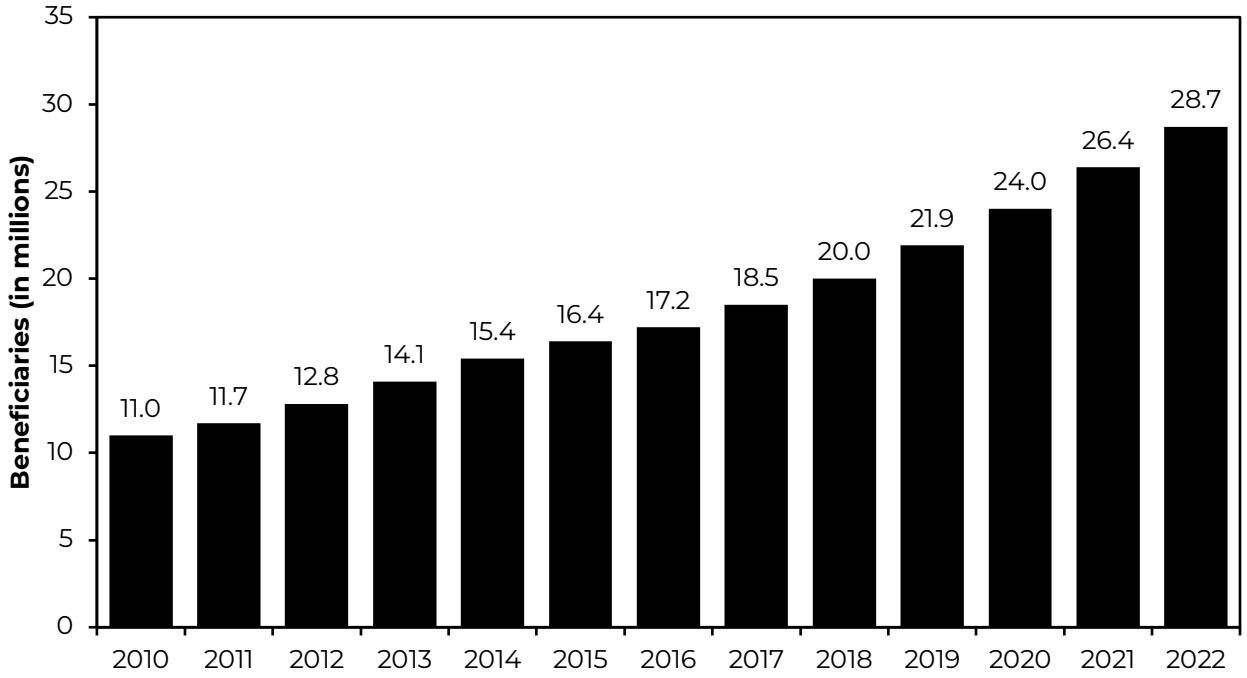
SECTION 9

Medicare Advantage

Chart 9-1. Enrollment in MA plans, 2010–2022



Note: MA (Medicare Advantage).

Source: CMS Medicare managed care contract reports and monthly summary reports, February 2010–2022.

- In February 2022, enrollment in MA plans, which are paid on an at-risk capitated basis, reached 28.7 million, or 49 percent of all eligible Medicare beneficiaries (only beneficiaries enrolled in both Part A and Part B are eligible to enroll in an MA plan). An additional 1 percent of all Medicare beneficiaries with both Part A and Part B coverage are enrolled in other private plans such as 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 (data not shown).
- MA enrollment has grown steadily since 2010 (increasing nearly threefold) and has grown particularly rapidly in recent years: In each of the last four years, MA enrollment has grown by at least 9 percent. The Medicare program paid MA plans about $350 billion in 2021 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, 2015–2022

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
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
2022	99	74	99	35	99	36

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 (special needs plans, employer plans) or are not paid based on MA rates (cost plans and certain demonstration plans). For 2015 through 2021, "share of Medicare beneficiaries" includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). For 2022, the share of Medicare beneficiaries includes only beneficiaries with both Part A and Part B coverage (i.e., MA-eligible beneficiaries).

Source: MedPAC analysis of plan bid data from CMS, 2015–2022.

- There are four types of MA plans, three of which are coordinated care plans (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 one or more entire states and have networks that may be looser than those of local PPOs. CCPs accounted for 98 percent of Medicare private plan enrollees as of February 2022 (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 99 percent of eligible Medicare beneficiaries in 2022, and regional PPOs are available to 74 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 2022.

- The number of plans from which beneficiaries may choose in 2022 is higher than at any time during the years examined. In 2022, beneficiaries can choose from an average of 36 plans operating in their counties.

Chart 9-3. Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands) 2018	2019	2020	2021	2022	Percent change 2021–2022
Local CCPs	18,463	20,502	22,704	25,325	27,878	10%
Regional PPOs	1,327	1,255	1,170	1,003	756	–25
PFFS	154	118	87	61	48	–21

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 2018–2022.

- Almost all MA enrollees (98 percent) choose local CCPs (HMOs or local PPOs), which limit or discourage use of out-of-network providers. Enrollment in local CCPs grew by 10 percent over the past year.
- Though network requirements may be looser in regional PPOs and PFFS plans, enrollment in both types of plans has been declining for several years and dropped sharply in 2022, with enrollment in regional PPOs falling by 25 percent and enrollment in PFFS plans falling by 21 percent.
- Combined enrollment in the three types of plans grew by 9 percent from February 2021 to February 2022 (data not shown).

Chart 9-4. MA and cost plan enrollment by state and type of plan, 2022

State or territory	All MA-eligible beneficiaries (in thousands)	Distribution (in percent) of beneficiaries by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	58,591	29%	19%	1%	0%	0%	49%
Alabama	996	27	30	0	0	0	58
Alaska	97	0	2	0	0	0	2
Arizona	1,299	38	13	0	0	0	52
Arkansas	608	20	16	3	1	0	40
California	5,883	48	4	0	0	0	52
Colorado	885	36	17	0	0	0	53
Connecticut	643	21	34	1	0	0	56
Delaware	209	13	15	0	0	0	29
Florida	4,558	36	18	2	0	0	56
Georgia	1,678	16	34	5	0	0	55
Hawaii	255	22	36	1	0	0	59
Idaho	341	29	17	0	0	0	46
Illinois	2,095	14	22	0	0	0	37
Indiana	1,219	19	26	1	0	0	47
Iowa	610	14	16	0	0	2	33
Kansas	517	9	20	1	1	0	31
Kentucky	881	24	25	2	0	1	51
Louisiana	838	43	10	1	0	0	54
Maine	332	30	24	1	0	0	55
Maryland	939	13	9	0	0	0	21
Massachusetts	1,250	18	13	1	0	0	31
Michigan	2,013	21	35	0	0	0	57
Minnesota	1,003	17	36	0	0	6	59
Mississippi	579	21	13	2	0	0	36
Missouri	1,180	27	22	1	0	0	51
Montana	228	9	18	0	0	0	27
Nebraska	336	14	13	0	0	2	30
Nevada	511	42	9	0	0	0	52
New Hampshire	288	13	18	1	0	0	32
New Jersey	1,486	14	27	0	0	0	41
New Mexico	403	26	24	0	0	0	50
New York	3,395	32	17	3	0	0	53
North Carolina	1,964	24	23	4	0	0	51
North Dakota	128	0	10	0	0	19	29
Ohio	2,239	32	19	1	0	0	52
Oklahoma	702	16	21	1	0	0	38
Oregon	839	34	21	0	0	0	55
Pennsylvania	2,588	30	22	0	0	0	53
Puerto Rico	663	93	1	0	0	0	95
Rhode Island	205	42	11	0	0	0	54
South Carolina	1,073	13	25	4	0	0	42
South Dakota	172	1	12	0	0	18	31
Tennessee	1,314	34	17	0	0	0	52
Texas	4,058	30	19	3	0	0	53
Utah	393	37	14	0	0	0	51
Vermont	144	6	19	3	0	0	29
Virgin Islands	19	1	29	0	0	0	29
Virginia	1,434	23	11	2	0	0	36
Washington	1,320	35	11	0	0	0	46
Washington, DC	78	11	22	0	0	0	33
West Virginia	414	7	38	1	0	4	50
Wisconsin	1,164	29	21	1	0	4	55
Wyoming	110	0	5	0	2	1	8

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. We report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage).

Source: CMS enrollment and population data, February 2022.

Chart 9-5. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2022

	All plans	HMOs	Local PPOs	Regional PPOs	All plans after coding estimate
Benchmarks/FFS	108%	108%	109%	97%	112%
Bids/FFS	85	84	89	84	88
Payments/FFS	100	100	102	92	104

Note: MA (Medicare Advantage), FFS (fee-for-service), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Employer plans do not submit plan bids and generally receive payment based on the bidding behavior of PPOs. Thus, employer plans are included only in the overall "Payments/FFS." All numbers in this table have been risk adjusted and reflect quality bonuses. To account for our most recent coding estimate of 3.6 percent, we estimated overall benchmarks, bids, and payments if coding differences between MA and FFS were fully reflected (i.e., if the risk-adjusted differences between MA and FFS did not include coding differences). The FFS spending denominator used in the table includes all Part A and Part B spending. Overall 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 2021.

- 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 a bidding target in each county that is 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 typically have their benchmarks raised by 5 percent (and up to 10 percent in some counties).

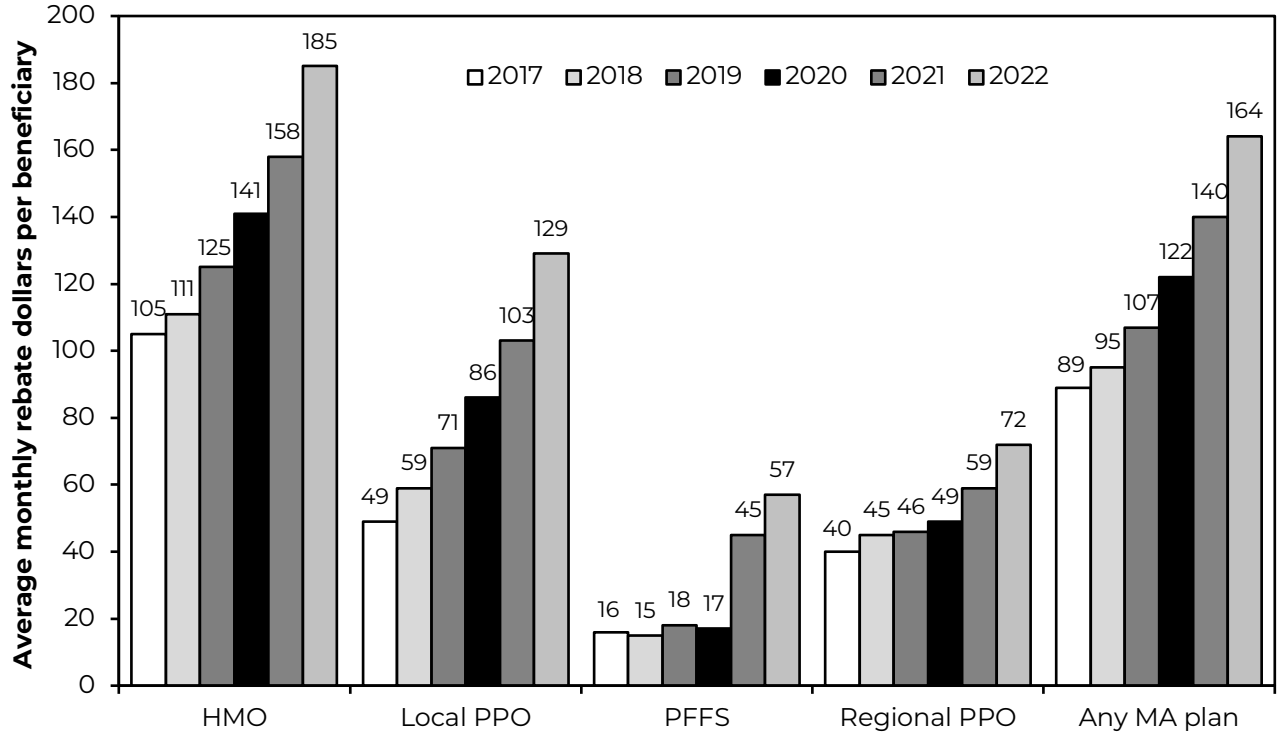
- If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it is typically 65 percent or 70 percent. After accounting for administrative expenses and profit, plans must return rebates to 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 85 percent of FFS spending in 2022. On average, each coordinated care plan type (HMO, local PPO, and regional PPO) has demonstrated the ability to provide the same services for less than FFS in the areas where they bid.

- After accounting for risk-coding differences between FFS and MA plans that have not been resolved through the coding intensity factor, we estimate that MA payments are 4 percent higher than spending for similar beneficiaries in FFS.

Chart 9-6. Average monthly rebate dollars, by plan type, 2017–2022



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 data from CMS.

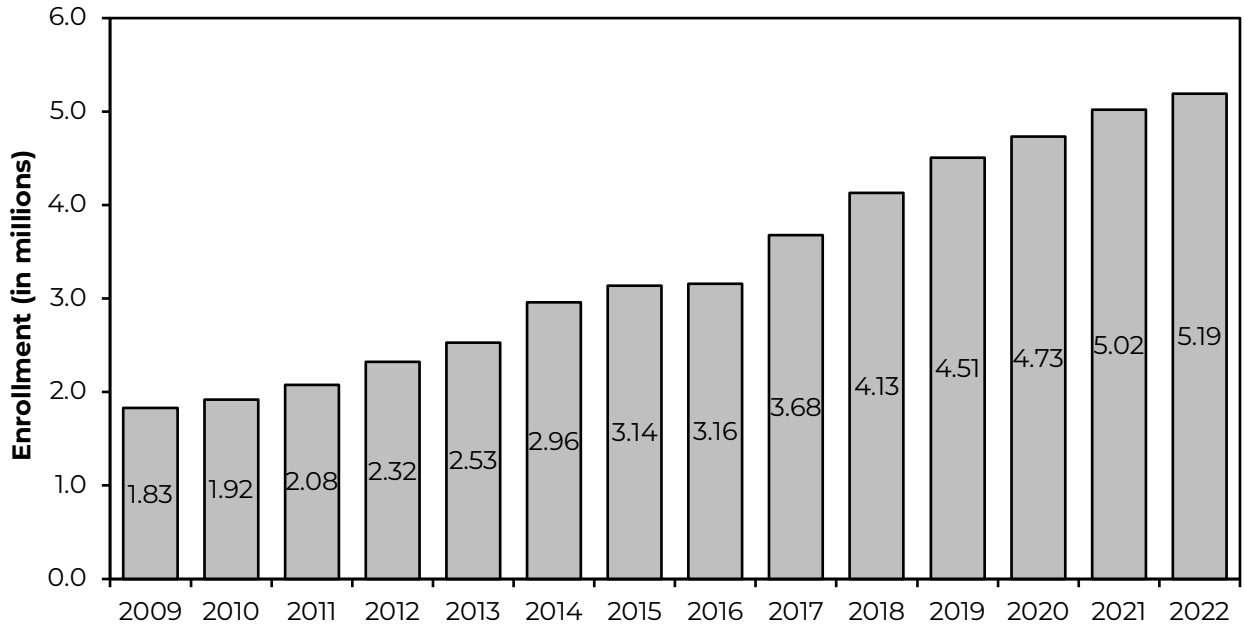
- Perhaps the best summary measure of plan benefit value is the average rebate, which plans receive to provide additional benefits that are not covered under Medicare Part A and Part B. Plans are awarded rebates for bidding under their benchmarks. The rebates must be returned to the plan members in the form of extra benefits (after accounting for plan margins and administrative costs). The extra benefits may be lower cost sharing, supplemental benefits, or lower premiums. The average rebate for all nonemployer, non–special needs plans rose to a high of $164 per month per beneficiary for 2022.

- 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 $185 per month per beneficiary for 2022.

- For local PPOs, rebates have risen sharply in recent years, more than doubling since 2018.

- While the availability of PFFS plans is relatively low, rebates for PFFS plans rose sharply in 2022 among the relatively small number of PFFS plans.

Chart 9-7. Enrollment in employer group MA plans, 2009–2022



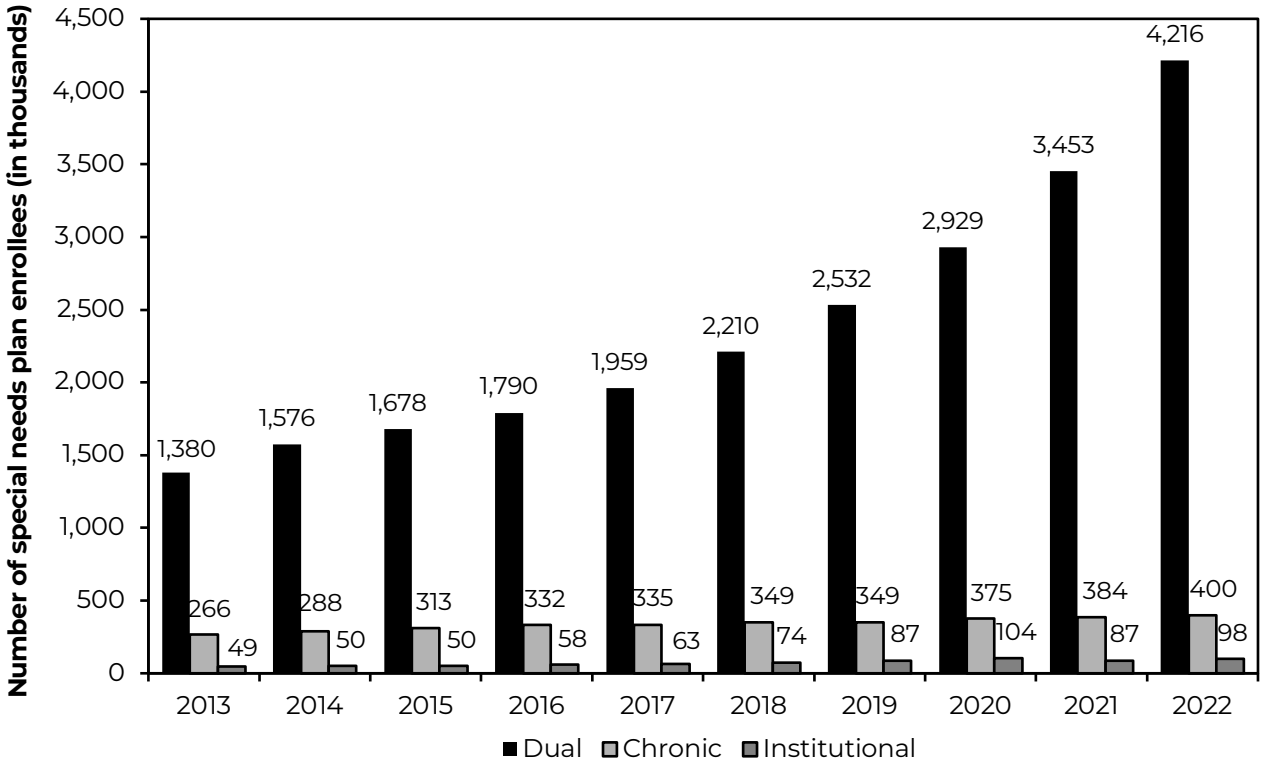
Note: MA (Medicare Advantage).

Source: CMS enrollment data, February 2009–2022.

- 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 2022, about 5.2 million enrollees were in employer group plans, or about 18 percent of all MA enrollees. Employer plan enrollment grew by 3 percent from 2021 and has more than doubled since 2013.

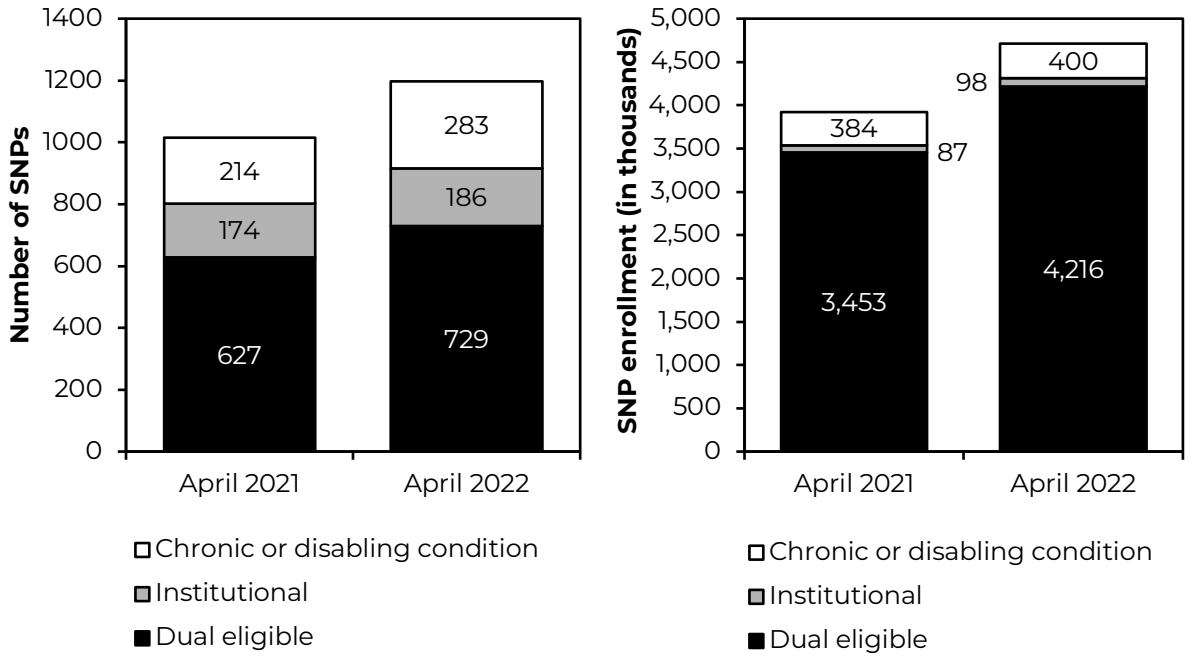
Chart 9-8. Number of special needs plan enrollees, 2013–2022



Source: CMS special needs plans comprehensive reports, April 2013–2022.

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (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 4.2 million in 2022, tripling since 2013.
- Enrollment in chronic condition SNPs has grown at varying rates as plan requirements have changed, but it has generally risen annually since 2013.
- Enrollment in institutional SNPs increased in 2022, after a decline in 2021.

Chart 9-9. Number of SNPs and SNP enrollment rose from 2021 to 2022



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2021 and 2022.

- The number of SNPs increased by 18 percent from April 2021 to April 2022. Dual-eligible SNPs increased by 16 percent, institutional SNPs increased by 7 percent, and the number of chronic condition SNPs increased by 32 percent.

- In 2022, most SNPs (61 percent) are for dual-eligible beneficiaries, while 16 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need), and 24 percent are for beneficiaries with chronic conditions.

- From April 2021 to April 2022, the number of SNP enrollees increased by 20 percent. Enrollment in SNPs for dual-eligible beneficiaries grew by 22 percent, enrollment in SNPs for institutionalized beneficiaries increased by 13 percent, and enrollment in SNPs for beneficiaries with certain chronic conditions grew by 4 percent. Enrollment in all SNPs has grown from 0.9 million in May 2007 (data not shown) to 4.7 million in April 2022.

- The availability of SNPs varies by type of special needs population served (data not shown). In 2022, 94 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 92 percent in 2021), 74 percent live where SNPs serve institutionalized beneficiaries (up from 72 percent in 2021), and 59 percent live where SNPs serve beneficiaries with chronic conditions (up from 57 percent in 2021).

Chart 9-10. The share of Medicare beneficiaries in MA plans is lower in rural areas, 2022

	MA-eligible population (in millions)	As percent of MA-eligible population	Share of MA-eligible population category in MA plans
All MA-eligible beneficiaries	**58.6**	**100%**	**49%**
Urban Influence Code designation			
Metropolitan	48.2	82	51
Rural: Micropolitan	5.9	10	41
Rural: Adjacent to metropolitan	2.8	5	41
Rural: Not adjacent to metropolitan	1.7	3	33

Note: MA (Medicare Advantage). Beneficiaries in the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and 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. We report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage). Urban Influence Codes (UICs) are designated by the Office of Management and Budget (OMB) based on the population size of the metropolitan 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 OMB UICs and CMS enrollment data, February 2022.

- Most (82 percent) of the total 58.6 million Medicare beneficiaries eligible for MA enrollment live in metropolitan areas. The share of MA-eligible beneficiaries who live in metropolitan areas enrolled in MA plans (51 percent) is higher than the share of rural beneficiaries enrolled in MA plans (40 percent; data not shown).

- Nearly all MA-eligible beneficiaries in rural areas reside in a micropolitan county or a county that is adjacent to a metropolitan area. More than 40 percent of MA-eligible beneficiaries in these areas are enrolled in MA plans. From 2021 to 2022, MA enrollment in these rural areas grew faster compared with metropolitan areas (13 percent compared with 8 percent; data not shown).

- About 3 percent of MA-eligible beneficiaries reside in a rural county that is not adjacent to a metropolitan area. One-third (33 percent) of these beneficiaries are enrolled in MA plans. From 2021 to 2022, MA enrollment in these areas grew by 16 percent—faster than the overall MA enrollment growth of about 9 percent during this period (data not shown).

Chart 9-11. MA enrollment patterns vary based on urban influence designation, 2022

	MA population (in millions)	As a percent of MA population	Share of category			
			HMO	Local PPO	Regional PPO	Other MA plans
All MA enrollees	**28.7**	**100%**	**59%**	**38%**	**3%**	**<0.5%**
Urban Influence Code designation						
Metropolitan	24.6	86	62	36	2	<0.5
Rural: Micropolitan	2.4	8	41	53	6	1
Rural: Adjacent to metropolitan	1.1	4	38	54	7	1
Rural: Not adjacent to metropolitan	0.5	2	34	57	8	1

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization). Beneficiaries in the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and 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. We report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage). Urban Influence Codes (UICs) are designated by the Office of Management and Budget (OMB) based on the population size of the metropolitan 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 OMB UICs and CMS enrollment and population data, February 2022.

- Local coordinated care plans (HMOs and local PPOs), which represent 97 percent of MA enrollees, may choose which individual counties to serve. Regional PPOs (3 percent of all MA enrollees) cover entire state-based regions.

- HMOs account for the largest share of MA plan enrollment in metropolitan areas (62 percent), but local PPOs account for the largest share (more than 50 percent) of MA plan enrollment in rural areas.

Chart 9-12. MA plans are available to nearly all beneficiaries in rural areas, 2022

	As a share of MA-eligible population	Share of Medicare beneficiaries living in counties with plans available in 2022					
		Any MA plan	CCPs				
			HMO	Local PPO	HMO or local PPO	Regional PPO	Any CCP
All MA-eligible beneficiaries	**100%**	**99%**	**97%**	**95%**	**98%**	**74%**	**99%**
Urban Influence Code designation							
Metropolitan	82	>99.5	99	98	>99.5	73	>99.5
Rural: Micropolitan	10	99	93	95	97	77	98
Rural: Adjacent to metropolitan	5	97	93	95	97	83	97
Rural: Not adjacent to metropolitan	3	92	80	83	87	71	91

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, or non-U.S. areas, and they do not include MA plans that have restricted enrollment (special needs plans, employer-only plans). 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. Urban Influence Codes (UICs) are designated by the Office of Management and Budget (OMB) based on the population size of the metropolitan 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 OMB UICs and CMS enrollment and population data February 2022.

- We examined the availability of MA plans to all MA-eligible beneficiaries. Consistent with prior work, we exclude employer-only 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.

- 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 99 percent of beneficiaries in micropolitan counties have access to an MA plan; 97 percent of 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, 92 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 typically have fewer plans from which to choose, 2022

	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 MA-eligible beneficiaries	**100%**	**36**	**98%**
Urban Influence Code designation			
Metropolitan	82	39	99
Rural: Micropolitan	10	24	93
Rural: Adjacent to metropolitan	5	22	95
Rural: Not adjacent to metropolitan	3	16	84

Note: MA (Medicare Advantage). These data do not include the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and non-U.S. areas, nor do they include MA plans that have restricted enrollment (special needs plans, employer-only plans). 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 OMB UICs and CMS enrollment and population data February 2022.

- In 2022, the average beneficiary has 36 plans from which to choose in their county.
- On average, Medicare beneficiaries residing in metropolitan areas have more MA plans from which to choose (an average of 39 plan choices) compared with beneficiaries in rural areas. Nevertheless, the average beneficiary in micropolitan counties or counties adjacent to a metropolitan area can choose among an average of 24 and 22 plans, respectively. Beneficiaries residing in rural counties that are not adjacent to a metropolitan area (3 percent of all beneficiaries) have 16 plans from which to choose, on average.
- At least one zero-premium plan with drug coverage is available to nearly all beneficiaries (98 percent). The availability of these plans in rural areas is somewhat less prevalent than in metropolitan areas. In metropolitan areas, 99 percent of beneficiaries have access to a zero-premium plan. In comparison, about 93 percent of beneficiaries in micropolitan counties and 95 percent of those adjacent to a metropolitan area have access to a zero-premium plan. In rural counties that are not adjacent to a metropolitan area, 84 percent of beneficiaries have an available zero-premium plan.

Chart 9-14. MA enrollment patterns, by age, dual-eligible status, and ESRD status, June 2021

	All MA-eligible beneficiaries		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	**56.5**	**100%**	**30.4**	**100%**	**26.1**	**100%**	**46%**
Aged (65 or older)	49.0	87	26.4	87	22.6	87	46
Under 65	7.5	13	4.0	13	3.5	13	47
Non–dual eligible	**45.7**	**81**	**25.2**	**83**	**20.4**	**78**	**45**
Aged (65 or older)	42.4	75	23.5	77	18.9	72	44
Under 65	3.3	6	1.7	6	1.6	6	48
Full dual eligibility	**7.6**	**13**	**4.1**	**13**	**3.5**	**13**	**46**
Aged (65 or older)	4.5	8	2.2	7	2.3	9	51
Under 65	3.1	5	1.8	6	1.2	5	40
Partial dual eligibility	**3.3**	**6**	**1.1**	**4**	**2.2**	**8**	**66**
Aged (65 or older)	2.1	4	0.7	2	1.5	6	69
Under 65	1.2	2	0.5	2	0.7	3	60
			Enrollment subcategories, all ages				
ESRD	**0.5**	**1**	**0.3**	**1**	**0.2**	**1**	**35**
Beneficiaries with partial dual eligibility							
QMB only	1.7	3	0.6	2	1.1	4	64
SLMB only	1.0	2	0.3	1	0.7	3	67
QI	0.6	1	0.2	1	0.4	2	68

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 (PACE), 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 2021, Puerto Rico had about 615,000 Medicare beneficiaries enrolled in MA plans, and about 282,000 were enrolled in dual-eligible special needs plans. Figures may not sum to totals due to rounding.

Source: MedPAC analysis of 2021 common Medicare environment files.

- Medicare beneficiaries with Medicaid benefits who have full dual eligibility (i.e., those who have coverage of 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 have 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 2021, 46 percent of full duals were in MA plans (up from 40 percent in 2020; data not shown), and 66 percent of partial dual-eligible beneficiaries were in MA plans (up from 60 percent in 2020; data not shown). QI beneficiaries have the highest rates of MA enrollment among partial duals (68 percent).
- A substantial share of the dually eligible (39 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 (40 percent vs. 51 percent, respectively). As a result, about the same share (13 percent) of MA enrollees is fully dual-eligible compared with FFS enrollees.
- Beginning in 2021, individuals with ESRD are no longer prohibited from joining an MA plan during open enrollment. As a result, ESRD beneficiaries had much higher rates of plan enrollment in 2021 (35 percent) compared with 2020 (23 percent; data not shown).