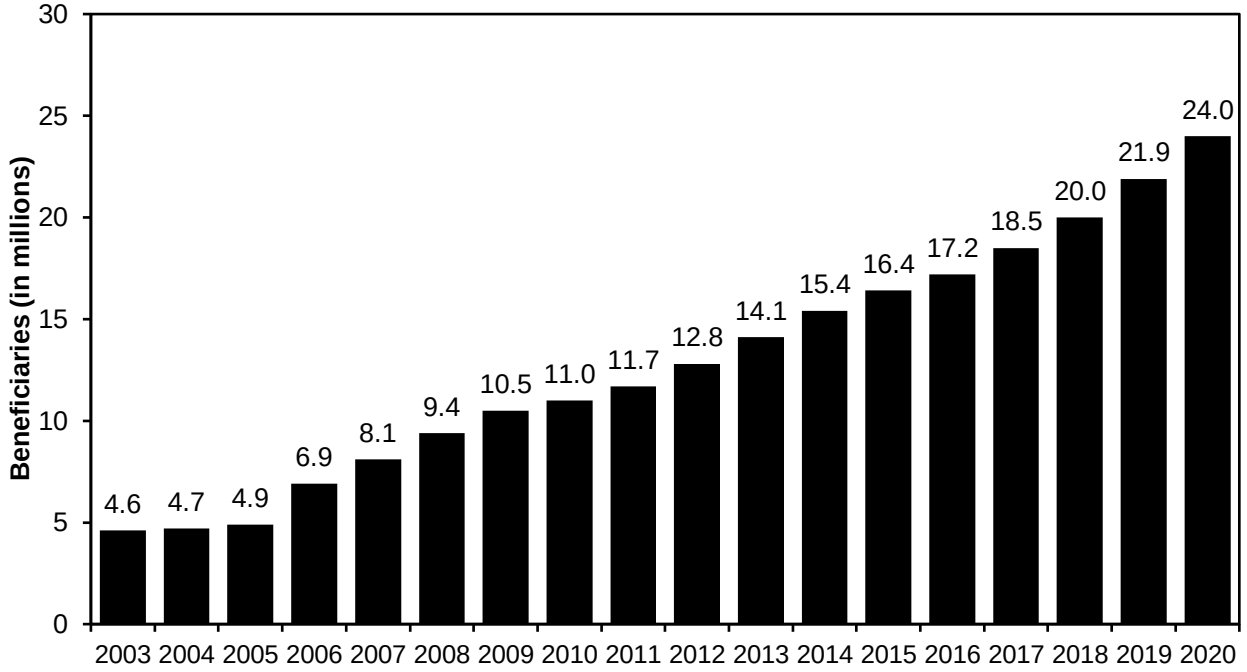
SECTION 9

Medicare Advantage

Chart 9-1. Enrollment in MA plans, 2003–2020



Note: MA (Medicare Advantage).

Source: CMS Medicare managed care contract reports and monthly summary reports, February 2003–2020.

- Historically, the Commission has used information on "Medicare eligibles" as the denominator in calculating the share of Medicare beneficiaries enrolled in Medicare Advantage (MA). "Medicare eligibles" include people previously, but no longer, covered by Medicare and people within 5 months of their 65th birthday. We now have data that allows us to calculate the share of MA enrollment as a share of Medicare beneficiaries with either Part A or Part B coverage and thus can calculate a more accurate MA enrollment percentage. The percentages published here supersede all prior estimates by the Commission of the share of Medicare beneficiaries enrolled in MA.
- Enrollment in MA plans that are paid on an at-risk capitated basis reached 24.0 million enrollees in February 2020. MA enrollment represents 39 percent of all 62.2 million Medicare beneficiaries (and 42 percent of all 56.5 million beneficiaries enrolled in both Part A and Part B). Medicare Advantage and other private plans account for 40 percent of all Medicare beneficiaries. (Other private plans consist of private fee-for-service plans, cost plans, Medicare medical savings account plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid plans participating in CMS's financial alignment demonstration.)
- MA enrollment has grown steadily since 2003, increasing more than fivefold. The Medicare program paid MA plans about $274 billion in 2019 to cover Part A and Part B services for MA enrollees (data not shown).

Chart 9-2. MA plans available to almost all Medicare beneficiaries, 2012–2020

	Share of Medicare beneficiaries living in counties with plans available					
	CCPs					
	HMO or local PPO (local CCP)	Regional PPO	Any CCP	PFFS	Any MA plan	Average plan offerings per beneficiary
2012	93%	76%	99%	60%	100%	19
2013	95	71	99	59	100	19
2014	95	71	99	53	100	18
2015	95	70	98	47	99	17
2016	96	73	99	47	99	18
2017	95	74	98	45	99	18
2018	96	74	98	41	99	20
2019	97	74	98	38	99	23
2020	98	73	99	36	99	27

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process (special needs plans, cost plans, employer-only plans, and certain demonstration plans).

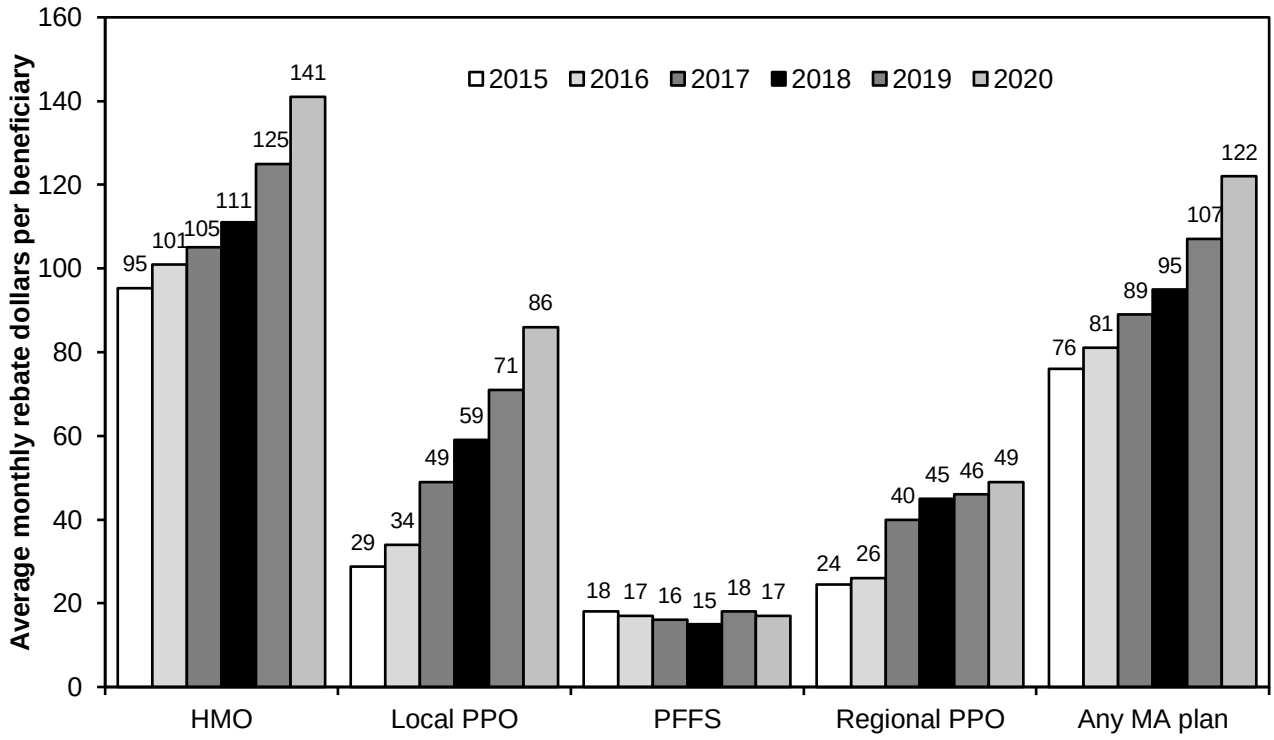
Source: MedPAC analysis of plan bid data from CMS, 2012–2020.

- There are four types of MA plans, three of which are CCPs. Local CCPs include HMOs and local PPOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional PPOs cover entire state-based regions and have networks that may be looser than those of local PPOs. These CCPs accounted for 97 percent of Medicare private plan enrollees as of February 2020 (data not shown). Since 2011, PFFS plans are required to have networks in areas with two or more CCPs. In other areas, PFFS plans are not required to have networks, and enrollees are free to use any Medicare provider.

- Local CCPs are available to 98 percent of Medicare beneficiaries in 2020, and regional PPOs are available to 73 percent of beneficiaries. Since 2006, almost all Medicare beneficiaries have had MA plans available (data not shown); 99 percent have an MA plan available in 2020.

- The number of plans from which beneficiaries may choose in 2020 is higher than at any time during the years examined. In 2020, beneficiaries can choose from an average of 27 plans operating in their counties.

Chart 9-3. Average monthly rebate dollars, by plan type, 2015–2020



Note: HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), MA (Medicare Advantage). Employer group waiver and special needs plans are excluded.

Source: MedPAC analysis of bid and plan finder data from CMS.

- Perhaps the best summary measure of plan benefit value is the average rebate, which plans receive to provide additional benefits. Plans are awarded rebates for bidding under their benchmarks. The rebates must be returned to the plan members in the form of extra benefits. The extra benefits may be lower cost sharing, supplemental benefits, or lower premiums. The average rebate for all non-employer, non–special needs plans rose to a high of $122 per month per beneficiary for 2020.

- HMOs have had, by far, the highest rebates because they tend to bid lower than other types of plans. Average rebates for HMOs have risen sharply over the past few years and are at a high of $141 per month per beneficiary for 2020.

- For both local and regional PPOs, the rebates rose sharply after 2016. Rebates for local PPOs have tripled since 2015.

- Rebates for PFFS plans have been relatively stable since 2015.

Chart 9-4. Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands) 2016	2017	2018	2019	2020	Percent change 2019–2020
Local CCPs	15,588	16,920	18,463	20,502	22,704	11%
Regional PPOs	1,315	1,353	1,327	1,255	1,170	–7
PFFS	238	190	154	118	87	–26

Note: CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). Local CCPs include HMOs and local PPOs.

Source: CMS health plan monthly summary reports, February 2016–2020.

- Enrollment in local CCPs grew by 11 percent over the past year. Enrollment in regional PPOs declined by 7 percent, and enrollment in PFFS plans dropped by 26 percent. Combined enrollment in the three types of plans grew by 10 percent from February 2019 to February 2020 (data not shown).

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2020

State or territory	All Medicare beneficiaries (in thousands)	Distribution (in percent) of enrollees by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	62,171	24%	13%	2%	0%	0%	39%
Alabama	1,054	21	23	1	0	0	45
Alaska	102	0	1	0	0	0	1
Arizona	1,342	35	7	1	0	0	43
Arkansas	641	16	5	7	1	0	29
California	6,350	40	3	0	0	0	43
Colorado	926	31	11	0	0	1	43
Connecticut	686	21	22	1	0	0	44
Delaware	211	8	10	0	0	0	18
Florida	4,608	32	12	5	0	0	49
Georgia	1,748	13	21	9	0	0	42
Hawaii	277	17	28	2	0	0	47
Idaho	340	22	14	0	0	0	37
Illinois	2,256	12	15	0	0	0	27
Indiana	1,271	14	19	2	0	0	35
Iowa	631	9	14	0	0	2	25
Kansas	540	8	12	0	1	0	21
Kentucky	935	14	20	3	0	1	38
Louisiana	880	35	6	1	0	0	41
Maine	342	22	16	1	0	0	39
Maryland	1,048	8	4	0	0	0	13
Massachusetts	1,344	16	7	1	0	0	24
Michigan	2,084	17	28	0	0	0	45
Minnesota	1,033	15	27	0	0	6	48
Mississippi	607	13	7	3	0	0	23
Missouri	1,238	24	12	3	0	0	40
Montana	233	9	11	0	0	0	20
Nebraska	350	12	6	0	1	1	20
Nevada	538	34	6	0	0	0	40
New Hampshire	303	10	9	2	0	0	21
New Jersey	1,630	15	17	0	0	0	32
New Mexico	427	21	17	0	0	0	39
New York	3,663	28	11	3	0	0	43
North Carolina	2,006	17	20	3	0	0	40
North Dakota	133	0	4	0	0	15	20
Ohio	2,359	25	17	1	0	0	43
Oklahoma	745	13	11	1	0	0	25
Oregon	874	31	17	0	0	0	47
Pennsylvania	2,756	27	17	0	0	0	44
Puerto Rico	752	78	2	0	0	0	80
Rhode Island	223	36	5	1	0	0	42
South Carolina	1,088	10	11	10	0	0	31
South Dakota	178	1	8	0	0	13	23
Tennessee	1,368	28	14	1	0	0	43
Texas	4,219	23	14	4	0	0	42
Utah	406	31	9	0	0	0	40
Vermont	149	5	5	4	0	0	14
Virgin Islands	20	0	0	0	0	0	1
Virginia	1,527	14	6	2	1	1	25
Washington	1,380	31	5	0	0	0	36
Washington, DC	94	8	13	0	0	0	22
West Virginia	441	4	29	1	1	4	38
Wisconsin	1,186	25	16	1	0	4	46
Wyoming	112	0	2	0	2	1	4

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports rather than bids to CMS. U.S. total includes beneficiaries in all outlying areas. Component percentages may not sum to totals due to rounding. In contrast with prior years, we report MA enrollment as a share of current Medicare beneficiaries. In prior years, we reported MA enrollment as a percentage of total Medicare eligibles, which included individuals who were (1) alive and ever enrolled but no longer in Medicare and (2) enrolled in Medicare with a future effective date.

Source: CMS enrollment and population data February 2020.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2020

	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	107%	107%	109%	105%	106%
Bids/FFS	88	87	94	91	105
Payments/FFS	100	100	104	97	105

Note: MA (Medicare Advantage), FFS (fee-for-service), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Data exclude employer plans, which do not submit plan bids but receive payment based on the bids and benchmarks of nonemployer plans.

Source: MedPAC analysis of plan bid data from CMS October 2019.

- Since 2006, plan bids have partly determined the Medicare payments that plans receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.

- The benchmark is an administratively determined bidding target. Benchmarks for each county are set by means of a statutory formula based on percentages (ranging from 95 percent to 115 percent) of each county's per capita Medicare FFS spending. Plans with quality ratings of 4 or more stars may have their benchmarks raised by 10 percent in some counties.

- If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare, and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it ranges from 50 percent to 70 percent. The plan must then return the rebate to its enrollees in the form of lower cost sharing, supplemental benefits, or lower premiums.

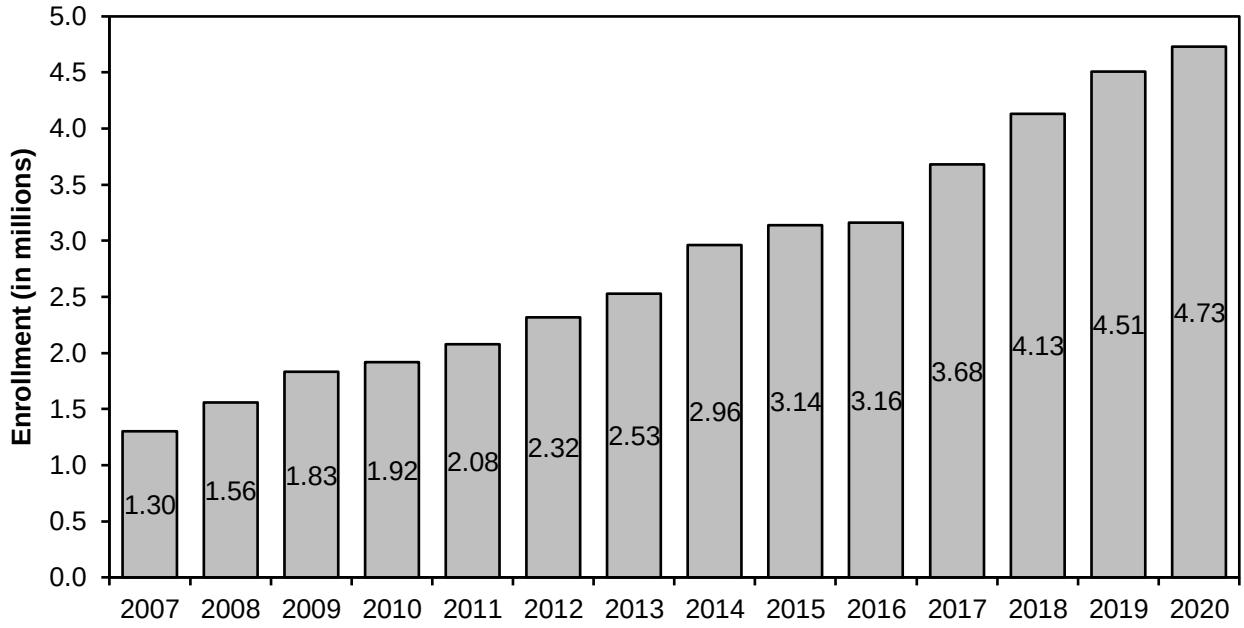
- We estimate that MA benchmarks average 107 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type because different types of plans tend to draw enrollment from different types of geographical areas.

- Plans' enrollment-weighted bids (excluding employer plans, which no longer submit bids) average 88 percent of FFS spending in 2020. On average, each coordinated care plan type (HMO, local PPO, regional PPO) has demonstrated the ability to provide the same services for less than FFS in the areas where they bid.

- We project that 2020 MA payments will be 100 percent of FFS spending. This figure does not include employer plans and does not account for risk-coding differences between FFS and MA plans that have not been resolved through the coding intensity factor. We estimate that coding differences add 2 percentage points to 3 percentage points to payments relative to FFS.

- The ratio of payments relative to FFS spending varies by the type of MA plan. HMO and regional PPO payments are estimated to be 100 and 97 percent of FFS, respectively, while payments to local PPOs and PFFS plans average 104 percent and 105 percent of FFS, respectively.

Chart 9-7. Enrollment in employer group MA plans, 2007–2020



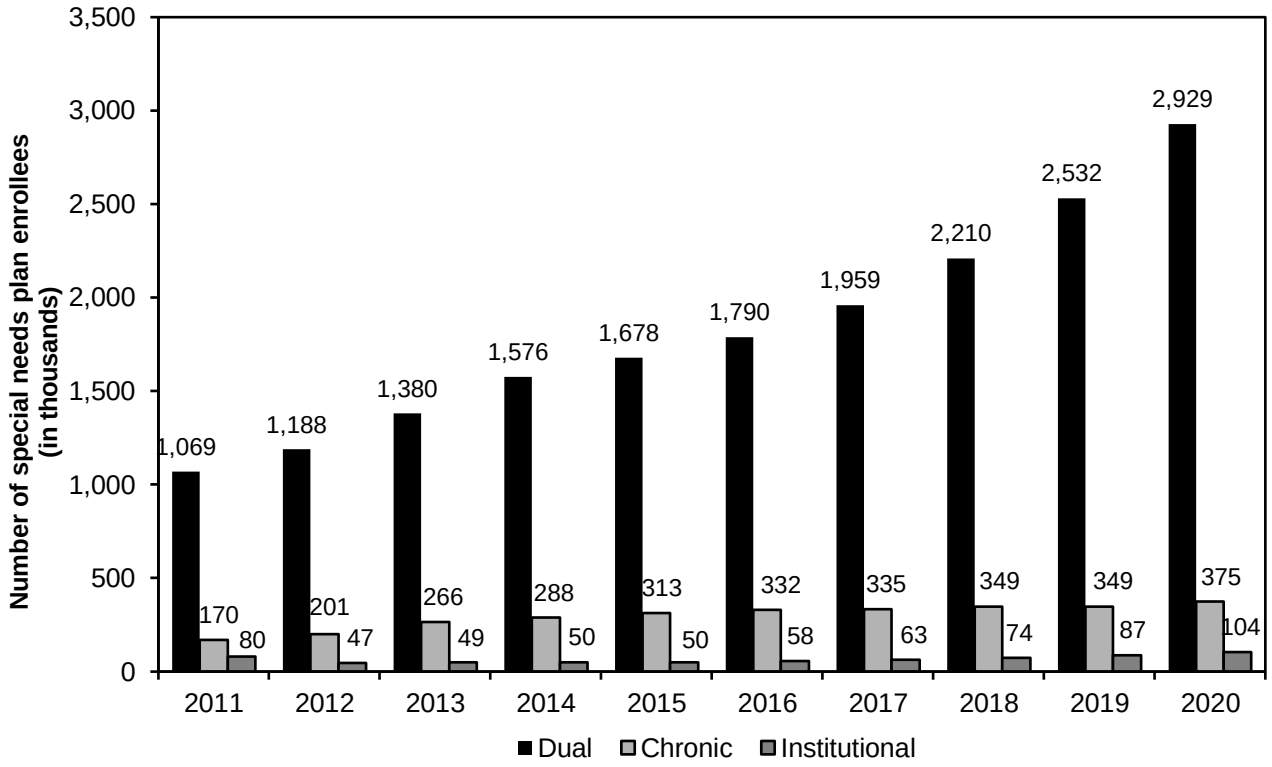
Note: MA (Medicare Advantage). Enrollment numbers are as of November for 2007 and February for 2008 through 2020.

Source: CMS enrollment data.

- While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.

- As of February 2020, about 4.7 million enrollees were in employer group plans, or about 20 percent of all MA enrollees. Employer plan enrollment grew by 5 percent from 2019 and has doubled since 2012.

Chart 9-8. Number of special needs plan enrollees, 2011–2020



Source: CMS special needs plans comprehensive reports, April 2011–2020.

- The Congress created special needs plans (SNPs) as a new MA plan type in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.

- SNPs were originally authorized for five years, but SNP authority was extended several times. The Bipartisan Budget Act of 2018 made SNPs permanent.

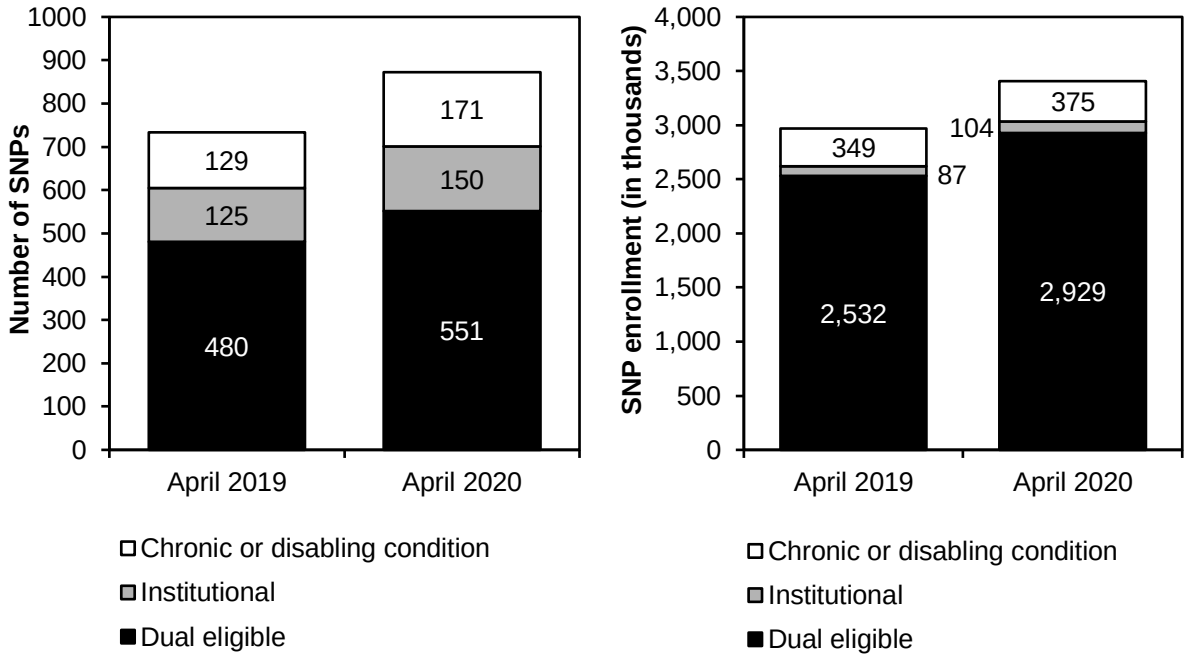
- CMS approves three types of SNPs: dual-eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing-home certified.

- Enrollment in dual-eligible SNPs has grown continuously and exceeds 2.9 million in 2020, doubling since 2013.

- Enrollment in chronic condition SNPs has fluctuated as plan requirements have changed but has generally risen annually since 2011.

- Enrollment in institutional SNPs has risen annually since 2015.

Chart 9-9. Number of SNPs and SNP enrollment rose from 2019 to 2020



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2019 and 2020.

- The number of SNPs increased by 19 percent from April 2019 to April 2020. Dual-eligible SNPs increased by 15 percent, institutional SNPs increased by 20 percent, and the number of chronic condition SNPs increased by 33 percent.

- In 2020, most SNPs (63 percent) are for dual-eligible beneficiaries, while 17 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need), and 20 percent are for beneficiaries with chronic conditions.

- From April 2019 to April 2020, the number of SNP enrollees increased by 15 percent. Enrollment in SNPs for dual eligibles grew by 16 percent, enrollment in SNPs for institutionalized beneficiaries grew by 19 percent, and enrollment in SNPs for chronic conditions grew by 7 percent. Enrollment in all SNPs has grown from 0.9 million in May 2007 (not shown) to 3.4 million in April 2020.

- The availability of SNPs varies by type of special needs population served (data not shown). In 2020, 90 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 89 percent in 2019), 67 percent live where SNPs serve institutionalized beneficiaries (up from 63 percent in 2019), and 52 percent live where SNPs serve beneficiaries with chronic conditions (up from 47 percent in 2019).

Chart 9-10. The share of Medicare beneficiaries in private plans does not differ substantially in medically underserved areas compared with other areas, but is somewhat lower in rural areas, 2020

	Medicare population (in millions)	As percent of Medicare population	Percent of category in MA and other private plans
All beneficiaries	**61.7**	**100%**	**40%**
County's medically underserved area designation			
Partial county	38.8	63	41
Entire county	10.9	18	38
No medically underserved areas	12.0	19	37
Urban influence code designation			
Metropolitan	44.5	72	43
Rural: Micropolitan	7.9	13	33
Rural: Adjacent to metropolitan	8.5	14	32
Rural: Not adjacent to metropolitan	0.7	1	23

Note: MA (Medicare Advantage). Beneficiaries in the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands or in foreign areas are excluded. MA plans consist of HMOs, local preferred provider organizations (PPOs), regional PPOs, private fee-for-service plans, and Medical Savings Account plans. Private plans include 0.7 million beneficiaries in non-MA private plans, which consist of Medicare–Medicaid plans, Program of All-Inclusive Care for the Elderly plans, and cost plans. Medically underserved areas (MUAs) are designated by the Health Resources and Services Administration (HRSA) as partial counties (census tracts and county subdivisions) or entire counties that disproportionately have a combination of indicators that may include a low number of primary care providers per 1,000 population, high infant mortality, high poverty, and a large elderly population. Urban influence codes (UICs) are designated by the Office of Management and Budget (OMB) by population size of the metro area, and nonmetropolitan counties by size of the largest city or town and proximity to metro and micropolitan areas (areas with a population of at least 10,000 people but fewer than 50,000). The UICs were last updated in 2013 and are updated every 10 years. Components may not sum to totals due to rounding.

Source: MedPAC analysis of HRSA MUAs, OMB UICs, and CMS enrollment data February 2020.

- In general, an MA plan's service area consists of one or more entire counties. (MA regional PPOs are required to cover entire regions, which consist of one or more states. In rare circumstances, MA "local" plans receive a waiver that allows them to serve only a portion of a county if the plan is able to prove that the demographic composition (e.g., income and race) of the portion of the county the plan intends to serve is not substantively different from the rest of the county.)

- We examined beneficiary access to MA plans and market share of MA plans by two geographic designations: MUAs and UICs.

(Chart continued next page)

Chart 9-10. The share of Medicare beneficiaries in private plans does not differ substantially in medically underserved areas compared with other areas, but is somewhat lower in rural areas, 2020 (continued)

- HRSA designates MUAs by census tract, county, or county subdivisions. HRSA designates MUAs based on a score of four combined indicators: (1) disproportionately low number of primary care providers per 1,000 people, (2) high infant mortality, (3) high poverty, and (4) a large elderly population. Part of a county may be designated as an MUA, the entire county may receive the designation, or the entire county may have no MUAs.

- The Office of Management and Budget UICs classify geographic areas as metropolitan, micropolitan, adjacent to metropolitan, and not adjacent to metropolitan; the latter three types of areas are considered rural. UICs distinguish metropolitan counties by the population size of their metro area and nonmetropolitan counties by the size of the largest city or town and proximity to metro and micropolitan areas (areas with a population of at least 10,000 people but fewer than 50,000). The UICs were last updated in 2013 and are updated every 10 years.

- Counties that have designated medically underserved areas (either partially or counties that are entirely composed of MUAs) have shares of MA enrollment similar to counties with no designated MUAs. The share of beneficiaries in MA and other private plans is the highest in counties partially designated as MUAs (41 percent). The proportion of Medicare beneficiaries in private plans located in counties that are designated entirely as MUAs (38 percent) is almost the same as counties that do not have any MUA designation (37 percent).

- Most (72 percent) of all 61.7 million Medicare beneficiaries live in metropolitan areas. The share of Medicare beneficiaries who live in metropolitan areas enrolled in MA and other private plans (43 percent) is higher than the share of rural beneficiaries enrolled in MA plans.

- Nearly all Medicare beneficiaries in rural areas reside in a micropolitan county or a county that is adjacent to a metropolitan area. Roughly one-third of Medicare beneficiaries in these areas are enrolled in MA and other private plans.

- About 1 percent of Medicare beneficiaries reside in a rural county that is not adjacent to a metropolitan area. Nearly one-quarter (23 percent) of these beneficiaries are enrolled in MA and other private plans.

Chart 9-11. MA and other private plan enrollment patterns do not differ by medically underserved area designation but do vary based on urban influence designation, 2020

	MA and private plan population (in millions)	As a percent of MA and private plan population	Percent of category			
			HMO	Local PPO	Regional PPO	Other private plans
All Medicare private plan enrollees	**24.7**	**100%**	**60%**	**32%**	**5%**	**3%**
County's medically underserved area designation						
Partial county	16.1	65	65	29	3	4
Entire county	4.2	17	52	35	12	2
No medically underserved areas	4.4	18	50	42	6	3
Urban influence code designation						
Metropolitan	19.2	78	66	28	3	3
Rural: Micropolitan	2.7	11	37	46	12	5
Rural: Adjacent to metropolitan	2.6	11	42	45	9	4
Rural: Not adjacent to metropolitan	0.2	1	28	49	13	10

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization). Beneficiaries in the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands or in foreign areas are excluded. MA plans consist of HMOs, local PPOs, regional PPOs, private fee-for-service plans, and Medical Savings Account plans. Private plans include 0.7 million beneficiaries in non-MA private plans, which consist of Medicare–Medicaid plans, Program of All-Inclusive Care for the Elderly plans, and cost plans. Medically underserved areas (MUAs) are designated by the Health Resources and Services Administration (HRSA) as partial counties (census tracts and county subdivisions) or entire counties that disproportionately have a combination of indicators that may include a low number of primary care providers per 1,000 population, high infant mortality, high poverty, and a large elderly population. Urban influence codes (UICs) are designated by the Office of Management and Budget (OMB) by population size of the metro area, and nonmetropolitan counties by size of the largest city or town and proximity to metro and micropolitan areas (areas with a population of at least 10,000 people but fewer than 50,000). The UICs were last updated in 2013 and are updated every 10 years. Components may not sum to totals due to rounding.

Source: MedPAC analysis of HRSA MUAs, OMB UICs, and CMS enrollment and population data February 2020.

- Local coordinated care plans (HMOs and local PPOs), which represent 92 percent of private plan enrollees, may choose which individual counties to serve. Regional PPOs (5 percent of all private plan enrollees) cover entire state-based regions.

- Enrollment by type of plan is not notably different between counties with different MUA designations. The proportion of enrollees in HMOs is similar for counties that are designated entirely as medically underserved areas (52 percent) compared with counties that do not have any medically underserved area designation (50 percent). The remainder of private plan enrollment in these areas is generally in either local or regional PPOs.

- HMOs account for the largest share of private plan enrollment in metropolitan areas (66 percent), but PPOs account for the largest share of private plan enrollment in rural areas (more than 50 percent combined between local PPOs and regional PPOs).

Chart 9-12. MA plans are available to nearly all beneficiaries in medically underserved and rural areas, 2020

		Share of Medicare beneficiaries living in counties with plans available in 2020					
			CCPs				
	As a percent of Medicare population	Any MA plan	HMO	Local PPO	HMO or local PPO	Regional PPO	Any CCP
All beneficiaries	**100%**	**99%**	**95%**	**93%**	**98%**	**73%**	**99%**
County's medically underserved area designation							
Partial county	63	99	98	93	99	69	99
Entire county	18	98	88	91	95	82	98
No medically underserved areas	19	98	94	95	97	81	98
Urban influence code designation							
Metropolitan	72	100	100	95	100	72	100
Rural: Micropolitan	13	97	87	90	94	71	97
Rural: Adjacent to metropolitan	14	96	84	88	92	81	96
Rural: Not adjacent to metropolitan	1	86	61	71	75	68	84

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization). These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process (special needs plans, cost plans, employer-only plans, Program of All-Inclusive Care for the Elderly, and certain demonstration plans). Medically underserved areas (MUAs) are designated by the Health Resources and Services Administration (HRSA) as partial counties (census tracts and county subdivisions) or entire counties that disproportionately have a combination of indicators that may include a low number of primary care providers per 1,000 population, high infant mortality, high poverty, and a large elderly population. Urban influence codes (UICs) are designated by the Office of Management and Budget (OMB) by population size of the metro area, and nonmetropolitan counties by size of the largest city or town and proximity to metro and micropolitan areas (areas with a population of at least 10,000 people but fewer than 50,000). The UICs were last updated in 2013 and are updated every 10 years. Components may not sum to totals due to rounding.

Source: MedPAC analysis of HRSA MUAs, OMB UICs, and CMS enrollment and population data February 2020.

- We examined the availability of MA plans to all Medicare beneficiaries. Consistent with prior work, we exclude employer plans and special needs plans. Although about one-third of MA enrollees are in these excluded plans, their availability is restricted to certain populations. In addition, we do not include other private plans such as cost plans.

- MA plans are available to nearly all Medicare beneficiaries, irrespective of whether beneficiaries reside in a county with a designated medically underserved area. Among counties that are designated entirely as medically underserved areas, 98 percent of beneficiaries have access to an MA plan.

- Nearly all Medicare beneficiaries residing in metropolitan areas have access to an MA plan.

- Nearly all beneficiaries in rural counties have access to an MA plan. Between 96 percent and 97 percent of beneficiaries in micropolitan counties or those adjacent to a metropolitan area have access to an MA plan. Among the 1 percent of Medicare beneficiaries residing in a rural county that is not adjacent to a metropolitan area, 86 percent have access to an MA plan.

Chart 9-13. Most Medicare beneficiaries have access to a considerable number of MA plans, but rural beneficiaries and beneficiaries in counties composed entirely of MUAs typically have fewer plans from which to choose, 2020

	As a percent of Medicare population	Average plan offerings per beneficiary	Share of Medicare beneficiaries living in counties with an available zero-premium plan with drug coverage
All beneficiaries	**100%**	**27**	**93%**
County's medically underserved area designation			
Partial county	63	30	93
Entire county	18	18	91
No medically underserved areas	19	25	95
Urban influence code designation			
Metropolitan	72	31	96
Rural: Micropolitan	13	16	82
Rural: Adjacent to metropolitan	14	16	85
Rural: Not adjacent to metropolitan	1	9	65

Note: MA (Medicare Advantage), MUA (medically underserved area). These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process (special needs plans, cost plans, employer-only plans, and certain demonstration plans). MUAs are designated by the Health Resources and Services Administration (HRSA) as partial counties (census tracts and county subdivisions) or entire counties that disproportionately have a combination of indicators that may include a low number of primary care providers per 1,000 population, high infant mortality, high poverty, and a large elderly population. Urban influence codes (UICs) are designated by the Office of Management and Budget (OMB) by population size of the metro area, and nonmetropolitan counties by size of the largest city or town and proximity to metro and micropolitan areas (areas with a population of at least 10,000 people but fewer than 50,000). The UICs were last updated in 2013 and are updated every 10 years.

Source: MedPAC analysis of HRSA MUAs, OMB UICs, and CMS enrollment and population data February 2020.

- In 2020, the average beneficiary has 27 plans from which to choose in his or her county.
- On average, beneficiaries residing in counties that are designated entirely as medically underserved areas have fewer MA plans from which to choose, but still have an average of 18 plans available to them. About 91 percent of beneficiaries in these counties have a zero-premium plan with drug coverage available.
- On average, Medicare beneficiaries residing in metropolitan areas have more MA plans from which to choose (an average of 31 plan choices) compared with beneficiaries in rural areas. Nevertheless, the average beneficiary in micropolitan counties or those adjacent to a metropolitan area can choose among an average of 16 plans. Beneficiaries residing in rural counties that are not adjacent to a metropolitan area (1 percent of all beneficiaries) have 9 plans from which to choose, on average.
- At least one zero-premium plan with drug coverage is available to most beneficiaries (93 percent). Availability of these plans in rural areas is somewhat less prevalent than in metropolitan areas. In metropolitan areas, 96 percent of beneficiaries have access to a zero-premium plan. In comparison, over 80 percent of beneficiaries in micropolitan counties or those adjacent to a metropolitan area have access to a zero-premium plan. In rural counties that are not adjacent to a metropolitan area, 65 percent of beneficiaries have an available zero-premium plan.

Chart 9-14. Twenty most common condition categories among MA beneficiaries, as defined in the CMS–HCC model, 2018

Conditions (defined by HCC)	Percent of beneficiaries with listed condition	Percent of beneficiaries with listed condition and no others
Diabetes with chronic complications	19.7%	3.6%
Vascular disease	18.7	2.2
COPD	14.0	1.7
CHF	11.6	0.5
Specified heart arrhythmias	11.4	1.3
Major depressive, bipolar, and paranoid disorders	11.3	1.9
Diabetes without complications	8.5	3.1
Morbid obesity	8.5	1.0
Rheumatoid arthritis and inflammatory connective tissue disease	6.5	1.1
Breast, prostate, colorectal, and other cancers and tumors	5.1	1.3
Coagulation defects and other specified hematological disorders	4.8	0.4
Angina pectoris	4.0	0.3
Drug/alcohol dependence	3.6	0.3
Other significant endocrine and metabolic disorders	3.5	0.3
Acute renal failure	3.4	0.1
Cardio-respiratory failure and shock	2.5	0.0
Seizure disorders and convulsions	2.5	0.3
Ischemic or unspecified stroke	2.2	0.1
Septicemia, sepsis, systemic inflammatory response syndrome/shock	1.8	0.0
Hemiplegia/Hemiparesis	1.6	0.1

Note: MA (Medicare Advantage), CMS–HCC (CMS–hierarchical condition category), COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure).

Source: MedPAC analysis of Medicare data files from Acumen LLC.

- CMS uses the CMS–HCC model to risk adjust capitated payments to MA plans so that payments better reflect the clinical needs of MA enrollees given the number and severity of their clinical conditions. The CMS–HCC model uses beneficiaries' conditions, which are collected into HCCs, to adjust the capitated payments.
- Diabetes with chronic complications is the most common HCC, and over 28 percent of MA enrollees are in at least one of the two diabetes HCCs.

Chart 9-15. Medicare private plan enrollment patterns, by age and Medicare–Medicaid dual-eligible status, December 2018

	As percent of Medicare population	Percent of category in FFS	Percent of category in private plans
All beneficiaries	**100%**	**65%**	**35%**
Aged (65 or older)	85	64	36
Under 65	15	68	32
Non–dual eligible	**82**	**66**	**34**
Aged (65 or older)	74	65	35
Under 65	8	69	31
Dual eligible	**18**	**60**	**40**
Aged (65 or older)	11	56	44
Under 65	7	67	33
Dual-eligible beneficiaries by category (all ages)			
Full dual eligibility	**13**	**65**	**35**
Beneficiaries with partial dual eligibility			
QMB only	3	53	47
SLMB only	2	48	52
QI	1	46	54

Note: FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualified individual). The Medicare population includes beneficiaries who have either Part A coverage or Part B coverage. Dual-eligible beneficiaries are eligible for Medicare and Medicaid. See accompanying text for an explanation of the categories of dual-eligible beneficiaries. "Plans" include Medicare Advantage plans as well as cost-reimbursed plans. Data exclude Puerto Rico because of the inability to determine specific dual-eligible categories. As of December 2018, Puerto Rico had 579,000 Medicare beneficiaries enrolled in private plans. Dual-eligible special needs plans in Puerto Rico had 281,000 enrollees in December 2018. Figures may not sum to totals due to rounding.

Source: MedPAC analysis of 2018 denominator and common Medicare environment files and CMS monthly Medicare Advantage reports.

- Medicare plan enrollment among the dually eligible continues to increase. In 2018, 40 percent of dual-eligible beneficiaries were in Medicare private plans, up from 36 percent in 2017.

- A substantial share of dual-eligible beneficiaries (40 percent (not shown in table)) are under the age of 65 and entitled to Medicare on the basis of disability or end-stage renal disease. Regardless of dual-eligibility status, beneficiaries under age 65 are less likely than aged beneficiaries to enroll in Medicare private plans (32 percent vs. 36 percent, respectively).

- Dual-eligible beneficiaries who have full dual eligibility—that is, those who have coverage for their Medicare out-of-pocket costs (premiums and cost sharing) as well as coverage for services such as long-term care services and supports—are less likely to enroll in private Medicare plans than beneficiaries with "partial" dual eligibility. Full dual-eligibility categories consist of beneficiaries with coverage through state Medicaid programs as well as certain QMBs and SLMBs who also have Medicaid coverage for services. The latter two categories are referred to as QMB-Plus and SLMB-Plus beneficiaries. Beneficiaries with partial dual eligibility have coverage for Medicare premiums (through the QI or SLMB program) or premiums and Medicare cost sharing, in the case of the QMB program. SLMB-only and QI beneficiaries have higher rates of plan enrollment (52 percent and 54 percent, respectively) than any other category shown in this chart, and the rates are higher than the average rate (35 percent) across all Medicare beneficiaries.