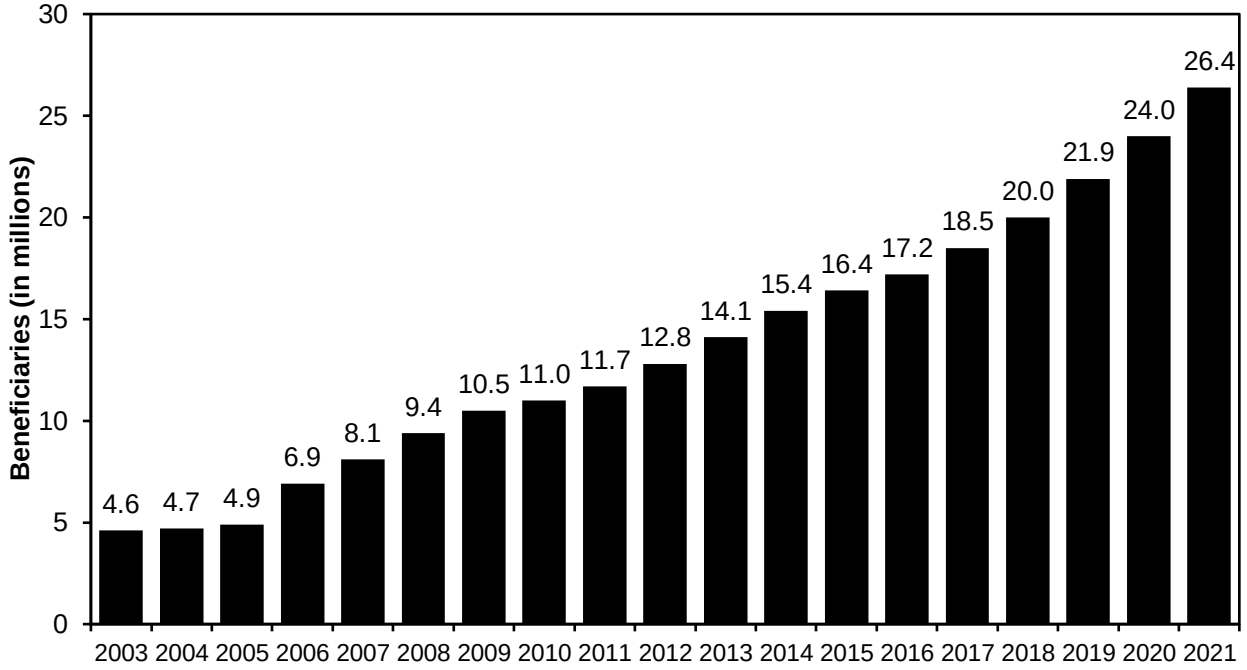
SECTION 9

Medicare Advantage

Chart 9-1. Enrollment in MA plans, 2003–2021



Note: MA (Medicare Advantage).

Source: CMS Medicare managed care contract reports and monthly summary reports, February 2003–2021.

- Enrollment in MA plans that are paid on an at-risk capitated basis reached 26.4 million enrollees in February 2021. MA enrollment represents 46 percent of all 57.7 million Medicare beneficiaries eligible to enroll in an MA plan (beneficiaries enrolled in both Part A and Part B). Other private plans account for an additional 1 percent of all Medicare beneficiaries with both Part A and Part B coverage. (Other private plans consist of cost 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 nearly sixfold) and has grown particularly rapidly in recent years: In each of the last three years, MA enrollment has grown by 10 percent. The Medicare program paid MA plans about $317 billion in 2020 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, 2013–2021

	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
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
2021	98	72	99	34	99	32

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).

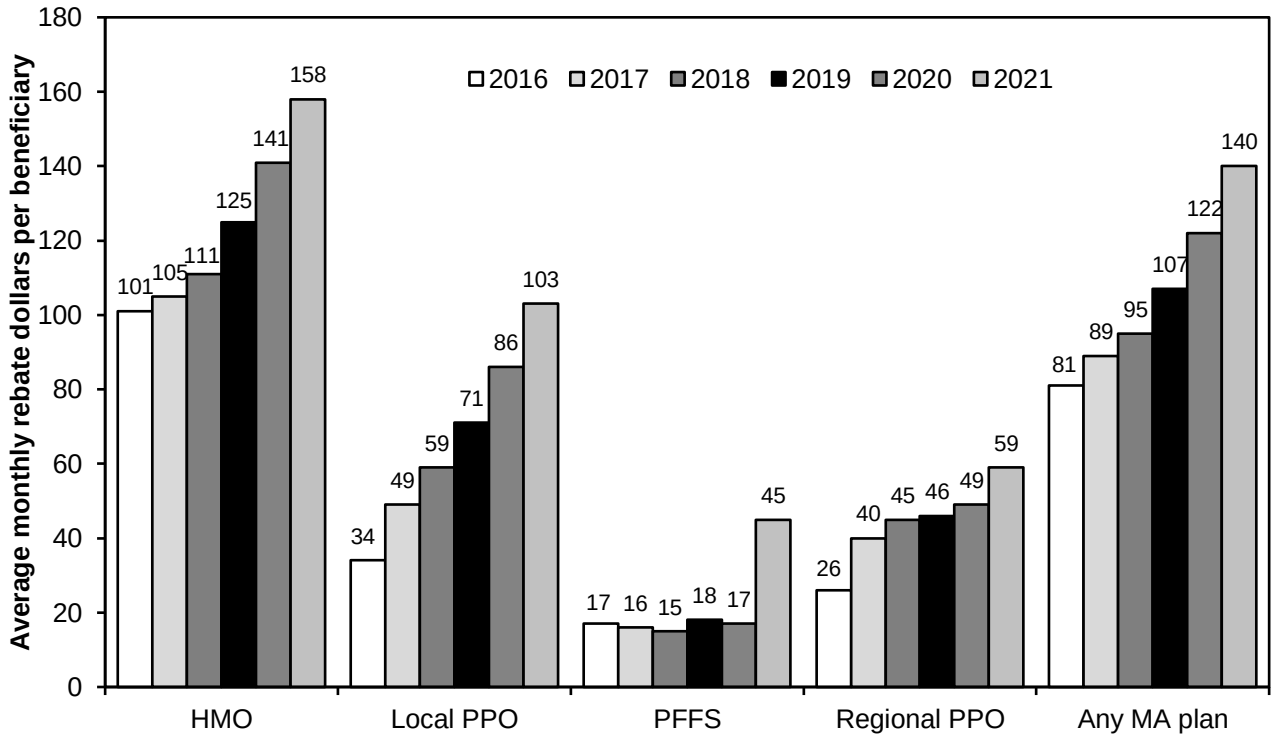
Source: MedPAC analysis of plan bid data from CMS, 2013–2021.

- 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. CCPs accounted for 97 percent of Medicare private plan enrollees as of February 2021 (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 2021, and regional PPOs are available to 72 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 2021.

- The number of plans from which beneficiaries may choose in 2021 is higher than at any time during the years examined. In 2021, beneficiaries can choose from an average of 32 plans operating in their counties.

Chart 9-3. Average monthly rebate dollars, by plan type, 2016–2021



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 $140 per month per beneficiary for 2021.

- 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 historical high of $158 per month per beneficiary for 2021.

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

- While the availability of PFFS plans continues to decline, rebates for PFFS plans rose sharply in 2021—reflecting both higher benchmarks and lower bids relative to benchmarks among remaining PFFS plans. Overall rebates for PFFS plans are susceptible to greater year-to-year changes as the number of enrollees in these plans becomes smaller.

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

Plan type	Total enrollees (in thousands) 2017	2018	2019	2020	2021	Percent change 2020–2021
Local CCPs	16,920	18,463	20,502	22,704	25,325	12%
Regional PPOs	1,353	1,327	1,255	1,170	1,003	–14
PFFS	190	154	118	87	61	–30

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 2017–2021.

- Enrollment in local CCPs grew by 12 percent over the past year. Enrollment in regional PPOs declined by 14 percent, and enrollment in PFFS plans dropped by 30 percent. Combined enrollment in the three types of plans grew by 10 percent from February 2020 to February 2021 (data not shown).

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2021

State or territory	All MA-eligible beneficiaries (in thousands)	Distribution (in percent) of enrollees by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	57,550	28%	16%	2%	0%	0%	46%
Alabama	985	26	28	1	0	0	54
Alaska	94	0	2	0	0	0	2
Arizona	1,267	39	10	1	0	0	49
Arkansas	601	19	8	7	1	0	36
California	5,782	47	4	0	0	0	51
Colorado	862	36	14	0	0	0	50
Connecticut	631	23	29	1	0	0	53
Delaware	202	11	13	0	0	0	24
Florida	4,434	35	15	4	0	0	54
Georgia	1,641	15	28	8	0	0	51
Hawaii	248	21	33	2	0	0	57
Idaho	330	27	16	0	0	0	43
Illinois	2,069	14	19	0	0	0	34
Indiana	1,200	17	24	2	0	0	43
Iowa	599	12	15	0	0	2	30
Kansas	507	8	17	1	1	0	27
Kentucky	873	20	24	2	0	1	46
Louisiana	827	40	8	1	0	0	50
Maine	324	27	21	2	0	0	50
Maryland	923	11	7	0	0	0	18
Massachusetts	1,229	18	10	1	0	0	29
Michigan	1,986	20	32	0	0	0	53
Minnesota	980	17	33	0	0	6	56
Mississippi	573	18	10	2	0	0	31
Missouri	1,161	27	17	3	0	0	47
Montana	222	10	14	0	0	0	25
Nebraska	328	14	10	0	1	2	26
Nevada	498	41	8	0	0	0	48
New Hampshire	280	12	15	1	0	0	28
New Jersey	1,466	16	23	0	0	0	39
New Mexico	396	25	21	0	0	0	46
New York	3,354	32	15	4	0	0	50
North Carolina	1,921	21	22	4	0	0	47
North Dakota	124	0	6	0	0	18	24
Ohio	2,209	29	19	1	0	0	49
Oklahoma	691	15	17	1	0	0	33
Oregon	826	34	19	0	0	0	53
Pennsylvania	2,553	30	20	0	0	0	51
Puerto Rico	653	92	2	0	0	0	94
Rhode Island	201	41	8	0	0	0	50
South Carolina	1,043	13	17	8	0	0	38
South Dakota	167	1	10	0	0	16	27
Tennessee	1,293	32	16	0	0	0	49
Texas	3,953	28	18	4	0	0	50
Utah	381	36	11	0	0	0	48
Vermont	141	7	9	4	0	0	21
Virgin Islands	18	0	28	0	0	0	28
Virginia	1,406	20	9	2	0	0	32
Washington	1,291	34	8	0	0	0	43
Washington, DC	78	11	19	0	0	0	30
West Virginia	414	5	35	1	1	4	45
Wisconsin	1,137	28	19	1	0	4	52
Wyoming	106	0	2	0	2	1	6

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 U.S. territories. Component percentages and U.S. total may not sum to totals due to rounding. In contrast with prior years, we report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage). In prior years, we reported MA enrollment as a percentage of total Medicare beneficiaries.

Source: CMS enrollment and population data February 2021.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2021

	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	108%	108%	109%	99%	107%
Bids/FFS	87	86	92	87	100
Payments/FFS	101	100	103	94	104

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. All numbers in this table have been risk adjusted and reflect quality bonuses, but they have not been adjusted for coding intensity differences between MA and FFS that exceed the statutory minimum adjustment. Payments for all MA plans would average 104 percent of FFS spending if coding differences were fully reflected. The FFS spending denominator used in the table includes all Part A and Part B spending. MA payments relative to spending for FFS enrollees with both Part A and Part B would decrease by about 1 percentage point.

Source: MedPAC analysis of plan bid data from CMS October 2020.

- 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.

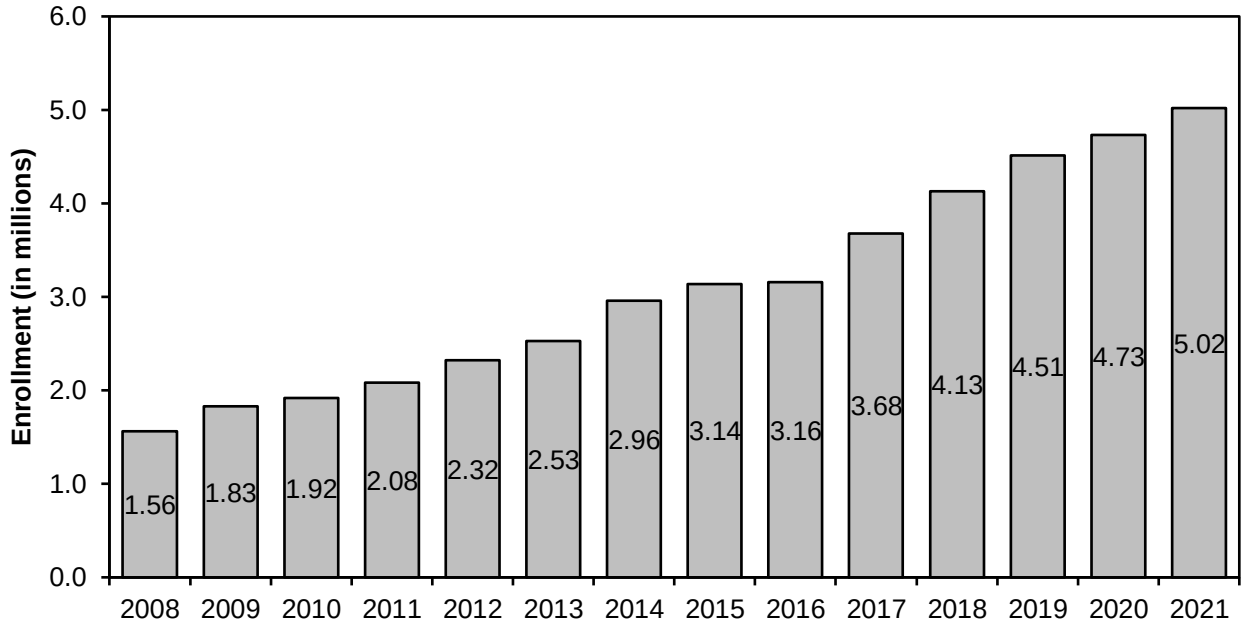
- We estimate that MA benchmarks average 108 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type, which draws enrollment from different geographic areas.

- Plans' enrollment-weighted bids average 87 percent of FFS spending in 2021. 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.

- Plan bid data indicate that 2021 MA payments will be 101 percent of FFS spending, but 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 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 percent and 94 percent of FFS, respectively, while payments to local PPOs and PFFS plans average 103 percent and 104 percent of FFS, respectively.

Chart 9-7. Enrollment in employer group MA plans, 2008–2021



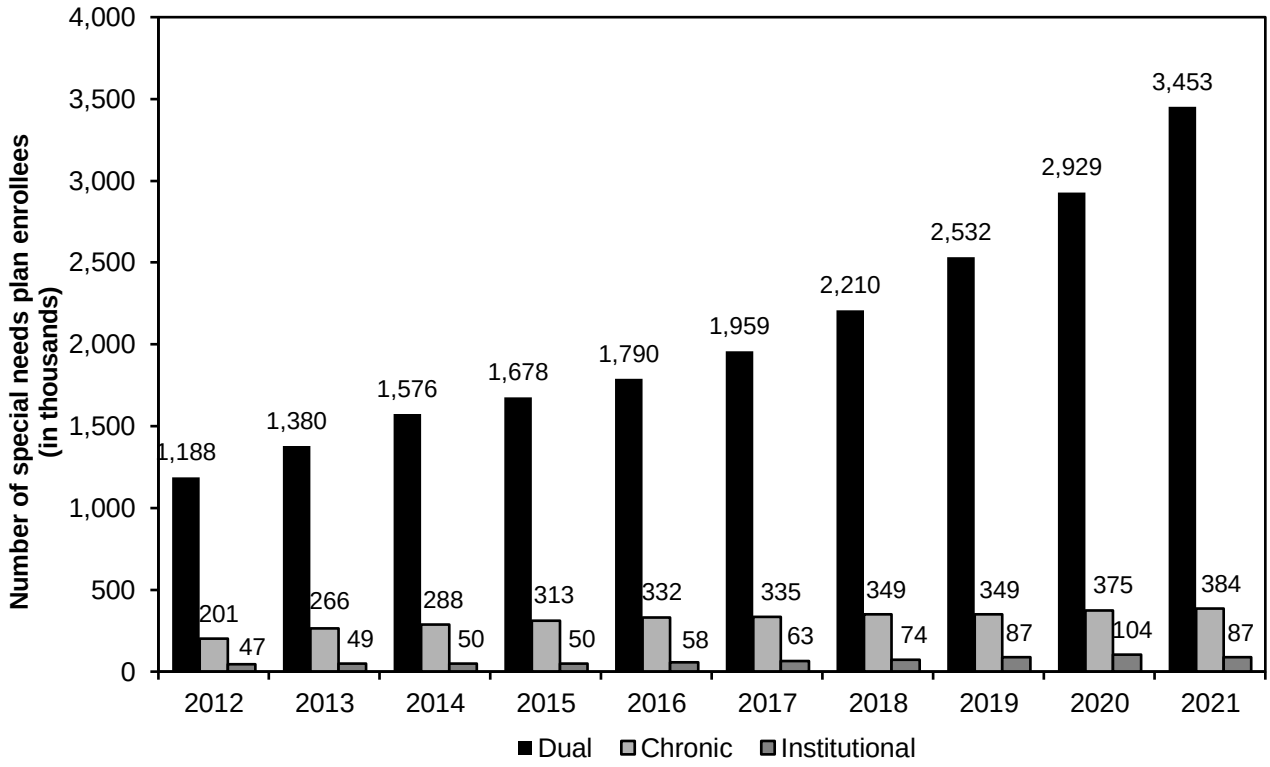
Note: MA (Medicare Advantage).

Source: CMS enrollment data, February 2008–2021.

- 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 2021, about 5.0 million enrollees were in employer group plans, or about 19 percent of all MA enrollees. Employer plan enrollment grew by 6 percent from 2020 and has more than doubled since 2012.

Chart 9-8. Number of special needs plan enrollees, 2012–2021



Source: CMS special needs plans comprehensive reports, April 2012–2021.

- 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.

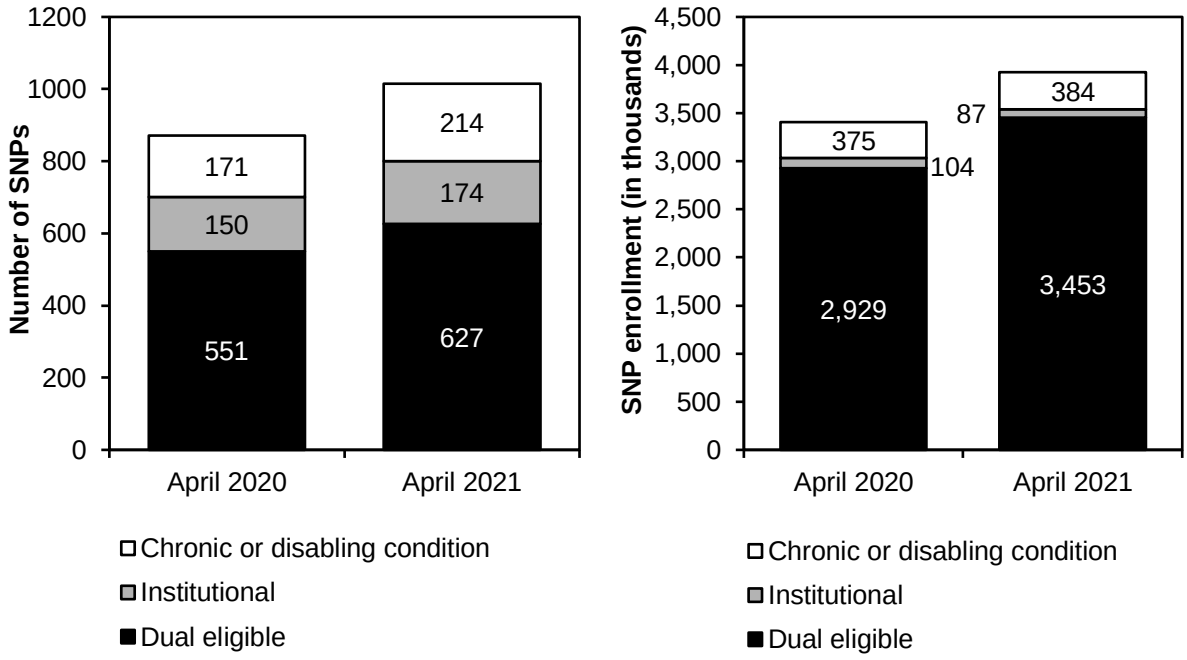
- CMS approves three types of SNPs: dual-eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or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

- Enrollment in dual-eligible SNPs has grown continuously and exceeds 3.4 million in 2021, more than doubling since 2014.

- Enrollment in chronic condition SNPs has grown at varying rates as plan requirements have changed, but it has generally risen annually since 2012.

- Enrollment in institutional SNPs declined in 2021, returning to its 2019 level.

Chart 9-9. Number of SNPs and SNP enrollment rose from 2020 to 2021



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2020 and 2021.

- The number of SNPs increased by 16 percent from April 2020 to April 2021. Dual-eligible SNPs increased by 14 percent, institutional SNPs increased by 16 percent, and the number of chronic condition SNPs increased by 25 percent.

- In 2021, most SNPs (62 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 21 percent are for beneficiaries with chronic conditions.

- From April 2020 to April 2021, the number of SNP enrollees increased by 15 percent. Enrollment in SNPs for dual-eligible beneficiaries grew by 18 percent, enrollment in SNPs for institutionalized beneficiaries declined by 16 percent, and enrollment in SNPs for beneficiaries with certain chronic conditions grew by 2 percent. Enrollment in all SNPs has grown from 0.9 million in May 2007 (not shown) to 3.9 million in April 2021.

- The availability of SNPs varies by type of special needs population served (data not shown). In 2021, 92 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 90 percent in 2020), 72 percent live where SNPs serve institutionalized beneficiaries (up from 67 percent in 2020), and 57 percent live where SNPs serve beneficiaries with chronic conditions (up from 52 percent in 2020).

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 lower in rural areas, 2021

	MA-eligible population (in millions)	As percent of MA-eligible population	Share of MA-eligible population category in MA plans
All beneficiaries	**57.5**	**100%**	**46%**
County's medically underserved area designation			
Partial county	35.9	62	47
Entire county	10.3	18	45
No medically underserved areas	11.3	20	43
Urban influence code designation			
Metropolitan	47.2	82	48
Rural: Micropolitan	5.8	10	37
Rural: Adjacent to metropolitan	2.8	5	36
Rural: Not adjacent to metropolitan	1.7	3	29

Note: MA (Medicare Advantage). Beneficiaries in the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands or in non-U.S. 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. In contrast with prior years, we report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage). In prior years, we reported MA enrollment as a share of total Medicare beneficiaries. 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 such as 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 the population size of the 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. Components may not sum to totals due to rounding.

Source: MedPAC analysis of HRSA MUAs, OMB UICs, and CMS enrollment data February 2021.

- 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 lower in rural areas, 2021 (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 (with both Part A and Part B coverage) in MA plans is the highest in counties partially designated as MUAs (47 percent). The proportion of Medicare beneficiaries in MA plans located in counties that are designated entirely as MUAs (45 percent) is almost the same as counties that do not have any MUA designation (43 percent).

- Most (82 percent) of all 57.5 million Medicare beneficiaries eligible for MA enrollment live in metropolitan areas. The share of Medicare beneficiaries who live in metropolitan areas enrolled in MA plans (48 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. More than one-third of Medicare beneficiaries in these areas are enrolled in MA plans. From 2020 to 2021, MA enrollment in these rural areas grew faster compared with metropolitan areas (16 percent compared with 9 percent; data not shown).

- About 3 percent of Medicare beneficiaries reside in a rural county that is not adjacent to a metropolitan area. More than one-quarter (29 percent) of these beneficiaries are enrolled in MA plans. From 2020 to 2021, MA enrollment in these areas grew by 19 percent (data not shown).

Chart 9-11. MA enrollment patterns do not differ by medically underserved area designation but do vary based on urban influence designation, 2021

	MA population (in millions)	As a percent of MA population	Share of category			
			HMO	Local PPO	Regional PPO	Other MA plans
All Medicare private plan enrollees	**26.4**	**100%**	**60%**	**36%**	**4%**	**<0.5%**
County's medically underserved area designation						
Partial county	16.9	64	65	32	2	<0.5
Entire county	4.6	17	52	38	9	<0.5
No medically underserved areas	4.9	18	50	45	4	<0.5
Urban influence code designation						
Metropolitan	22.8	86	64	33	3	<0.5
Rural: Micropolitan	2.2	8	41	50	9	1
Rural: Adjacent to metropolitan	1.1	4	37	50	12	1
Rural: Not adjacent to metropolitan	0.5	2	32	55	12	2

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 non-U.S. areas are excluded. MA plans consist of HMOs, local PPOs, regional PPOs, private fee-for-service plans, and Medical Savings Account plans. In contrast with prior years, we report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage). In prior years, we reported MA enrollment as a percentage of total Medicare beneficiaries. 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 such as 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 the population size of the 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. Components may not sum to totals due to rounding.

Source: MedPAC analysis of HRSA MUAs, OMB UICs, and CMS enrollment and population data February 2021.

- Local coordinated care plans (HMOs and local PPOs), which represent 96 percent of private plan enrollees, may choose which individual counties to serve. Regional PPOs (4 percent of all MA enrollees) cover entire state-based regions.

- Enrollment by type of plan is not notably different among 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 MA plan enrollment in metropolitan areas (64 percent), but PPOs account for the largest share of MA plan enrollment in rural areas (more than 60 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, 2021

	As a share of MA-eligible population	Share of Medicare beneficiaries living in counties with plans available in 2021					
			CCPs				
		Any MA plan	HMO	Local PPO	HMO or local PPO	Regional PPO	Any CCP
All MA-eligible beneficiaries	**100%**	**99%**	**97%**	**95%**	**98%**	**74%**	**99%**
County's medically underserved area designation							
Partial county	63	99	98	95	99	69	99
Entire county	18	99	92	94	96	83	99
No medically underserved areas	19	98	96	96	98	81	98
Urban influence code designation							
Metropolitan	82	>99.5	99	96	>99.5	73	>99.5
Rural: Micropolitan	10	97	89	91	94	77	96
Rural: Adjacent to metropolitan	5	97	89	91	95	83	96
Rural: Not adjacent to metropolitan	3	90	73	77	82	71	88

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization). These data do not include the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, non-U.S. areas, and they do not include MA plans that have restricted enrollment (special needs plans, employer-only plans). In contrast with prior years, we report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage) rather than as a share of all Medicare beneficiaries. As a result, regional PPO availability slightly increased compared with using all Medicare beneficiaries as our denominator. 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 such as 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 the population size of the 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.

Source: MedPAC analysis of HRSA MUAs, OMB UICs, and CMS enrollment and population data February 2021.

- We examined the availability of MA plans to all MA-eligible 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, 99 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. About 97 percent of beneficiaries in micropolitan counties or those adjacent to a metropolitan area have access to an MA plan. Among the 3 percent of Medicare beneficiaries residing in a rural county that is not adjacent to a metropolitan area, 90 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, 2021

	As a share of MA-eligible 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%**	**32**	**96%**
County's medically underserved area designation			
Partial county	63	35	97
Entire county	18	22	94
No medically underserved areas	19	29	96
Urban influence code designation			
Metropolitan	82	34	98
Rural: Micropolitan	10	19	88
Rural: Adjacent to metropolitan	5	18	91
Rural: Not adjacent to metropolitan	3	13	76

Note: MA (Medicare Advantage), MUA (medically underserved area). These data do not include the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, non-U.S. areas, and MA plans that have restricted enrollment (special needs plans, employer-only 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 such as 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 the population size of the 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.

Source: MedPAC analysis of HRSA MUAs, OMB UICs, and CMS enrollment and population data February 2021.

- In 2021, the average beneficiary has 32 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 22 plans available to them. About 94 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 34 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 19 plans. Beneficiaries residing in rural counties that are not adjacent to a metropolitan area (3 percent of all beneficiaries) have 13 plans from which to choose, on average.
- At least one zero-premium plan with drug coverage is available to most beneficiaries (96 percent). Availability of these plans in rural areas is somewhat less prevalent than in metropolitan areas. In metropolitan areas, 98 percent of beneficiaries have access to a zero-premium plan. In comparison, about 90 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, 76 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, 2019

Conditions (defined by HCC)	Share of beneficiaries with listed condition
Vascular disease	21.9%
Diabetes with chronic complications	21.7
COPD	15.0
Major depressive, bipolar, and paranoid disorders	14.3
CHF	13.0
Specified heart arrhythmias	12.2
Morbid obesity	10.3
Chronic kidney disease, moderate (stage 3)	8.9
Rheumatoid arthritis and inflammatory connective tissue disease	7.9
Diabetes without complications	6.9
Coagulation defects and other specified hematological disorders	6.5
Breast, prostate, colorectal, and other cancers and tumors	5.2
Substance abuse disorder, moderate/severe, or substance use with complications	5.1
Other significant endocrine and metabolic disorders	4.9
Angina pectoris	4.3
Acute renal failure	3.8
Cardio-respiratory failure and shock	3.0
Seizure disorders and convulsions	2.7
Ischemic or unspecified stroke	2.4
Septicemia, sepsis, systemic inflammatory response syndrome/shock	2.1

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

Source: MedPAC analysis of Medicare risk score files.

- 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.
- Vascular disease 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. MA enrollment patterns, by age, Medicaid dual-eligible status, and ESRD status, June 2020

	All MA eligible		FFS		MA		MA enrollment as a share of all MA-eligible category
	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	
Total	**55.4**	**100%**	**31.8**	**100%**	**23.7**	**100%**	**43%**
Aged (65 or older)	47.7	86	27.2	86	20.5	87	43
Under 65	7.7	14	4.5	14	3.2	13	41
Non–dual eligible	**45.1**	**81**	**26.3**	**83**	**18.9**	**80**	**42**
Aged (65 or older)	41.5	75	24.2	76	17.3	73	42
Under 65	3.6	7	2.0	6	1.6	7	44
Full dual eligibility	**7.1**	**13**	**4.2**	**13**	**2.9**	**12**	**40**
Aged (65 or older)	4.2	8	2.3	7	1.9	8	45
Under 65	2.9	5	1.9	6	1.0	4	33
Partial dual eligibility	**3.2**	**6**	**1.3**	**4**	**1.9**	**8**	**60**
Aged (65 or older)	2.0	4	0.7	2	1.3	5	64
Under 65	1.2	2	0.6	2	0.6	3	53
	Enrollment subcategories, all ages						
ESRD	**0.5**	**1**	**0.4**	**1**	**0.1**	**<0.5**	**23**
Beneficiaries with partial dual eligibility							
QMB only	1.6	3	0.7	2	0.9	4	58
SLMB only	1.0	2	0.4	1	0.6	3	61
QI	0.6	1	0.2	1	0.4	1	62

Note: MA (Medicare Advantage), ESRD (end-stage renal disease), FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualified individual). Data exclude cost plans, plans under the Program of All-Inclusive Care for the Elderly, and Medicare–Medicaid Plans participating in CMS's financial alignment demonstration. MA-eligible beneficiaries are Medicare beneficiaries with both Part A and Part B coverage. Dual-eligible beneficiaries are eligible for Medicare and Medicaid. Data exclude Puerto Rico because enrollment data undercount dual-eligible categories. As of June 2020, Puerto Rico had nearly 600,000 Medicare beneficiaries enrolled in MA plans, and 276,000 were enrolled in dual-eligible special needs plans. Figures may not sum to totals due to rounding.

Source: MedPAC analysis of 2020 common Medicare environment files.

- Medicare beneficiaries with Medicaid benefits 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 MA plans than beneficiaries with "partial" dual eligibility. Fully dual-eligible beneficiaries are those with coverage through state Medicaid programs including certain QMBs (i.e., QMB-Plus) and certain SLMBs (i.e., SLMB-Plus) who also have Medicaid coverage for services. Beneficiaries with partial dual eligibility (such as QIs or SLMBs) have coverage for Medicare premiums or premiums and Medicare cost sharing (as QMBs).

- Medicare plan enrollment among the dually eligible continues to increase. In 2020, 40 percent of full duals were in MA plans (up from 36 percent in 2019; data not shown), and 60 percent of partial dual-eligible beneficiaries were in MA plans (up from 53 percent in 2019; data not shown). QI beneficiaries have the highest rates of MA enrollment among partial duals (62 percent).

- A substantial share of the dually eligible (40 percent; data not shown) are under the age of 65 and entitled to Medicare on the basis of disability or ESRD. Beneficiaries under age 65 who are fully dual eligible are far less likely than aged fully dual-eligible beneficiaries to enroll in MA (33 percent vs. 45 percent, respectively). As a result, a similar share of MA enrollees is fully dual-eligible compared with FFS enrollees (13 percent vs. 12 percent, respectively).

- Before 2021, individuals with ESRD were largely prohibited from joining an MA plan during open enrollment, although they could remain in their current plan or join an ESRD chronic condition special needs plan. Therefore, ESRD beneficiaries had relatively low rates of plan enrollment in 2020 (23 percent).