hardware coverage, hearing exam coverage, and/or hearing hardware benefits.[5] Numerous other supplemental benefits continue to increase in popularity, such as combined benefits,[6] OTC benefits, meals, NEMT, and acupuncture, among many others.

While not discussed specifically in this paper, the MA program has also been trying to address accessibility to nonmedical services through benefit flexibilities such as value-based insurance design (VBID), special supplemental benefits for the chronically ill (SSBCI), and uniformity flexibility (UF).[7,8] The benefit landscape is ever-changing, with MAOs continuously bringing new and innovative benefits to the market.

[3] CMS. History: CMS’s Program History. Retrieved April 4, 2023, from https://www.cms.gov/About-CMS/Agency-Information/History.

[4] CMS, MA State/County Penetration, op cit.

[5] Laktas, J. Yeh, M., & Friedman, J.M. (March 21, 2023). Prevalence of Supplemental Benefits in the General Enrollment Medicare Advantage Marketplace: 2019 to 2023. Milliman White Paper. Retrieved April 4, 2023, from https://www.milliman.com/en/insight/prevalence-supplemental-benefits-general-enrollment-ma-marketplace-2023.

[6] Friedman, J.M., Yeh, M., & Yen, I. (January 2023). 2023 Combined Benefits in Medicare Advantage – Tracking Benefit Strategy and Options. Milliman White Paper. Retrieved April 4, 2023, from https://www.milliman.com/en/insight/2023-combined-benefits-in-medicare-advantage-tracking-benefit-strategy.

[7] Murphy-Barron, C., Buzby, E.A., & Pittinger, S. (November 2022). Review of Contract Year 2023 Medicare Advantage Expanded Supplemental Healthcare Benefit Offerings. Milliman Brief. Retrieved April 4, 2023, from https://bettermedicarealliance.org/wp-content/uploads/2022/11/Milliman-Issue-Brief-CY-2023-MA-EPHR-Supplemental-Benefits-final.pdf.

[8] Murphy-Barron, C., Buzby, E.A., & Pittinger, S. (March 2023). Overview of Medicare Advantage Supplemental Healthcare Benefits and Review of Contract Year 2023 Offerings. Milliman Brief. Retrieved April 4, 2023, from https://www.milliman.com/en/insight/ma-supplemental-healthcare-benefits-review-cy2023.

MEDICARE ADVANTAGE FUNDING OVERVIEW

MAOs receive revenue from CMS to fund total plan costs, based on what are known as Part C benchmarks. These benchmark payment rates are released annually by CMS for the upcoming projection year. They are derived from FFS Medicare costs and vary by county because FFS Medicare costs vary by county for multiple reasons, including FFS Medicare provider reimbursement rate differences and varying morbidity levels across the country. These benchmarks are intended to be equivalent to costs for Medicare Parts A and B costs with no medical management.

MAOs must aim to manage medical and administrative costs and/or improve provider contracting rates to achieve total claim levels below the benchmark rates (where the benchmark rates are risk-adjusted up or down to the plan's projected risk score levels). When a plan's projected costs for traditional Medicare services (those covered under Parts A and B, plus administrative costs and anticipated margin, known as the "Part C bid") are compared to the aggregate service area benchmark, the goal is to have the Part C bid be less than the benchmark. When this happens, "savings" are created, and a portion of the "savings" can be retained as "rebates" to use on supplemental benefits, where the level of the portion of "savings" retained is based on the MAO's star rating.

The projected supplemental benefit costs must be funded through at least one of two ways: 1) beneficiary premiums, and/or 2) rebates. To remain competitive, MAOs typically focus on the latter, aiming to keep beneficiary premiums as low as possible. Therefore, the level of medical management and provider contracting levels dictate the savings and thus the rebates that are generated through the bid development process, determining the level of premiums still needed to fund supplemental benefits, if necessary.

NETWORK ADEQUACY REQUIREMENTS

An MAO newly entering the MA market, or one looking to expand a current contract's service area, must show compliance with network adequacy criteria prescribed by CMS in its service area application and must maintain this adequacy. This application is due to CMS in February of the calendar year prior to the desired entrance or expansion.

The criteria for network adequacy include 27 provider specialty types and 23 facility specialty types. MAOs must ensure at least 90% of beneficiaries residing in a given county have access to at least one provider and facility of each specialty type within the published time and distance standards. However, the maximum travel time and distance standards generally vary by county type and specialty type.[9] Network adequacy is assessed at the county level, and counties are classified into five different types:

- Large metro
- Metro
- Micro
- Rural
- Counties with Extreme Access Considerations (CEAC)

These definitions are based on classifications from the U.S. Census Bureau and by the U.S. Office of Management and Budget (OMB). While there are different criteria for network adequacy, partially depending on county types, CMS expects that, in some micro, rural, and CEAC areas, MAOs may need to request an exception in the application for network adequacy. However, CMS is explicit that it does not expect exception requests in large metro or metro areas based on the abundance of providers and facilities. These exceptions can only be submitted when network adequacy cannot be met from provider and facility supply (and not, for example, an MAO's inability to contract with a provider or facility).

If an MAO does not meet or maintain network adequacy requirements or fails to submit an exception request when the network is not considered adequate, it may result in CMS denying the application, bid, or operational contract. It is critical for MAOs to understand these guidelines and potential risks when implementing a service area expansion or starting a new contract.

[9] CMS (January 10, 2017). Medicare Advantage Network Adequacy Criteria Guidance. Retrieved April 4, 2023, from https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

Analysis

We analyzed the 2023 MA market to understand differences in urban and rural areas' enrollment patterns, payment rates, plan types, and select supplemental benefits offered across the country. We defined each county in the United States as either urban or rural using the Metropolitan Statistical Area (MSA) definition from the OMB as of March 2020.[10] We defined a county as urban if the OMB defined it as being an MSA and as rural if the OMB defined it as a "Micropolitan Statistical Area." We further grouped these urban and rural counties into regions using the U.S. Census definitions, assigning each state to either Northeast, South, Midwest, or West.[11] We excluded the U.S. territories of Guam, Puerto Rico, American Samoa, and the Virgin Islands. We focused on only non-SNP plans.

We note each region will have different geographic characteristics within its urban and rural areas. For example, in the Northeast, urban areas include large cities such as New York City and Boston, which may have greater variation in characteristics from the rural counties in the same region than might be observed in other regions. We did not attempt to normalize for these characteristic differences at the regional level.

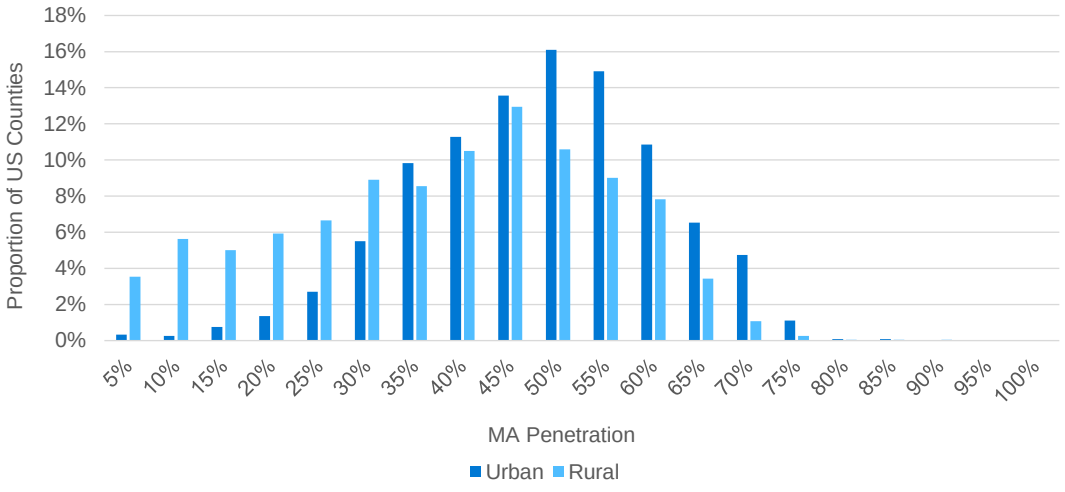
MARKET ENROLLMENT: MA PENETRATION

MA penetration is defined as the proportion of Medicare-eligible beneficiaries enrolled in an MA plan in a given area. As noted previously, nearly 50% of Medicare-eligible beneficiaries nationwide are enrolled in MA plans. In other words, the nationwide MA penetration rate is nearly 50%. MA penetration varies substantially by county and region.

Figure 2 shows the distribution of county penetration levels, using the January 2023 enrollment file released by CMS,[12] for all urban and rural counties across the country. The distribution for rural counties is more heavily weighted toward lower penetration rates, where most counties have less than 45% of Medicare eligibles enrolled in an MA plan, averaging approximately 41% penetration overall. In contrast, most urban counties have at least 45% penetration, averaging approximately 48% overall.

With most rural counties having less than 45% penetration in MA, and with a notable proportion of rural counties in the 5% to 25% range, MAOs should consider whether the remaining Medicare eligibles present an opportunity for enrollment growth, after considering many of the factors outlined throughout this article.

FIGURE 2: DISTRIBUTION OF MA PENETRATION IN JANUARY 2023, URBAN VERSUS RURAL COUNTIES



Source: MA State/County Penetration 2023 01 | CMS

[10] U.S. Census Bureau. Delineation Files. Retrieved April 4, 2023, from https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html.

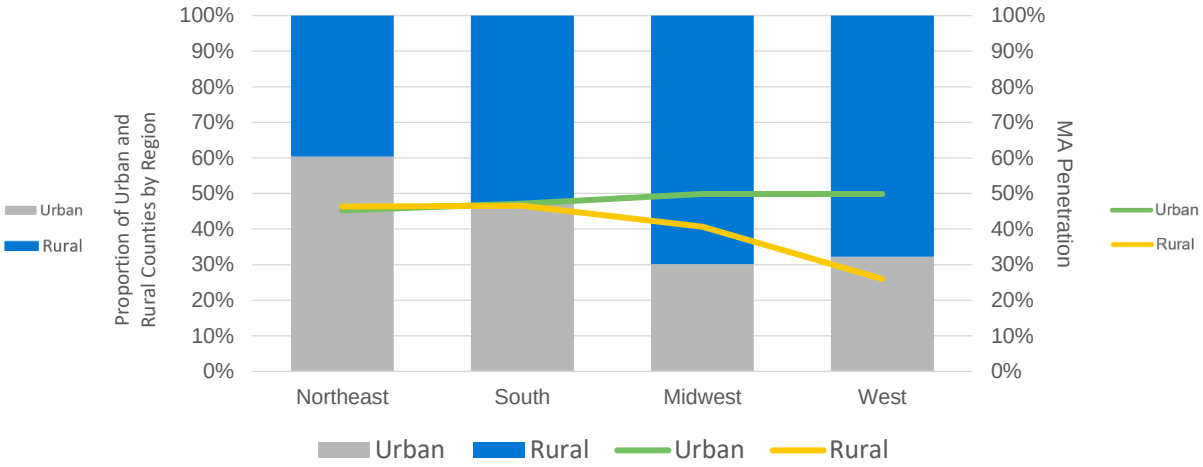
[11] U.S. Census Bureau. Statistical Groupings of States and Counties. Retrieved April 4, 2023, from https://www2.census.gov/geo/pdfs/reference/GARM/Ch6GARM.pdf.

[12] CMS, MA State/County Penetration, op cit.

MAOs should also consider how Medicare eligibles who are not currently enrolled in an MA plan are accessing their coverage. In 2022, approximately 20% of all Medicare-eligible beneficiaries were enrolled in Medicare Supplement plans, or Medigap.[13] In other words, slightly less than half of Medicare-eligible beneficiaries not enrolled in an MA plan are enrolled in Medigap. This varies by area, where 25% of all Medigap beneficiaries were in rural areas as of 2019.[14] This may help MAOs determine where they can draw new membership from—Medicare FFS, Medigap, or other MA plans—and how best to accomplish their growth objectives.

We also summarized the distribution of urban and rural counties by region and their respective average penetration rates in Figure 3. The bar graph shows the proportion of counties within each region considered urban or rural, and the line graph shows the MA penetration level. For example, in the Northeast region, approximately 60% of the counties in that region are considered urban, and the average penetration rates are approximately 45% for both urban and rural counties.

FIGURE 3: DISTRIBUTION OF URBAN AND RURAL COUNTIES BY REGION AND MA PENETRATION IN JANUARY 2023



Source: MA State/County Penetration 2023 01 | CMS

Average urban penetration rates are generally consistent across all four regions. Average rural penetration rates are similar to average urban penetration rates in the Northeast and South regions but differ substantially in the Midwest and West regions, where the penetration rates for rural counties are significantly lower than for urban counties. There are also significantly more rural counties in the Midwest and West regions as a proportion of the total.

MAOs should consider the opportunity cost of attracting new beneficiaries in rural areas. These considerations can be summarized as follows:

- **Total Medicare-eligible beneficiaries**: Many rural counties have a small Medicare-eligible population to begin with, likely presenting little opportunity for material incremental membership growth.
- **Provider networks**: There is a nonzero cost to building an adequate provider network. Additionally, rural areas by nature have limited providers to choose from. CMS guidelines, as discussed above, provide some flexibility for meeting network adequacy in rural areas, but meeting these adjusted guidelines could still prove challenging.

[13] MedPAC (July 2022). Data Book: Section 2: Medicare Beneficiary Demographics. Retrieved April 4, 2023, from https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_Sec2_SEC.pdf.

[14] AHIP (March 2022). The State of Medicare Supplement Coverage. Retrieved April 4, 2023, from https://www.ahip.org/documents/202202-AHIP_MedicareSuppCvg-02_v03.pdf.

Network adequacy requirements are one of the main reasons why there is more limited MA penetration in the West and Midwest regions—it is challenging and can be costly to meet and maintain CMS network adequacy requirements. This is likely why Alaska, the state with 0% MA penetration, has no non-MSA MA plan offerings available.

- **Marketing**: There are nonzero costs to market MA plans in rural areas, which may require different strategies than marketing efforts in urban areas.

An MAO must consider whether these risks will be outweighed by the revenue and membership growth's impacts on overall profitability.

REVENUE: PAYMENT RATES

As discussed previously, Part C benchmark payment rates are a major factor in the development of revenue for MAOs and are based primarily on FFS costs by county.

5% quality bonus payment rate comparison

Figure 4 summarizes the average 2023 payment rates by region for urban and rural counties weighted using the number of Medicare-eligible beneficiaries from January 2023 enrollment released by CMS. We used the payment rates including the 5% quality bonus payment because the majority of MA organizations (nearly 70% of plans[15]) achieved a 4.0 or higher star rating for 2023, which is the criteria for receiving the 5% bonus.

FIGURE 4: AVERAGE 2023 PAYMENT RATES WITH 5% QUALITY BONUS PAYMENT, URBAN VS. RURAL, BY REGION

REGION	URBAN	RURAL	RELATIVITY (URBAN/RURAL)
Northeast	$1,162.62	$1,094.89	1.06
South	$1,147.74	$1,101.42	1.04
Midwest	$1,148.89	$1,125.22	1.02
West	$1,160.43	$1,130.25	1.03

Source: https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsratebooks-and-supporting-data/2023

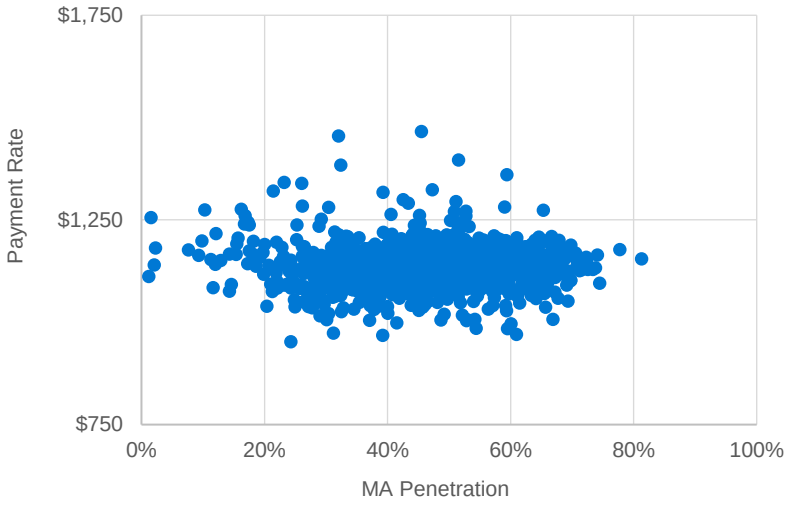
The average payment rates of urban and rural areas within each region are not substantially different. The biggest difference is in the Northeast region, where the average payment rate in urban areas is approximately 6% higher than rural areas. All other regions have urban payment rates slightly higher than rural payment rates.

Comparing the urban to rural relativity in Figure 4, we also observe there is an inverse relationship with the MA penetration in rural areas shown in Figure 3. In the Northeast, where rural payment rates are the lowest compared to urban, MA penetration is nearly identical between the areas. In contrast, the West and Midwest are where urban and rural average payment rates are the closest but have the biggest gap in MA penetration. Rural areas there are significantly lower-cost than urban. This could suggest payment rate levels may not be driving the difference in penetration rates by region.

Additionally, we analyzed the 2023 5% quality bonus payment rates compared to January 2023 MA penetration in Figures 5 and 6. Each dot on the scatter plot represents a unique urban or rural county.

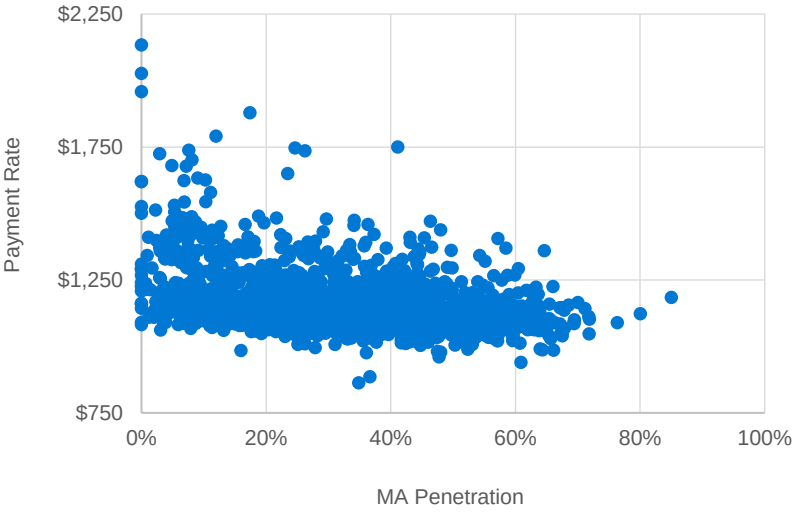
[15] CMS (October 6, 2022). Fact Sheet: 2023 Medicare Advantage and Part D Star Ratings. Retrieved April 5, 2023, from https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf.

FIGURE 5: URBAN COUNTY 5% QUALITY BONUS PAYMENT RATES VS. MA PENETRATION, JANUARY 2023



Sources: https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsratebooks-and-supporting-data/2023
https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/ma-state/ma-state/county-penetration-2023-01

FIGURE 6: RURAL COUNTY 5% QUALITY BONUS PAYMENT RATES VS. MA PENETRATION, JANUARY 2023



Sources: https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsratebooks-and-supporting-data/2023
https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/ma-state/ma-state/county-penetration-2023-01

Payment rates in rural counties are more variable than in urban areas, particularly at the penetration rates below 40%, with some rates being higher than the highest urban counties. In rural areas with lower MA penetration, the average payment rate is higher and more variable.

Quartiles

There are many complexities underlying the development of the county payment rates, which are mostly outside the scope of this paper. However, as noted previously, county payment rates are based on FFS costs in the respective county. Counties are then segmented into four distinct quartiles by costs (95%, 100%, 107.5%, and 115%) impacting the payment rates as follows:

- The 95% quartile counties have the highest FFS costs. The payment rates in these counties are reduced by 5% (in other words, 95% of the estimated FFS costs in the county).
- The 115% quartile counties have the lowest FFS costs. The payment rates in these counties are increased by 15% (in other words, 115% of the estimated FFS costs in the county). This increase is intended to induce MA plans to participate in low-cost counties.
- The 100% and 107.5% quartile counties follow a similar logic as the endpoints above.

In Figure 7, we summarized the average 2023 quartile by urban and rural areas, where higher average quartiles are associated with lower FFS costs. This relationship aligns with Figure 4 above, where the average quartile for rural counties in most regions is slightly higher than for the urban areas in the same region. Said differently, urban areas have lower quartile percentages because they are more costly regions than rural areas in terms of FFS costs, and the higher benchmark rates in urban areas are intended to compensate for this—though it is unclear whether utilization, unit price, or both are driving those higher costs.

FIGURE 7: AVERAGE 2023 QUARTILES BY REGION, URBAN VS. RURAL, BY REGION

REGION	URBAN	RURAL	RELATIVITY (URBAN/RURAL)
Northeast	1.024	1.074	0.95
South	1.050	1.081	0.97
Midwest	1.049	1.044	1.01
West	1.030	1.038	0.99

From Figure 4 above, all regions had higher average payment rates in urban counties even after quartile adjustments. This is because FFS costs in these urban counties are relatively much higher than in rural counties and much higher than the quartile percentages would imply.

Even though rural payment rates are, on average, lower than urban areas (shown in Figure 4), the average quartiles are higher, signifying an incentive through increased revenue if an MAO expands into certain rural areas. Therefore, MAOs are still able to receive adequate funding to design plans that provide benefits aligned with the needs of beneficiaries in these areas. For an MAO that offers a plan in rural areas, it is important to understand what level of cost management is possible, relative to FFS. If cost management is expected to be high, this would result in overall projected costs that are less than payment rates, which generate MA rebates through savings, providing an opportunity to fund supplemental benefits.

We also analyzed the current landscape of plan characteristics and select supplemental benefits in the following section.

Plan characteristics and supplemental benefit offerings

We used the Milliman Medicare Advantage Competitive Value-Added Tool (Milliman MACVAT®), which provides a comprehensive benefit summary of individual MA plans using up-to-date nationwide data sets from various sources. Milliman MACVAT allows examination of differences in plan characteristics and benefit offerings of urban and rural MA beneficiaries in 2023. We focused on non-special needs plans (non-SNPs) as these plans are the majority of the overall MA market, comprising more than 78% of covered beneficiaries nationwide.

In all analyses and results below, in addition to focusing on the non-SNP population, we excluded Medicare Medical Savings Account (MSA), private fee-for-service (PFFS), and cost plans, as these plans comprise only a small portion of the current market.

The following sections outline our key findings. Note that the following conclusions are based on the market as of 2023, which is subject to change, particularly at the regional level, for future years.

Plan designs

Across the MA market today, local preferred provider organization (LPPO) plans are becoming increasingly popular both in terms of total plan offerings and total enrollment. Based on the Milliman MACVAT, approximately 40% of 2023 MA plans are LPPOs, covering around 36% of beneficiaries, compared to 37.5% of plans covering around 33% of beneficiaries in 2022. HMO-POS plans are also seeing increasing market share, providing beneficiaries the opportunity to receive select services from providers that are not in a plan's provider network (sometimes with service area and provider type limitations). Total enrollment in HMO-POS plans more than doubled from 2022 to 2023, and the HMO-POS plan counts also grew significantly, by nearly 65%. (Note that there was a significant shift in enrollment from HMO to HMO-POS plans due to several UnitedHealthcare plans adding the POS benefit in 2023.) On the other hand, HMO market share is decreasing, covering just over 38% of the market in 2023, down from over 50% in 2022, as beneficiaries move to, enroll in, or have their plans converted to LPPO or HMO-POS plans.

Figure 8 summarizes how these distributions differ between urban and rural beneficiaries for 2023, as well as the relative change from 2022.

FIGURE 8: DISTRIBUTION OF JANUARY 2023 ENROLLMENT BY PLAN TYPE, URBAN VS. RURAL, NATIONWIDE

	JANUARY 2023 ENROLLMENT		ENROLLMENT DISTRIBUTION CHANGE FROM 2022	
Plan Type	Urban	Rural	Urban	Rural
HMO	40.9%	22.5%	-14.7%	-7.8%
HMO-POS	24.3%	21.2%	12.8%	7.7%
LPPO	33.1%	51.8%	2.3%	1.8%
RPPO	1.8%	4.5%	-0.4%	-1.8%

In 2023, approximately 78% of rural beneficiaries are enrolled in a plan with some type of out-of-network coverage option, compared to 59% of urban beneficiaries, through either an LPPO, regional PPO (RPPO), or HMO-POS, though the most predominant plan type by far is the LPPO plan design. One of the reasons plans with an out-of-network option are attractive to rural beneficiaries is because they allow beneficiaries better or more comprehensive access to care, likely in larger metropolitan areas, under the coverage of their out-of-network benefit.

Premiums

On average, 2023 monthly MA beneficiary premiums are approximately $2.50 lower for urban beneficiaries than for rural beneficiaries. However, the direction and magnitude of the difference varies by region, as shown in Figure 9. The difference between urban and rural premiums is highest in the Midwest and West regions, where the difference between the payment rates is the lowest (in Figure 4 above).

FIGURE 9: 2023 MONTHLY MA BENEFICIARY PREMIUM BY REGION, URBAN VS. RURAL

REGION	URBAN	RURAL	DIFFERENCE (URBAN – RURAL)
Northeast	$25.52	$23.55	$1.97
South	$6.99	$9.85	-$2.86
Midwest	$15.47	$19.73	-$4.26
West	$16.33	$24.47	-$8.14
Nationwide	$15.14	$17.68	-$2.54

These differences can be due to various factors, including underlying plan designs and their respective levels of benefits as well as overall medical costs, among others. Regional differences are volatile and may change more significantly year over year compared to nationwide values.

Supplemental benefits

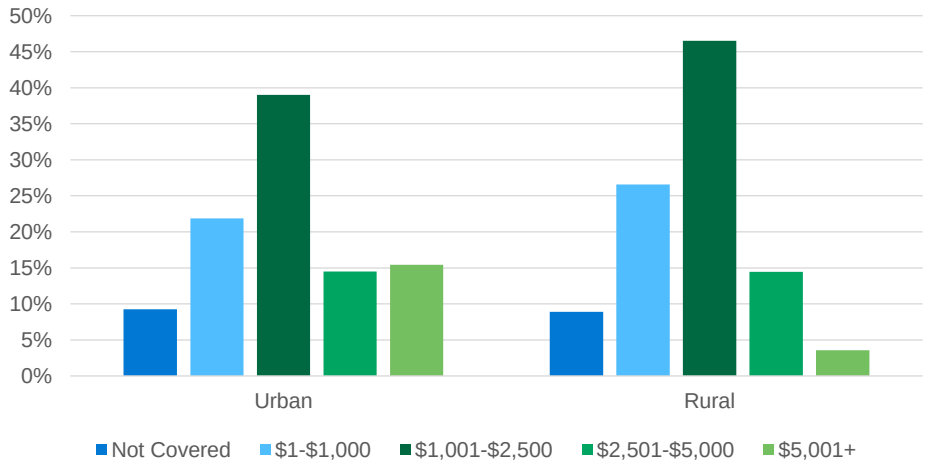
We also looked at differences in select supplemental benefit offerings—dental, vision hardware, nonemergency medical transportation, and over-the-counter (OTC) benefits.

We summarized the January 2023 membership distribution by 2023 supplemental benefit levels, including the proportion of members enrolled in a plan without the benefit. Figures 10 through 14 summarize our findings.

Dental

We only included a plan as having coverage if it had both preventive and comprehensive coverage. In other words, the "Not Covered" bucket includes plans with no dental at all, or only supplemental preventive dental coverage. When there were separate limits for preventive and comprehensive, we added the limits together to create one overall limit, which allows a broad analysis across individual and shared dental limits. Plans are grouped based on their total annual benefit allowances across both coverages. The $5,001+ category also includes plans that indicated unlimited coverage.

FIGURE 10: DISTRIBUTION OF BENEFICIARIES' 2023 DENTAL COVERAGE BY TOTAL ANNUAL DENTAL BENEFIT LIMIT, URBAN VS. RURAL, NATIONWIDE



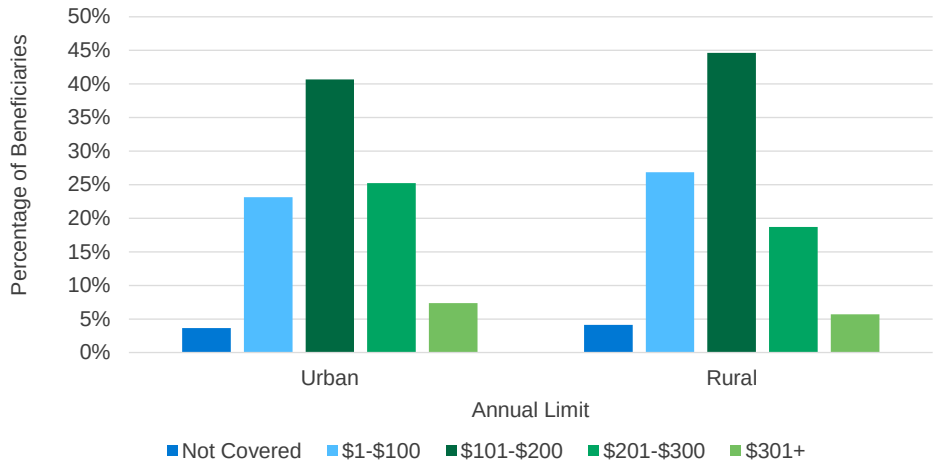
Approximately 10% of beneficiaries in both urban and rural areas are enrolled in a plan without both preventive and comprehensive dental coverage, indicated by the "Not Covered" bucket in Figure 10. For those who do have access to both coverages, a limit between $1,001 and $2,500 annually is the most commonly selected. Plans offering more than $5,000 in coverage are far more popular in urban areas than rural.

At the regional level, this pattern generally holds. The exception is coverage over $5,000, which is the most popular in the West urban areas and the least prevalent in Northeast and Midwest urban areas.

Vision hardware

To standardize these benefits across plans, we converted all limits to an annual basis. In other words, if a benefit is offered once every two years, we divided the limit by two and assumed half of the limit in one year.

FIGURE 11: DISTRIBUTION OF BENEFICIARIES' 2023 VISION HARDWARE COVERAGE BY TOTAL ANNUAL VISION HARDWARE BENEFIT LIMIT, URBAN VS. RURAL, NATIONWIDE



As shown in Figure 11, for both urban and rural areas the most popular vision hardware coverage is in the $101 to $200 annual range. Around 40% to 45% of urban and rural beneficiaries, respectively, are enrolled in plans with this level of annual vision hardware benefit limit. In urban areas, more beneficiaries are enrolled in richer benefits ($201 and higher) than leaner ($1 to $100). Conversely, in rural areas, more beneficiaries are in the leaner vision coverage of $1 to $100. Only approximately 4% of beneficiaries are in a plan with no vision hardware in both urban and rural areas.

At the regional level, this pattern is generally true as well, with the exception of the West urban areas, where $1 to $100 and $201 to $300 are more popular than $101 to $200.

Non-emergency medical transportation (NEMT)

We looked at the proportion of 2023 beneficiaries who are in a plan with an NEMT benefit in urban and rural areas across regions.

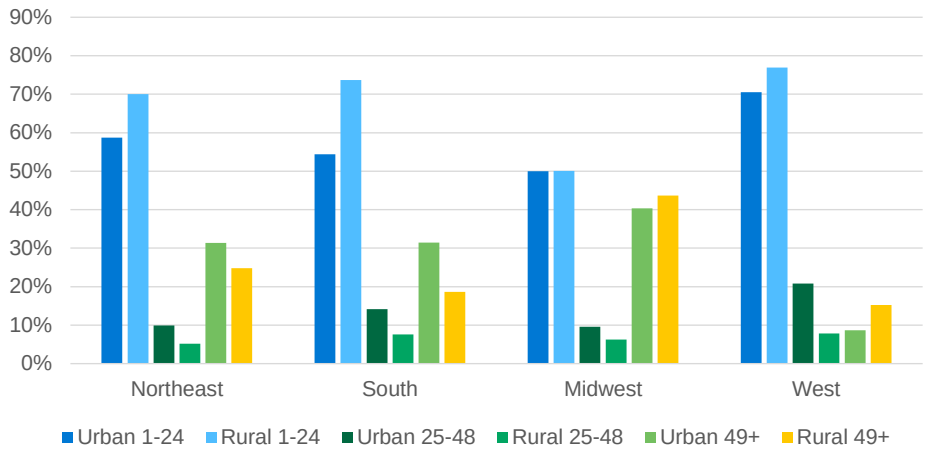
FIGURE 12: PROPORTION OF 2023 BENEFICIARIES IN A PLAN WITH AN NEMT BENEFIT, URBAN VS. RURAL, BY REGION

REGION	URBAN	RURAL
Northeast	36.8%	36.3%
South	51.8%	41.2%
Midwest	43.2%	30.1%
West	43.6%	31.0%

More beneficiaries in urban areas across all regions, as a proportion of the total, are in a plan with an NEMT benefit compared to rural areas. Typically, an NEMT benefit is contracted through vendors, which may not be as widely available in rural areas and may cause some of the differences above.

Next, we looked at the distribution of membership by trip limits in plans that had the benefit. Plans that indicated coverage of unlimited trips were included in the 49+ bucket.

FIGURE 13: DISTRIBUTION OF 2023 PLANS BY NEMT TRIP LIMITS AND REGION, URBAN VS. RURAL



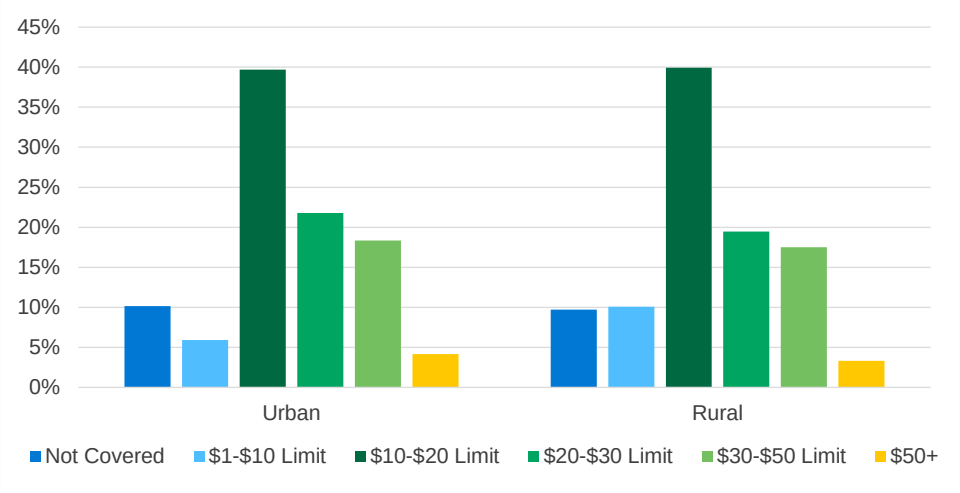
For all regions, both urban and rural, the most popular benefit limit is between one and 24 one-way trips per year. More than 49 one-way trips annually (including plans offering unlimited coverage) is also a popular option, with prevalence in rural areas being higher than urban areas in two of the four regions, Midwest and West.

This benefit is important, particularly for rural areas, where public transportation may not be available or easily accessible. Compared to 2022, we observed that significantly more beneficiaries in rural areas were in a plan with an NEMT benefit in 2023, with some regions seeing over 10% more beneficiaries having access to this benefit.

OTC benefit

We standardized all plans offering an OTC benefit to a monthly allowance basis, regardless of their actual frequency, to compare them on a consistent basis.

FIGURE 14: DISTRIBUTION OF BENEFICIARIES' 2023 OTC COVERAGE BY MONTHLY OTC BENEFIT LIMIT, URBAN VS. RURAL, NATIONWIDE



As shown in Figure 13, the distribution of beneficiaries' selection of benefits is similar across urban and rural areas. Approximately 10% of them do not have access to OTC benefits, and the most popular coverage option is between $10 and $20 per month.

This varies by region, where, in the Northeast, significantly more members are in plans with no OTC benefit, at around 25%, and, in the Midwest, under 5% of members have no OTC.

Conclusion

Across the country, Medicare Advantage (MA) enrollment is increasing significantly each year. However, the landscape of plans and MA penetration vary significantly across the country, particularly when looking by region and at urban versus rural areas. MAOs that decide to offer plans in rural areas with low MA penetration must consider whether the costs and risks outweigh the revenue and membership growth potential.

One of the biggest hurdles MAOs may need to overcome is the creation of an adequate provider network that meets the CMS network adequacy standards. Even though there is more leniency for rural areas in terms of time and distance standards, it may still prove challenging if there are sparse providers for each of the specialties required to begin with.

From a benefits perspective, in general, the distribution of members and their benefit levels are not significantly different between urban and rural areas for key supplemental benefits on a nationwide basis, although there do appear to be some differences at a regional level. An MAO that offers plans in rural areas should understand the current landscape as well as the needs of rural beneficiaries, and tailor those plan designs accordingly. This may include structuring plan designs to address both access to and availability of services. The design of a plan network would be the most crucial factor to help rural beneficiaries more easily access medical services.

As mentioned previously, in addition to the standard supplemental benefits the MA program has been introducing various benefit flexibilities for MAOs to tailor benefits to their specific populations, particularly offering nonmedical services such as food, technology, transportation, housing, and financial needs. These flexibilities, particularly value-based insurance design (VBID), special supplemental benefits for the chronically ill (SSBCI), and uniformity flexibility (UF), are also becoming increasingly prevalent. MAOs may want to consider utilizing them to structure benefit designs based on the specific needs of target populations in specific areas.

Methodology

As discussed throughout, we used a variety of sources to complete our analysis. We focused on January 2023 enrollment, published by CMS on January 13, 2023,[16] and 2023 plan year benefits, occasionally compared to 2022 enrollment and benefits. We limited our analysis to non-SNP individual plans, i.e., non-employer group waiver plans (non-EGWPs) that were either an HMO, HMO-POS, LPPO, or RPPO. We excluded MSA, PFFS, and cost plans as well as data from these U.S. territories: American Samoa, Guam, Puerto Rico, and the Virgin Islands.

The enrollment, MA penetration, and payment rates used are all publicly available and published by CMS.

For plan attributes, premiums, and detailed benefit information, we used the Milliman MACVAT®, which is developed from data released by CMS on all MA plans across the country. We supplemented our analysis with information from the Office of Management and Budget[17] for county-level indicators of urban and rural.

[16] In the original January 2023 enrollment file published by CMS on January 13, 2023, new or cross-walked contracts included low or no enrollment. These plans make up a small portion of the overall Medicare membership. We used this enrollment as is. The impact of any revised membership would have no material effect on the results of our analysis.

[17] U.S. Census Bureau. Delineation Files. Retrieved April 4, 2023, from https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html.

Caveats, Limitations, and Qualifications

Ali M. Heinrich, Sam R. Smetek, and Julia M. Friedman are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this paper is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The material in this paper represents the opinion of the authors and is not representative of the view of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views contained in this paper related to the Medicare Advantage program.

The information in this paper is designed to provide an overview of the 2023 Medicare Advantage landscape and plan offerings between urban and rural counties across the country. This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit any third party that receives this work product. Any third-party recipient of this paper that desires professional guidance should not rely upon Milliman's work product but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this paper to a third party should be in its entirety.

The credibility of certain comparisons provided in this paper may be limited, particularly where the number of plans in certain groupings is low. Some metrics may also be distorted by premium and benefits in a few plans with particularly high enrollment.

In preparing our analysis, we relied upon public information from CMS, which we accepted without audit. However, we did review it for general reasonableness. If this information is inaccurate or incomplete, conclusions drawn from it may change.

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