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# Medicare Advantage Plan Availability, Premiums and Benefits, and Beneficiary Enrollment in 2008

## Report

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## EXECUTIVE SUMMARY

This report presents findings on Medicare Advantage (MA) plan availability, premiums and benefits, and beneficiary enrollment in 2008. This report focuses on elements of the MA program implemented as a result of the Medicare Modernization Act (MMA) of 2003, including the Part D prescription drug benefit, the regional preferred provider organization (PPO) plan type, the more widely available special needs plans (SNPs), and the Medical Savings Account (MSA) option. This report captures the plan availability, premiums, benefits, and enrollment patterns associated with the Medicare Advantage payment policies that were in effect through 2008. The Patient Protection and Affordable Care Act, enacted in March 2010, restructures payments to MA plans. Continued monitoring of the impacts of the new changes on plan availability, premiums and benefits, and beneficiary enrollment, will be conducted.

When comparing the data in this report to other sources, the plans that are included in our analysis should be kept in mind. We focused specifically on open-access MA plans and SNPs, not all Medicare private health plans. We excluded employer-specific, cost, the Program of All-Inclusive Care for the Elderly (PACE), inactive, and other non-MA Medicare private health plans, as well as plans located in Puerto Rico and the U.S. territories.[1] Other sources that include some or all of the plans we excluded will show larger numbers of plans and enrollment. Also, even for the same sample of plans, results can vary slightly because of differences in underlying data sources, reflecting, for example, the timing with which alternative data sources are updated to incorporate new information.

### Key Findings[2]

#### Plan availability

*1) Access to MA plans*

- Continuing a trend observed after the passage of the MMA in 2003, the total number of MA contracts increased to a total of 556 in 2008, up from 408 in July 2006. The gain in total contracts between 2006 and 2007 was approximately 100, compared to a slower increased of 50 observed between 2007 and 2008 (Table 3-1). This increase in contracts can be attributed in part to the end of the moratorium on new local PPOs and an extension of SNP contract authority.

- Health maintenance organizations (HMOs) added 55 new contracts in 2008. Corresponding to the end of the Congressionally imposed moratorium, the number of local PPO contracts increased in 2008 relative to 2007, with 23 new local PPO

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1 We excluded plans that had demonstration status throughout 2006 to 2008, except for MSA demonstration plans from 2007 on. However, plans that were a non-demonstration MA plan in at least 1 year in this period were included in all years to obtain consistent time trends. In other years, we excluded demonstration plans except for PPO demonstration plans from 2003 to 2005.

2 In addition to this Executive Summary, the concluding Section 7 of this report presents a summary of findings.

contracts. Regional PPO contracts decreased from 14 to 13 in 2008. Substantial growth in private fee-for-service (PFFS) contracts continued, with an approximately 50-percent increase (from 41 to 63) of the number of contracts between 2007 and 2008. (Table 3-1).

- HMOs remained the dominant plan type of MA contract, but alternative types have grown in importance. In 2008, nearly 63 percent of MA contracts were HMOs, compared to 98 percent in 2000. Local PPOs grew from 1 to 130 contracts from 2000 to 2008 and comprised 23 percent of MA contracts in 2008. PFFS plans and regional PPOs accounted for a relatively small percentage of MA contracts, but tended to cover very large service areas relative to other plan types. (Table 3-1)

- All Medicare beneficiaries had access to at least one MA option in 2008. HMO availability continued to increase significantly to include at least one plan in 47 percent of counties. Local PPO availability also increased, to 34 percent of counties. Regional PPO access remained unchanged between 2006 and 2008 at 90 percent of counties. As of 2008, all counties (100 percent) had access to at least one PFFS option, only a slight change relative to 2007 (99.9-percent access), but a symbolic one in that, for the first time, all Medicare beneficiaries had a choice of at least one MA plan. By 2008 active MSA contracts, offered for the first time under MA in 2007, were available in only 3 percent of counties, which is a significant drop relative to 71 percent of counties in 2007. This change is attributable to the net exit of MSA contracts. (Table 3-2)

- By 2008, all MA plan types except MSAs were available to a majority of Medicare beneficiaries. HMOs were available to 82 percent of Medicare beneficiaries, 65 percent had access to a local PPO, 88 percent to a regional PPO, and but only 9 percent to an MSA. Access to PFFS plans, already high at 81 percent of beneficiaries in 2006, rose to all beneficiaries by 2008. (Table 3-3)

- In 2008, PFFS plans, regional PPOs, and SNPs were widely available throughout urban and rural areas. Access to PFFS plans improved in 2008 to 100 percent of counties—a symbolic milestone for the MA program. HMOs and local PPOs were more widely available in medium and large urban areas. Of particular note is the increased availability of SNPs, which were offered in 82 percent of counties in 2008 compared to 23 percent in 2006. SNPs were available in 75 percent of rural counties in 2008, which was a substantial improvement compared to 38 percent of rural counties in 2007 and only 13 percent of rural counties in 2006. (Table 3-4)

- HMOs and local PPOs were most widely available in the Northeast. SNPs are now available in the majority of counties with the exception of the West. PFFS plans were available everywhere in 2008, raising their already high presence in the Northeast and West since 2006. Regional PPOs were universally available in the Midwest and South and had substantial, though lesser, availability in the Northeast and West. MSAs, extensively available in 2007, were only sporadically available in 2008. (Table 3-5)

*2) Access to multiple MA plan types and contracts in 2008*

- From 2006 to 2008, the percentage of beneficiaries with access to all three major plan types—HMOs, PPOs (including regional PPOs), and PFFS—rose dramatically from 54 percent to 81 percent. Primarily this occurred because PFFS plans were first offered in 2007 in specific large urban areas where previously only HMOs and local PPOs were available. Another 17 percent of beneficiaries had access to at least one PPO and one PFFS plan in 2008, but no HMO. All three major plan types were available in 46 percent of counties in 2008; 49 percent of counties had access to PPOs and PFFS, but not to HMOs. (Table 3-6)

- In urban areas, 91 percent of beneficiaries had access to all three major plan types (HMOs, PPOs, and PFFS). Nearly half (45 percent) of rural beneficiaries had access to all three plan types due primarily to the relative paucity of HMO offerings in rural areas. Still, 50 percent of rural beneficiaries had access to at least PFFS plans and PPOs, if not to HMOs. (Table 3-7)

- Availability of plan options had improved by 2008 to the point where all census regions offered wide access to all plan types. Northeastern and Western beneficiaries were most likely to have access to all three major plan types or to HMOs and PPOs. Midwestern and Southern beneficiaries were most likely to have access to all three plan types or PFFS and PPOs. Access to all three plan types improved substantially in the Northeast and West from 2006 to 2008 as a result of the continued growth of PFFS plans. (Table 3-8)

- Over 85 percent of Medicare beneficiaries had access to 10 or more MA contracts in 2008, which is a vast increase over 2006, when just under 25 percent had this extensive plan choice. Even in rural areas, the percentage of beneficiaries with access to 10 or more contracts rose to 63 percent in 2008 from just under 3 percent in 2006, and the percentage that had 3 or fewer MA contracts to choose from fell from 46 percent in 2006 to 0 percent in 2008. (Table 3-9)

- Continuing the trend found in 2007, a large majority of beneficiaries in all census regions had a choice among 10 or more MA contract options in 2008, compared to between 18 and 36 percent in 2006. (Table 3-10)

- In 2008, access to SNPs improved significantly. SNPs were offered through both HMO and PPO contracts, including eight regional PPOs. Eighty-seven percent of contracts offering SNPs were HMOs. Just over one-third of the contracts offering at least one SNP in 2008 specialized in offering SNPs only. The total number of MA contracts offering SNPs rose from 139 in 2006 to 196 in 2007, and then increased again to 285 in 2008, with 37 additional HMO, 11 local PPO, and 2 additional regional PPO contracts offering at least one SNP. (Table 3-11)

- Growth occurred in all three types of SNPs (i.e., institutional, dual Medicare/Medicaid eligible, and chronic condition), but was most striking in dual-

eligible and chronic-condition options. Growth in chronic-care options may be attributable to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) legislative requirement that future new chronic-condition SNPs focus on specified conditions only. The number of chronic-condition SNPs increased from only 10 in 2006 to 211 in 2008, surpassing by far the number of institutional SNPs. Similarly, the number of dual-eligible SNPs grew from 212 in 2006 to 379 in 2008; this option remains the dominant SNP type. (Table 3-12)

Premiums and benefits[3,4]

*1) Premiums*

- Half (49 percent) of MA enrollees received their Part C and Part D benefits at zero additional premium in 2008, a slight decline from 2007. (Table 4-2a)

- The 2008 average monthly MA total (Part C + D) premium was $32.72, a 1.1 percent increase from $32.35 in 2007. The 2008 average Part C premium was $20.24, down 2.3 percent from $20.72 in 2007; and the 2008 average Part D premium was $12.62, up 9.8 percent from $11.49 in 2007. (Tables 4-1a and 4-1b)

- PFFS plan total premiums rose by 36 percent, from an average of $23.20 in 2007 to an average of $31.61 in 2008. HMO and local PPO total premiums fell by 4 and 8 percent, respectively, to $31.64 and $70.70, respectively, in 2008. (Tables 4-1a and 4-1b).

- From 2006 to 2008, average MA total premiums rose by 10 percent. PFFS premiums more than doubled in these 2 years, whereas HMO premiums rose a modest 3 percent. The result was that after considerably underpricing among HMOs in 2006, by 2008, PFFS total premiums had reached parity with HMO total premiums. PFFS Part C premiums were still lower than HMO Part C premiums in 2008, but PFFS Part D premiums were higher. (Tables 4-1a and 4-1b)

- Although most MA enrollees paid zero or modest premiums in 2008, more than one-fifth (21 percent) paid a total monthly premium of $75 or greater and 11 percent paid $100 or more. (Table 4-3a)

- Urban premiums were somewhat lower than rural premiums in 2008. The average total (Parts C + D) urban premium was $31.88 compared to $40.11 in rural areas.

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[3] All premium and benefits results are weighted by plan enrollment and thus represent the average (or median) enrolled beneficiary premium or benefits, *not* the average plan offerings. Premiums are those charged by plans and are not necessarily paid out of pocket by enrollees (e.g., enrollees receiving Part D low-income subsidy assistance do not themselves pay the full Part D premium).

[4] Average Parts C+D premiums do not equal the sum of the Part C and the Part D premiums because some MA plans do not offer Part D. Part D and total premiums (Parts C + D) are for MA plans offering Part D.

From 2007 to 2008, the urban-rural premium gap widened as urban premiums fell by 1 percent, whereas rural premiums rose by 9 percent. (Tables 4-4a and 4-4b)

- Regional premium differences remained pronounced in 2008. Average monthly premiums were highest in the Northeast ($56.29) and lowest in the South ($16.05). More than 6 of 10 Southern MA enrollees paid no total premium, and less than 1 in 4 of Northeast MA enrollees elected zero total premium plans. The Northeast had an unusually low percentage of enrollees in zero-premium MA Part D plans, only 25 percent, compared to at least 49 percent in the other regions. From 2007 to 2008, total premiums fell in the Northeast and West, but rose in the Midwest and South. This had the effect of somewhat compressing regional premium differences. (Tables 4-6a, 4-6b, and 4-7a)

- In 2008, 2.7 percent of MA enrollees had their Part B premium reduced, by an average of $38.88. Six percent of Southern enrollees and more than 3 percent of HMO enrollees had their Part B premium reduced. The percentage of MA enrollees with a Part B premium reduction fell from 3.4 percent in 2007 to 2.7 percent in 2008. (Table 4-8a)

*2) Part D benefits*

- Approximately 13 percent of MA enrollees did not elect a Part D benefit in both 2007 and 2008. Among PFFS enrollees, whose plans are not required to offer a Part D option, 43 percent were in plans without a drug benefit in 2008, the same percentage as in 2007. In rural areas, 31 percent of MA enrollees were in plans without drug benefits, down slightly from 34 percent in 2007. (Tables 4-9a and 4-10a)

- In 2008, 75 percent of MA enrollees had an enhanced plan-provided integrated drug benefit, up from 65 percent in 2007.[5] More than three-quarters of HMO and PPO enrollees had enhanced coverage, and the majority of PFFS enrollees had enhanced integrated drug coverage. From 2007 to 2008, more widespread enhanced coverage primarily replaced actuarially equivalent basic coverage. (Table 4-9a)

- In 2008, Northeastern MA enrollees were least likely to have enhanced drug coverage (68 percent), whereas Western enrollees were the most likely to have it (81 percent). The proportion of MA enrollees with enhanced drug coverage rose by 18 percentage points in the West from 2007 to 2008 and by 14 percentage points in the Northeast. (Tables 4-11a and 4-11b)

- The vast majority (90 percent) of Medicare Advantage Prescription Drug Plan (MA-PD) enrollees paid no Part D deductible in 2008, as in 2007. (Table 4-12a)

- Approximately 94 percent of 2008 MA-PD enrollees were in plans with drug co-payment tiers before the initial coverage limit. The number of co-payment tiers was

[5] These percentages are of all MA enrollees, including those in MA plans not offering Part D.

usually 3. Approximately 93 percent of MA-PD enrollees were in plans with one or two co-insurance tiers (usually employed for specialty, injectable, or expensive drugs). More than half (62 percent, up from 55 percent in 2007) of MA-PD enrollees were in plans with three co-payment and one co-insurance tiers. (Tables 4-12a and 4-13a)

- Typical (median) prescription co-payments were fairly stable between 2007 and 2008. In the most common 3 co-payment/1 co-insurance tier structure, the median co-payment for Tier 1 (generics) was $4; for Tier 2 (preferred brand) was $30; and for Tier 3 (non-preferred brand) was $60.[6] Median co-insurance (specialty drugs) was 30 percent. (Table 4-13a)

- More than 91 percent of 2008 MA-PD enrollees were in plans with the standard $2,510 initial coverage limit (ICL), up from 86 percent in 2007 (when the standard limit was $2,400). In 2008, approximately 3 percent of enrollees had a lower initial coverage limit (ICL) than standard, and approximately 6 percent had a higher ICL than standard. (Table 4-14a)

- In 2008, 63 percent of non-SNP MA-PD enrollees was in plans with some form of gap coverage, up substantially from 34 percent in 2007. Typically gap coverage was for generic drugs only (39 percent of non-SNP MA-PD enrollees), but the percentage of enrollees with some brand gap coverage nearly tripled from 2007 to 2008—from 9 to 25 percent.[7] (Table 4-15a)

- In 2008, approximately 60 percent of HMO and PPO enrollees had gap coverage. Approximately 85 percent of PFFS MA-PD enrollees had gap coverage, a huge increase from 2007, when only 8 percent of PFFS MA-PD enrollees had gap coverage. Approximately 70 percent of PFFS enrollees had some brand coverage in the gap in 2008, compared to approximately 15 percent of HMO enrollees.[7] The percentage of enrollees with some gap coverage rose substantially from 2007 to 2008 for all plan types. (Tables 4-15a and 4-15b)

- In 2008, a higher percentage of rural than urban MA-PD enrollees had gap coverage, and rural enrollees were more than twice as likely to have some brand coverage. (Table 4-15a)

- By region, in 2008, Northeastern MA-PD enrollees were least likely to have gap coverage (approximately half had none), and Southern enrollees most likely to have gap coverage (nearly three-quarters had it). Brand gap coverage was rare in the Northeast and the West, but approximately one-third of Midwestern enrollees and 44 percent of Southern enrollees had it. From 2007 to 2008, there was very strong

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6 Co-payments are for a 30-day drug supply at in-network retail pharmacies.

7 The brand gap coverage percentages assume that the MA-PD reporting category “all formulary drugs” includes some brand drugs.

growth of gap coverage in all regions except the Northeast, and of some brand gap coverage in the South and Midwest. The Northeast had the highest percentage of gap coverage of any region in 2007 and the lowest in 2008. (Tables 4-15a and 4-15b)

*3) Other benefits and cost sharing*

- In 2008, 84 percent of MA enrollees had vision coverage (eye exams and glasses). Approximately two-thirds of MA enrollees had coverage for hearing exams, 39 percent for dental coverage, approximately one-quarter coverage for podiatry, and 5 percent for chiropractic treatment. The percentages of MA enrollees with these benefits in 2008 rose slightly from 2007, with the exception of a slight decline in the proportion of enrollees with chiropractic and podiatrist coverage. The proportion of PFFS enrollees with vision and dental benefits lagged the provision of these benefits in HMO and PPO plan types, but hearing exam benefits are more prevalent in PFFS. (Table 4-16a)

- In 2008, as in 2007 and 2006, most MA enrollees faced co-payments of $5 to $15 for primary care physician visits; however, an increasing portion of MA enrollees were paying co-insurance and fewer co-payments for primary care visits. The percentage of enrollees with no ($0) co-payment rose from 10 percent to 19 percent between 2007 and 2008, whereas the percentage with co-insurance rose from 4 percent to 11 percent. The greater proportion with co-insurance was driven by the increase in PFFS plans, whereas the higher proportion with no co-payment resulted from changes among HMOs and local PPOs. (Table 4-17a)

- The most common specialist physician visit amounts in 2008 were in the ranges of $25.01 to $35 and $15.01 to $25. Changes from 2007 were small. Emergency department co-payments were usually approximately $50. Nearly 90 percent of MA enrollees faced co-payments or co-insurance for hospital services, either acute inpatient admissions, or outpatient care. High proportions were also charged co-payments or co-insurance for X-ray and clinical laboratory services, with the proportion being charged for X-rays rising and the proportion for laboratory services declining from 2007. (Table 4-17a)

- Nearly half (46 percent) of MA enrollees had an out-of-pocket (OOP) maximum in 2008, approximately the same as in 2007. The most common OOP maximum in 2008 was in the $3,001 to $4,000 range. The median OOP maximum was $3,200 in 2008, up from $3,100 in 2007 and $3,000 in 2006. (Tables 4-18a and 4-19a)

- OOP maximums were least common in HMOs—only 35 percent of HMO enrollees had one in 2008. All regional PPO and MSA enrollees and nearly two-thirds of PFFS and local PPO enrollees had an OOP maximum. The proportion of local PPO enrollees with an OOP maximum grew 10 percentage points from 2007 to 2008, but the proportion of PFFS enrollees with a maximum fell 12 percentage points to 66 percent, down from 80 percent in 2006. Of enrollees with an OOP maximum, local PPO enrollees had the lowest (in-network) 2008 median OOP maximum of $2,400 (but up from $1,000 from 2007). HMO, regional PPO, and MSA enrollees had

median OOP maximums of $3,000 or $3,100. PFFS plan enrollees had the highest median OOP maximum of $4,000, but this was down from $5,000 in 2007. (Table 4-19a and 4-19b)

- Urban enrollees were less likely to have OOP cost maximums than rural enrollees, but the median urban and rural maximums were nearly the same. Urban-rural differences in percentage of enrollees with maximums and median maximums narrowed from 2006 to 2008. Regionally, more than half of Midwestern and Southern MA enrollees were protected by an OOP maximum, but only one-quarter of Northeastern enrollees were. Median maximums ranged from $3,000 to $3,500 across regions. (Table 4-19a)

*4) Simulated MA enrollee OOP costs in 2008*

- Across all MA enrollees, 2008 OOP costs were simulated to be $298.50 per month. Thirty-two percent of total 2008 OOP cost was the Medicare Part B premium; 11 percent comprised the plan Part C and Part D premiums; 30 percent more comprised the total represented outpatient drug expenses (even with prescription drug coverage through Medicare Parts D and B); and 27 percent was payments for inpatient (8 percent), dental (8 percent), and all other services (11 percent). (Table 4-20a)

- Simulated OOP costs are 77 percent greater, $416 versus $235 per month, for beneficiaries in poor health compared to those in excellent health. The largest contributor to higher OOP costs with poor health is increased outpatient prescription drug expenses, accounting for about half (54 percent) of the total increase. The remaining 46 percent of increased OOP costs with poorer health are higher expenses for inpatient and other medical services. (Table 4-20a)

- Simulated OOP costs do not vary greatly across MA plan types. The range between the highest cost plan type (local PPOs) and the lowest cost plan type (PFFS) is only 6 percent for enrollees in average health. Most plan type differences are related to variations in average Part C and Part D premiums. (Table 4-20a)

- Simulated MA enrollee OOP costs are slightly higher in rural than urban areas (3 percent greater in rural areas for enrollees of average health). (Table 4-21a)

- Across regions, simulated average OOP costs range from 10 percent below the national average in the South to 7 percent above the average in the Northeast for enrollees in average health. The Northeast/South difference is mostly due to higher plan Part C and Part D premiums in the Northeast than in the South. (Table 4-22a)

- Total average monthly OOP costs for all plan types and any health status enrollees fell by $5, or 2 percent, from 2007 to 2008. Greater generosity of outpatient prescription drug coverage more than offset a rise in the Medicare Part B premium. Local PPO OOP costs decreased the most between 2007 and 2008, by $24 per month, or 7 percent. PFFS average OOP costs were almost flat between the 2 years, and

chronic/institutional SNP average OOP costs rose during this time period. (Table 4-20b)

Enrollment

*1) Total enrollment and penetration*

- MA enrollment in 2008 was 7.4 million, with a penetration rate (enrollees/eligibles) of 19.0 percent. MA enrollment rose 13.9 percent from 2007 to 2008, and MA penetration increased by 1.8 percentage points. (Tables 5-1a and 5-1b)

- From 2007 to 2008, MA enrollment grew by 941,354, with 399,161 of this increase (42 percent) in HMO plans, 234,830 (25 percent) in PFFS plans, and 217,022 (23 percent) in local PPO plans. Although the enrollment change between 2006 and 2007 was broadly similar (1,080,277), it was primarily due to an increase of 668,676 (62 percent) in PFFS enrollment. (Tables 5-1a and 5-1b)

- Several factors might explain the large increase in MA enrollment between 2006 and 2008 (35 percent). One likely key factor is higher MA payments relative to FFS expenditures, which are positively correlated with the percentage growth in MA enrollment. (Figure 5-1, and Tables 5-1a and 5-1b)

- Although HMOs were still the dominant plan type in MA, together PFFS and PPOs (local and regional) had approximately one-third of 2008 MA enrollment. Compared to the HMO increase in enrollment of 8 percent from 2007 to 2008, the local PPO increase was 62 percent, PFFS increased by 16 percent, and the regional PPO increase was 48 percent. Active MSA contracts had an enrollment of 473 beneficiaries in 2008. (Table 5-1a and 5-1b)

*2) Geographic enrollment patterns*

- Among 2008 MA enrollees, 88 percent resided in urban areas and 12 percent lived in rural areas. At 21 percent versus 11 percent, the MA penetration rate was approximately double for urban compared to rural beneficiaries. However, the percentage increase in rural enrollment from 2007 to 2008 was 25 percent, compared to only 14 percent for urban enrollment. (Tables 5-3a and 5-3b)

- In 2008, the MA penetration rate was 27 percent in the West, 21 percent in the Northeast, 17 percent in the South, and 14 percent in the Midwest. However, the Midwest and South had the highest percentage growth in MA enrollment from 2007 to 2008, with the Midwest growing by 21 percent and the South by 16 percent. This compares to 11 percent MA growth in the Northeast and 10 percent in the West. (Tables 5-4a and 5-4b)

- Only 5 percent of MA HMO enrollees and 10 percent of local PPO enrollees resided in rural areas in 2008. This contrasted with 34 percent of PFFS enrollees, 27 percent of MSA enrollees, and 14 percent of regional PPO enrollees. (Tables 5-5a and 5-5b)

- In 2008, HMOs accounted for 73 percent of urban MA enrollment and PFFS plans 16 percent. In contrast, PFFS plans accounted for 59 percent of rural MA enrollment and HMOs 27 percent. PPOs accounted for slightly greater than 10 percent of MA enrollment in both urban and rural areas and 2008. MSA enrollment was negligible. (Tables 5-6a and 5-6b)

- Regional PPO enrollment was heavily concentrated in the South in 2008 (57 percent). More than three-quarters of PFFS enrollment was in the South or Midwest (41 and 36 percent, respectively). (Tables 5-7a and 5-7b)

- In 2008, MA enrollment in the Northeast and West was dominated by HMOs, comprising approximately 80 percent of enrollment in each of these regions. This differs substantially from the Midwest and South, where PFFS plans were much more popular (comprising 45 percent and 27 percent of enrollment, respectively). (Tables 5-8a and 5-8b)

*3) Enrollment in SNPs and Part D*

- Among MA enrollees in 2008, 1,002,334 (13 percent) were enrolled in an SNP, which was a 34 percent increase over 2007. Among SNP enrollees, two-thirds were enrolled in a dual-eligible SNP, with 13 percent in a chronic-condition SNP, and 19 percent in an institutional SNP. Enrollment in chronic-condition SNPs rose substantially from 74,039 in 2007 to 194,497 in 2008. (Tables 5-9a and 5-9b)

- Most SNP enrollees (838,033 out of 1,002,334) were in HMOs in 2008. The majority of HMO SNP enrollees were in dual-eligible SNPs (77 percent). Regional PPOs had the highest percentage of their enrollment in SNPs (27 percent), with a relatively strong chronic-condition SNP proportion. Local PPOs also had a high percentage of their enrollment in SNPs (15 percent), as did HMOs (16 percent). (Tables 5-9a and 5-9b)

- At 94 percent, the vast majority of MA enrollees were enrolled in the Medicare Part D drug program (in either MA or stand-alone prescription drug plans). The Part D take-up (voluntary enrollment) rate was approximately 95 percent for HMOs and PPOs, with PFFS enrollees somewhat less likely to have Part D coverage than enrollees in other non-MSA plan types. Nearly all of the MA enrollees in Part D were enrolled in an MA-PD (93 percent), although 7 percent were enrolled in a stand-alone drug plan. Approximately 35 percent of PFFS enrollees with Part D coverage were enrolled in stand-alone drug plans. (Tables 5-10a and 5-10b)

<u>MA Benchmark Payment Rates and Their Impacts</u>

*1) Variations in MA county benchmark payment rates*

- There is a large variation in MA county monthly benchmark payment rates, ranging from a low of $716.25 to a high of $1,323.40. In 2008, nearly two-thirds of counties' benchmark payment rates were updated 2004 floor rates. The South accounted for

approximately 80 percent of the counties with the highest benchmark rates—those more than $900. (Table 6-1)

- Less than 3 percent of 2008 county benchmark payment rates were comprised of the FFS rate, whereas more than 16 percent of counties had benchmark payment rates more than 25 percent higher than the FFS rate. The counties with benchmark to FFS rate ratios greater than 1.25 were fairly evenly distributed across census regions. (Table 6-2)

*2) Impacts of variations in county benchmark payment rates*

- HMO plan availability, premiums, and OOP costs were correlated with the county benchmark payment rate. HMO plan availability increased from less than 1 contract in counties with benchmark rates below $750, to more than 11 contracts in counties with benchmark rates higher than $900. (Table 6-3) Part C monthly premiums fell from $49.35 to $5.79 as the benchmark payment rate increased from less than $750 to more than $900 (Table 6-5), and monthly OOP costs fell from $339.53 to $253.06. (Table 6-7)

- PFFS contract availability, premiums, and OOP costs were correlated with a higher benchmark to FFS payment ratio, but ***not*** with a higher county benchmark payment rate. PFFS plan availability increased from less than 5 contracts in counties with a benchmark to FFS payment rate ratio less than 1.05 to approximately 10 contracts in counties with a ratio greater than 1.15. There was no additional gain in the average number of contracts for benchmark to FFS payment ratios higher than 1.15. (Table 6-4)

- PFFS Part C premiums fell steadily from $31.38 to $6.64 as the benchmark to FFS payment rate ratio increased from 1 to more than 1.25. (Table 6-6) OOP costs also fell from $323.34 to $280.72 as the ratio increased to more than 1.25. As with contract availability, there was little decrease in OOP costs once the ratio exceeded 1.15, falling less than $3 from $285.22 to $280.72. (Table 6-8)

- PPO plan availability, premiums, and OOP costs did not appear to be correlated with either the county benchmark payment rate or the benchmark to FFS payment rate ratio. (Tables 6-3 to 6-8)

- These findings, which differed by MA contract type, may be attributable to different provider network and access models, care management strategies, and resulting medical care costs.

- The analysis also considered the impact of the discontinuity in MA county benchmark payment rates created by the urban floor rate. We found that the higher payment rates in counties subject to the urban floor were related to lower average MA plan simulated OOP costs (Table 6-13). This relationship was especially strong for PFFS plans; however, the average difference in OOP costs was much smaller than the average difference in benchmark rates ($13 average reduction in OOP costs versus

$60 average increase in benchmark payments in counties subject to the urban floor). There are several potential reasons for this disparity, including differences in plan costs and benefits that are not accounted for in our measure of OOP costs.

- The decrease in average MA plan simulated OOP costs associated with the urban floor rate results primarily from a decrease in Part C premiums. No statistically significant differences were found in non-premium enrollee cost sharing, either overall or for particular plan types (HMO or PFFS). (Tables 6-13 and 6-15)

# SECTION 1
# BACKGROUND, CONTEXT, AND REPORT OVERVIEW

## 1.1 Project Background and Overview of this Report

For more than 20 years, Medicare has offered enrollment in private health plans as an option to beneficiaries in areas where these plans were available. Private healthcare plans cover all the services of the traditional Medicare fee-for-service (FFS) program and often offer additional benefits that are attractive to beneficiaries. Plans may charge their enrollees a monthly premium. Many different options are available, including health maintenance organizations (HMOs), which typically provide coverage for services obtained from their "network" hospitals and physicians, and preferred provider organizations (PPOs), which include coverage for services provided "out of network," generally for a higher co-payment. A fast-growing option is private fee-for-service (PFFS) plans, which can and often do operate without formal provider networks.

The Medicare private health plan program is known as the Medicare Advantage (MA) program. Medicare pays MA plans a fixed, prospective amount per enrollee per month, independent of the actual medical services used by the enrollee. MA plans historically have participated unevenly around the country, with greater availability in large urban areas and more limited presence in rural areas. Over the years, the types of plans and benefit offerings have undergone substantial changes. In the Balanced Budget Act of 1997 (BBA), Congress expanded the types of plans that could contract with Medicare to serve Medicare beneficiaries, citing beneficiary "access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare." In the *Conference Report for Balanced Budget Act of 1997 (Report 105-217, p. 585)*, the conferees also noted the goal of making these options "available to beneficiaries nationwide." Subsequently, in 2003, Congress made changes in the payment methodology, explaining that "The goal is to increase beneficiary choice, by increasing private plan participation in Medicare." *In the Conference Report for Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Report 108-391:527 and 531)*, the conferees also referred to the goal of "bring[ing] greater health plan choices to areas not previously served by private plans, particularly rural areas." The current phase in the evolution of the MA program is noteworthy with the continued integration of Part D (prescription drug) benefits, the introduction of regional PPO plans, and the expansion of PFFS. This report captures the plan availability, premiums, benefits, and enrollment patterns associated with the Medicare Advantage payment policies that were in effect through 2008. The Patient Protection and Affordable Care Act, enacted in March 2010, restructures payments to MA plans. Continued monitoring of the impacts of the new changes on plan availability, premiums and benefits, and beneficiary enrollment, will be conducted.

This report documents 2008 MA plan availability, premiums, benefits, cost sharing, and enrollment, and it describes trends relative to earlier years. When comparing the data in this report to other sources, readers should keep in mind the plans included in our analysis. We focused specifically on open-access MA plans and special needs plans (SNPs), not on all Medicare private health plans. We excluded employer-specific, cost, the Program of All-Inclusive Care for the Elderly (PACE), inactive, and other non-MA Medicare private health

plans, as well as plans located in Puerto Rico and the U.S. territories.[8] Other sources that include some or all of the plans we excluded will show larger numbers of plans and enrollment. Also, even for the same sample of plans, results can vary slightly because of differences in underlying data sources, reflecting, for example, the timing with which alternative data sources are updated to incorporate new information.

This project is divided into two phases. Project Phase I produced a Report to Congress that "described the impact of additional financing provided under this Act (i.e., the Medicare Modernization Act [MMA]) and other Acts (the Balanced Budget Refinement Act of 1999 [BBRA] and the Benefits Improvement and Protection Act of 2000 [BIPA]) on the availability of MA plans in different areas and its impact on lowering premiums and increasing benefits under such plans." This report was completed in late 2005 and was transmitted to Congress.[9] The Report to Congress analyzed trends in the MA program from 2000 through 2005.

Project Phase II, which is the current phase, focuses on monitoring the MA program from 2006 through 2008. This third and final report presents analyses of the program in 2008 in three key areas: plan availability, plan premiums and benefits, and beneficiary enrollment. Section 1.2 briefly reviews the key findings from the first phase of this project (2000 to 2005) and from our first and second interim reports for the second project phase (2006 and 2007) as background for this report. Section 1.3 describes the major legislated changes in the MA program that took effect in 2008; these changes provide an important focus and context for this report. Section 1.4 outlines the goals and objectives of this report. Section 2 describes the methods, including the sample and data sources that were used for this report. Sections 3 to 6 present the empirical findings of the 2008 analyses. Section 3 presents findings on plan availability, Section 4 on premiums and benefits, and Section 5 on beneficiary enrollment. Section 6 presents several analyses of the relationship of the MA county benchmark payment rates to plan availability, premiums, and benefits. Section 7 provides brief conclusions.

## 1.2 Review of Key Project Findings 2000 to 2007

### 1.2.1 Project Phase I: 2000 to 2005

Historically, payments to Medicare health plans were tied to local FFS per capita costs. The BBA fundamentally changed the method for setting rates used to pay Medicare health plans. BBA established a minimum floor for capitation rates, introduced a blended national and local rate, and limited rate updates in counties with higher rates in an attempt to narrow geographic payment differences. Following the BBA, and prompted in part by the limited rate updates in counties with higher rates, large numbers of health plans withdrew from the Medicare program, constricted service areas, raised premiums, and/or reduced benefits. Partly in response to these

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8 We excluded plans that had demonstration status throughout 2006 to 2008, except for Medical Savings Account (MSA) demonstration plans from 2007 on. However, plans that were a non-demonstration MA plan in at least 1 year in this period were included in all years to obtain consistent time trends. In other years, we excluded demonstration plans except for PPO demonstration plans from 2003 to 2005.

9 The basis of the Report to Congress, with some subsequent updating, is available as the final report of project Phase I (Pope et al., 2006).

developments, Congress enacted several laws to refine and modify the payment provisions of the BBA, including the BBRA of 1999 and the BIPA of 2000. However, the next fundamental change in the Medicare health plans program was the Medicare Modernization Act (MMA) of 2003. The MMA set 100 percent of estimated FFS costs as a minimum payment level in each county, raised payment update amounts, and increased urban and rural floor rates. During previous work for this project (Pope et al., 2006), the following key developments in the MA program from 2000 to 2005 were documented in response to these legislative changes:

Plan Availability

- Medicare plan availability decreased substantially after the implementation of the BBA, and despite interim legislation (BBRA and BIPA) aimed at addressing some of the effects of the BBA, availability of the plans did not improve until after the MMA provisions were implemented.

- Managed care availability (HMO and PPO) outside of large and medium urban areas improved under the MMA, but remained relatively weak in these areas. However, access to PFFS plans increased considerably in all areas, especially rural areas.

Plan Premiums, Benefits, and Cost Sharing

- Plan premiums and cost sharing generally increased and benefits decreased in response to the BBA. These conditions improved after passage of the MMA, with many plans lowering premiums and cost sharing and improving benefits, after the March 2004 MMA payment increases.

Enrollment

- Although MA plan enrollment continued to grow through 1999, it declined steadily between 2000 and 2003 and rebounded somewhat in 2005 after the passage and full implementation of the MMA.

- Enrollment in urban counties continued to dominate the MA program through 2008. Enrollment in rural counties improved slightly as of 2005, although overall rural enrollment remained small.

### 1.2.2 Project Phase II: Interim Reports

Once the MMA moved into a full implementation mode, several important changes occurred in the MA program in beginning in 2006. The MMA added a major new benefit to the basic Medicare benefit package in 2006 (i.e., the Part D prescription drug benefit). Many MA plans had offered a drug benefit prior to 2006, but the benefit was usually limited, such as covering generic drugs only and/or having annual drug benefit caps. Beginning in 2006, most MA plans were required to offer at least one plan in an area with the standard Part D prescription drug benefit (or an actuarially equivalent benefit). MA plans could also offer enhanced alternative drug coverage. Implementation of this new benefit continued to impact and change MA plan coverage and enrollment in 2007.

New types of plans were created by the MMA or the earlier BBA that offer alternative provider access, premiums, and benefits to beneficiaries. These new types of plans include local PPOs, which allow access to out-of-network providers at a higher cost-sharing level; regional PPOs, which are PPOs that cover an entire region as specified by the Centers for Medicare & Medicaid Services (CMS), and these regional definitions include either an entire state or a mix of entire states; PFFS plans, which permit access to any provider who accepts the plan's terms and conditions for payment on a service-by-service basis; and SNPs, which are targeted at beneficiaries with special needs. Medical Savings Accounts (MSAs) were added to the MA program in 2007.

Beginning in 2006, payments to MA plans were determined through a new bidding process. Bids below the benchmark (with 25 percent of any difference between bid and benchmark retained in the Medicare trust funds) created rebate funds that are used to enhance benefits, reduce cost sharing, or reduce Part D or Part B premiums; the portion of any bid amount in excess of the "benchmark" rate became the beneficiary premium. For the period from March to December 2004, the MMA changed county capitation rates by establishing a FFS per capita cost minimum capitation rate, raising floor rates, and establishing a minimum of the national Medicare expenditure growth percentage with a 2-percent increase. Another significant payment change is that the phase-in of risk adjustment continued; 75 percent of plan payments were risk adjusted in 2006 and 100 percent in 2007 and thereafter.

Given these continued changed to the MA program, project Phase II of this contract required a series of interim reports documenting these yearly changes. During this phase, the following key developments in the MA program were documented in interim reports covering calendar years 2006 and 2007 (Pope et al., 2007 and 2008).[10]

Plan Availability

- Almost all Medicare beneficiaries had access to at least one MA option in 2006 and 2007. The policy goal of extending access to MA plans to all areas, including rural areas, has largely succeeded. This widespread access has been achieved largely through the proliferation of PFFS, regional PPO, and (in 2007) MSA plans—options widely available, but not as popular in terms of enrollment as traditional HMO plans.

- Some MA plan types were available in more counties in 2007 than in 2006. In 2006, HMOs were available in just over one-third of all counties, 30 percent of counties had access to a local PPO, PFFS plans were available in 96 percent of counties, and regional PPOs were available in just under 90 percent of all counties. SNPs were offered in 25 percent of counties in 2006; however, growth and availability of some plans slowed in 2007. HMO availability continued to increase significantly to include at least one plan in 40 percent of counties. In 2007, local PPO availability reduced

[10] The data for 2006 and 2007 cited here are consistent with the 3-year trends presented later in this report in Sections 3 through 6. There have been some changes in the samples, data, and methods since our earlier reports, which can cause generally minor changes in the results. The 3-year trends were recalculated for this report using our latest methods and data consistently for the full 3-year period and may differ from what was presented in earlier reports.

slightly to 29 percent of counties. Regional PPO access remained unchanged between 2006 and 2007 at 90 percent of counties. Virtually all counties (99.9) had access to at least one PFFS option in 2007. MSAs, which were offered for the first time under MA in 2007, were available in 71 percent of counties under three contracts, including a demonstration contract.

- By 2006, all MA plan types were available to a majority of Medicare beneficiaries. HMOs were available to 72 percent of Medicare beneficiaries; 65 percent had access to a local PPO, 89 percent to a regional PPO, and 81 percent to a PFFS plan. This widespread availability was maintained in 2007. HMOs were available to 77 percent of Medicare beneficiaries; 64 percent had access to a local PPO, 88 percent to a regional PPO, and 79 percent to an MSA. Access to PFFS plans, already high at 81 percent of beneficiaries in 2006, rose to virtually all beneficiaries in 2007.

Plan Premiums, Benefits, and Cost Sharing

- Half (51.4 percent) of MA enrollees received their Part C and Part D benefits at zero additional premium in 2007, which is a slight decline from 53.8 percent in 2006.

- The enrollment-weighted 2007 average monthly MA total (Part C + D) premium was $32.35, which is a 9.0 percent increase from $29.67 in 2006. The 2007 average Part C premium was $20.72, up from $19.16 in 2006; and the 2007 average Part D premium was $11.49, almost equal to the 2006 premium of $11.45.

- Approximately 13 percent of 2007 MA enrollees were in plans without a Part D benefit, up from 10 percent in 2006. Among PFFS enrollees, 43 percent were in plans without a drug benefit in 2007, compared to 35 percent in 2006. In rural areas, 34 percent of MA enrollees were in plans without drug benefits, up from 29 percent in 2006.

- In 2007, 65 percent of MA enrollees had an enhanced Part D benefit, up slightly from 63 percent in 2006.[11] A majority of non-SNP enrollees in each plan type had enhanced coverage (excluding MSAs, which do not offer Part D coverage). Among HMOs, local PPOs, and SNPs in 2007, enhanced coverage increased at the expense of basic coverage. Among regional PPO and PFFS enrollees, the opposite occurred: the percentage with enhanced coverage decreased and the percentage with basic coverage increased.

- In 2007, 34 percent of (non-SNP) MA-PD enrollees were in plans with some form of gap coverage, up from 28 percent in 2006. Overwhelmingly, gap coverage was for generic drugs only (25 percent of the 34 percent with gap coverage had it for generics only). In 2007, only 8 percent of PFFS Medicare Advantage Prescription Drug Plan (MA-PD) enrollees had gap coverage, compared to 39 percent of HMO MA-PD enrollees.

[11] These percentages are of all MA enrollees, including those in MA plans not offering Part D.

- In 2007, as in 2006, most MA enrollees faced co-payments of $5 to $15 for primary care physician visits.

- Nearly half (45 percent) of MA enrollees had an OOP maximum in 2007, up from 41 percent in 2006. In 2007, most maximums ranged from $2,001 to $5,000. The median OOP maximum was $3,100 in 2007, up $100 from $3,000 in 2006.

Enrollment

- MA enrollment in 2007 was 6.8 million, with a penetration rate (enrollees/eligibles) of 17.2 percent. MA enrollment rose 19 percent from 2006 to 2007, and MA penetration increased 2.5 percentage points.

- Most of the increase in 2007 MA enrollment was in PFFS plans and SNPs. From 2006 to 2007, MA enrollment grew by 1,080,277, with 668,676 of this increase (62 percent) in PFFS plans and 257,683 (24 percent) in SNPs.

- Although HMOs were still the dominant plan type in MA, together PFFS and PPOs (local and regional) had approximately 29 percent of 2007 MA enrollment, which was approximately 10 percent higher than in 2006. Compared to the HMO increase in enrollment of 5 percent from 2006 to 2007, the local PPO increase was 27 percent, the PFFS increase was 87 percent, and the regional PPO increase was 124 percent. MSA plans had an enrollment of 2,260 beneficiaries in 2007.

In short, the context for developments in 2008 is that the MA program had declined in the early years of this decade, but had rebounded since 2005 following the passage and implementation of the MMA.

### 1.3 Managed Care Legislative Mandates

A primary focus of this project is the impact of legislated changes on MA plan availability, premiums and benefits, and beneficiary enrollment. Although the MMA was passed in 2003, many of its most far-reaching mandates relevant to the MA program did not become effective until January 1, 2006. The MMA mandates effective in 2006 fell into three primary categories: bid-based payment methodology, mandate for Part D benefits in MA coordinated care plans, and implementation of a new plan type with regional service areas (regional PPO plans). The details of these major MMA-related changes implemented in 2006 can be found in Section 1.3 of our 2006 interim report (Pope et al., 2007).

Although the post-MMA implementation period was relatively active for new provisions affecting the MA program, 2008 (similar to 2007) represented a relatively quiet year for new programmatic changes. Modifications to the MA program in 2008 were limited to small regulatory modifications. For example, effective for only 2007 and 2008, the Tax Relief and Health Care Act of 2006 added section 1851(e)(2)(E) of the Social Security Act. This section allowed Medicare FFS enrollees to enroll in an MA-only (i.e. without Part D prescription drugs) plan outside of the open-enrollment period. This may have had a slight impact on enrollment in MA plans. We also note that the MMA-established moratorium on new local PPO plans

continued into 2007, but ended as of 2008, allowing entry of local PPOs to new service areas. This change has had some impact on plan availability.

## 1.4 Goals of This Report

Implementation of the legislative mandates, including in particular the MMA, has significantly impacted the MA program over time. The goal of this report is to document MA plan availability, premiums and benefits, and beneficiary enrollment in 2008 as they evolved in response to these legislative changes and other factors. We also focus on changes from 2007 to 2008. For availability analyses, we put the 2008 developments in a longer run context of 2000 to 2008 trends; for premiums, benefits, and enrollment, our context is the shorter-run 2006 to 2008 trends. This report focuses especially on key recently implemented features of MA, including Part D prescription drug benefits, MSAs, more widely available SNP plans, and other new MA plan options mandated under the MMA.

In part, as a result of broader healthcare reform discussions, more attention was focused in 2008 on the "overpayment" of MA plans. Therefore, we discuss this issue in this report—in Section 6, we present several new analyses of the relationship of MA county benchmark payment rates to MA plan availability, premiums, and benefits. What is typically meant by "overpayment" in this context is the growing gap between MA plan payments and the traditional FFS baseline per capita costs. For example, MedPAC (2008) has estimated that, on average, MA plans are reimbursed 14 percent more than similar beneficiaries would cost the program had they remained in FFS. There are multiple reasons for this extra payment relative to FFS; essentially, these excess payments are the cumulative effect of legislative payment changes dating back to the BBA. First, the BBA established, continued under MMA, minimum payments for certain traditionally low FFS cost (and therefore low MA payment) counties. These minimums, all in excess of average FFS costs, were either increased in future updated rate books or subject to minimum guaranteed annual increases. Second, MA payment legislation established under the BBA, and again continued under the MMA, a pattern of guaranteed minimum payment rate updates regardless of actual cost performance of FFS. In the early years of post-BBA implementation, these standards initially appeared to constrain MA payment rates, causing plans to cite a payment "fairness gap" to their disadvantage between MA and FFS. However, in subsequent years, these guaranteed increases—coupled with an MMA guaranteed standard of 100 percent of FFS—fueled the growing "overpayment." Finally, although payment to plans under the MMA is based in part on plan bids, these bids are evaluated relative to county rates established under the cumulative effect of the legislative methodologies that by design raised MA payment rates relative to FFS.

Whether MA plans are "overpaid" is a complex question that will likely be debated in Congress and among other policy makers during 2009 and beyond. On one hand, as previously noted, MA payment rates are clearly often in excess of payments made for similar beneficiaries enrolled in FFS. On the other hand, MA plans universally offer to Medicare beneficiaries coverage that exceeds the statutory Medicare FFS benefits as an incentive for their voluntary enrollment. Prior to Part D, these additional benefits have included prescription drugs. Common additional benefits offered currently include substitution of modest co-payments for physician services in place of the statutory Medicare FFS 20-percent co-insurance and other protection from Medicare FFS cost sharing. Therefore, the payment for MA enrollees is for a different set

of benefits—benefits not mandated, but nonetheless received. In this report, we use the term "overpayment" to refer to the payment difference between MA and similar FFS beneficiaries because it is the common reference to this issue; we do not undertake a policy analysis based on whether this overpayment is justified.

# SECTION 2
# METHODOLOGY

## 2.1 Overview

In this section, we provide an overview of our empirical methodological approach for monitoring the Medicare Advantage (MA) program in 2008. Additional methodological details specific to certain analyses are presented in subsequent sections of this report. Our quantitative analyses were performed on Centers for Medicare & Medicaid Services (CMS) administrative data. We describe in this section the primary methodological definitions, approaches, issues, challenges, samples, and data sources used in our analyses.

## 2.2 Contracts and Plans

In this report, we conducted analyses at both the MA contract level and plan level. The term "contract" refers to a contract between an "MA Organization" (typically an insurer) and CMS to enroll Medicare beneficiaries and provide them with medical services in a defined geographic area. The term "plan" refers to a specific benefit package and premium offered by an MA organization in specific counties. Several "plans" may be offered by the same contract (MA organization) in the same county (e.g., a plan including the Part D drug benefit and a plan without a drug benefit). In some sections of this report, such as in Section 3 where we analyze the availability of MA options to beneficiaries, our unit of analysis is generally the contract. However, because benefits and cost sharing vary by plans within overall contracts, the unit of analysis in Section 4 is the plan, weighted by plan enrollment.

One of our major analytical variables in this report is "plan type," that is, health maintenance organization (HMO), local preferred provider organization (PPO), regional PPO, private fee-for-service (PFFS), or Medical Savings Account (MSA). Each MA contract contains only one of these plan types (although a contract may contain multiple plans of the same type). So contracts and plans may be classified into the plan types and analyzed on that basis. HMO point-of-service (POS) plans may be offered by HMO contracts and are grouped with them in our analyses. We also group the uncommon "provider-sponsored organization" (PSO) plan type with HMOs in our analyses. PSOs are similar to HMO plans that are sponsored by a provider organization rather than by an insurer.

One important type of MA plan—special needs plans (SNPs)—is not also a contract type. SNPs are defined by their targeted population, not by their provider network requirements. An MA contract may offer both SNP and non-SNP plans, or only one or the other. SNPs are allowed to restrict enrollment to their targeted population, whereas other non-employer–only MA plans must enroll any beneficiary eligible for MA. Therefore, we refer to non-employer–only, non-SNP plans as "open-access" plans. In our analyses, SNPs are sometimes distinguished as a separate category and sometimes combined with open-access plans in other categories (e.g., total MA, HMOs). PFFS plans cannot offer an SNP.

## 2.3 Types of Plans Analyzed

Our analysis focuses on MA plans. The Medicare law specifies three types of MA plans: (1) coordinated care plans, which include HMOs (with or without a POS option), local and regional PPOs, and PSOs; (2) PFFS plans; and (3) MSA plans. We discuss these options below:

- **Health Maintenance Organizations**—HMOs are a traditional form of Medicare coordinated care contract in which enrollees are covered only for services received from a defined network of participating providers. Enrollees usually must choose a primary care provider who authorizes all or most services. A variant of HMOs is HMO/POS plans, in which out-of-network coverage is available with higher cost sharing on a service-by-service basis.[12]

- **Local Preferred Provider Organizations**—PPOs are a variant of coordinated care contracts in which non-network healthcare providers are covered with increased cost sharing. In-network providers can be accessed without referrals from a primary care provider. Local PPOs define their service areas on a county-by-county basis. As of 2006, the Medicare PPO demonstration plans that began prior to 2006 converted to local PPO status. Prior to 2006, we included the PPO demonstration plans in the local PPO category.

- **Regional Preferred Provider Organizations**—Regional PPOs are coordinated care plans and were new to Medicare in 2006. Similar to local PPOs, regional PPOs offer out-of-network services for additional cost sharing and do not require in-network referrals, but regional PPOs must offer uniform products at the same premiums and in an entire MA region rather than defining their service area on a county-by-county basis. CMS defines 26 MA regions comprised of single states or groups of states.

- **Special Needs Plans—**SNPs are coordinated care plans that target beneficiaries with special needs. These plans can be offered through HMOs or local or regional PPOs. The three types of SNPs are targeted at dual Medicare/Medicaid eligibles, institutionalized beneficiaries, or beneficiaries with a severe chronic or disabling condition. Unlike other MA plans, SNPs are allowed to exclusively enroll or enroll a disproportionate percentage of their target group of beneficiaries. SNPs must provide services tailored to their special population. All SNPs are required to offer Part D drug benefits.

- **Private Fee-for-Service**—Most PFFS plans do not have a defined provider network. Enrollees are covered for services from any provider willing to accept the payment terms of the PFFS plan. Enrollee cost sharing for services may differ from traditional Medicare. Providers are paid on a fee-for-service (FFS) basis and at the traditional Medicare payment rates or higher.

[12] As noted, we also group the uncommon "PSO" plan type with HMOs in our analyses.

There are a few PFFS plans with a network of providers (providers who have a contract with the plan) for some or all categories of services. Enrollees can still seek healthcare from out-of-network providers who are willing to accept the payment terms of the PFFS plan, but the enrollees may have higher cost sharing. Payment to contracted providers may be less than the traditional Medicare payment rates.

PFFS contracts are not required to offer plans with a Part D benefit. Also, unlike other MA plans, PFFS and MSA plans are not considered coordinated care or managed care plans, and federal regulations prevent them from offering SNPs.

- **Medical Savings Account**—New in 2007, MSAs are "consumer-directed" health plans that combine a high-deductible health plan that covers catastrophic medical expenses with an MSA. Medicare pays an amount to the MSA plan, which makes a deposit into the enrollees' interest-bearing MSA. The enrollee can make tax-free withdrawals from his or her savings account to pay for qualified medical expenses. When the MSA has been exhausted, the enrollee pays out of pocket for expenses until the plan deductible is reached. Only Medicare-covered expenditures count toward the plan deductible. Above the deductible, the plan pays for all Medicare-covered services. MSA plans are not allowed to restrict enrollees to a network of providers. MSA plans are not permitted to offer Part D benefits, but MSA enrollees may enroll in a stand-alone PDP Part D plan. MSA plans are allowed to offer additional benefits for an extra enrollee premium ("optional supplemental benefits").

  Both regular and demonstration MSA plans were offered in 2007. Demonstration plans may offer the following features not found in regular plans: coverage of preventive services below the deductible, a lower deductible than the out-of-pocket (OOP) maximum, cost sharing between the deductible and the OOP maximum, and differential in- and out-of-network cost sharing. We included both demonstration and non-demonstration MSA plans in our analysis.

In general, we did not include non-MA plans in our analyses. Non-MA plans include demonstration,[13] cost reimbursement, the Program of All-Inclusive Care for the Elderly (PACE), and other plan types. Non-MA plans often have unique payment arrangements, enrollment limitations, or benefit design features not found in MA plans. However, to obtain consistent trends, we included contracts throughout 2006–2008 that had regular MA status in any of these years. In practice, this meant that we included several contracts that had demonstration status in 2006 and/or 2007, but became regular MA plans—primarily SNPs—in 2008. We excluded employer-only plans from our analyses because these type of plans are restricted to enrollees sponsored by specific employers, typically retirees of a specific employer, and are tailored to that employer's situation. Beginning with analyses in 2006, we were able to exclude enrollment from employer-only plans completely because of the availability of plan-level enrollment data. Prior to 2006, only contract-level enrollment was available, and we could not exclude enrollment from

[13] We did include PPO demonstration contracts in 2003–2005, many of which became local PPO contracts in 2006, in our analysis. We also included MSA demonstration contracts in our analysis to give a complete picture of the availability of this new Medicare plan option.

MA contracts that offered a mix of employer-only and non-employer plans. Finally, we included only plans that were Part A and Part B plans.

Tables 2-1 through 2-3 show the exclusions that created our final 2008 analysis sample in terms of contracts (Table 2-1), plans (Table 2-2), and enrollment (Table 2-3). Beginning with the contracts and plans in CMS' Health Plan Management System (HPMS) Plan Information File, we exclude Part B–only plans, employer-only plans, non-MA plans, plans not in the HPMS enrollment file, Puerto Rico plans, and plans that do not have "active" status.[14,15] The exclusions that remove the most health plan enrollment from our sample (Table 2-3) are employer-only plans (1,718,199 enrollees), Puerto Rico plans (344,174 enrollees), and non-MA plans such as cost plans (212,711 enrollees)—these three exclusions account for 91 percent of the total enrollment exclusions. In Table 2-3, we also compare enrollment in analysis sample plans by plan type between HPMS and an alternative CMS data system called the Management Information Integrated Repository (MIIR). In general, the enrollment counts are quite similar between HPMS and MIIR, but slightly higher in the MIIR data.

## 2.4 Enrollment Weighting of Premiums and Benefits

Unless otherwise noted, our analyses of MA plan premiums and benefits are weighted by plan enrollment. The analyses reveal what premiums MA enrollees paid and what benefits they received, on average. Enrollment-weighted premiums and benefits reflect both plan offerings and beneficiary choices among available plans. An unweighted analysis, or an analysis weighted by the number of Medicare program enrollees in an area (MA and non-MA), would reflect plan offerings only. An unweighted analysis would count a plan with 1 enrollee the same as a plan with 1-million enrollees.

Our previous trend analyses of 2000 to 2005 were limited to basic HMO plans, defined as the lowest-premium plan offered by an HMO contract in a county (Pope et al., 2006). We focused on HMOs because we wanted to examine the effects of payment changes on trends in the premiums and benefits of a consistent plan type over time. We selected the single basic HMO plan because our analyses were enrollment weighted, and only total contract enrollment, not enrollment for each plan offered by a contract, was available.

Beginning in 2006, enrollment weights by contract and plan within contract were newly available. For 2006 and after, we no longer needed to use the concept of "basic HMO plan," but rather included all plans in our analysis, weighting each by its enrollment. Our MA totals for premiums and benefits in 2006 through 2008 include HMOs, PPOs, and PFFS and include all

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14 Plans without "active" contract status can have the statuses "novation," "termination," or "withdrawn contract." "Withdrawn contract" accounts for most of the contracts without active status.

15 Specific analyses presented later in this report often required merging data from multiple sources. Contracts or plans without data from all necessary sources for an analysis were dropped from that analysis. This may cause the sample of contracts and/or plans to differ slightly across analyses.

## Table 2-1
## Creation of analysis sample of MA contracts, 2008

| MA contracts | **Original sample** HPMS plan information file, July 2008 | Part B only plans exclusions | Employer-only plans exclusions | "1876 Cost" "continuing care retirement community," "ESRD I," "ESRD II," "national PACE" exclusions | Not in HPMS enrollment file exclusions | Puerto Rico plans exclusions | **Final analysis sample** Plan status not "active" exclusions |
|---|---|---|---|---|---|---|---|
| **MA contracts, total** | **703** | **703** | **694** | **603** | **597** | **577** | **556** |
| 1876 Cost | 16 | 16 | 16 | — | — | — | — |
| Continuing care retirement community | 10 | 10 | 10 | — | — | — | — |
| ESRD I | 4 | 4 | 4 | — | — | — | — |
| ESRD II | 3 | 3 | 3 | — | — | — | — |
| Employer/union only direct contract PFFS | 2 | 2 | — | — | — | — | — |
| HMO | 353 | 353 | 339 | 339 | 336 | 324 | 319 |
| HMO POS | 61 | 61 | 60 | 60 | 58 | 55 | 55 |
| MSA | 9 | 9 | 9 | 9 | 9 | 9 | 2 |
| National PACE | 58 | 58 | 58 | — | — | — | — |
| PFFS | 77 | 77 | 71 | 71 | 70 | 67 | 63 |
| Local PPO | 137 | 137 | 137 | 137 | 136 | 133 | 130 |
| PSO (state license) | 4 | 4 | 4 | 4 | 4 | 4 | 3 |
| Regional PPO | 14 | 14 | 14 | 14 | 14 | 14 | 13 |
| **MA contracts with SNPs** | **325** | **325** | **325** | **312** | **303** | **292** | **285** |
| with Chronic condition | 107 | 107 | 107 | 94 | 92 | 88 | 87 |
| with Dual-eligible | 270 | 270 | 270 | 270 | 263 | 252 | 247 |
| with Institutional | 66 | 66 | 66 | 60 | 49 | 48 | 47 |

NOTES:

1. There are no contracts with only Part B only plans, so this exclusion does not exclude any contracts.
2. ESRD is end-stage renal disease.
3. The HMO and HMO POS contract types are not mutually exclusive. Some contracts have both HMO and HMO POS plan types and are counted in both categories.

SOURCE: RTI analysis of the July 2008 HPMS file.

## Table 2-2
## Creation of analysis sample of MA plans, 2008

| MA plans | **Original sample** HPMS plan information file, July 2008 | Part B only plans exclusions | Employer-only plans exclusions | "1876 Cost" "continuing care retirement community," "ESRD I," "ESRD II," "national PACE" exclusions | Not in HPMS enrollment file exclusions | Puerto Rico plans exclusions | **Final analysis sample** Plan status not "active" exclusions |
|---|---|---|---|---|---|---|---|
| **MA contracts, total** | 703 | 703 | 694 | 603 | 597 | 577 | 556 |
| **MA plans, total** | 4,816 | 4,776 | 3,698 | 3,431 | 3,294 | 3,213 | 3,164 |
| 1876 Cost | 120 | 117 | 103 | — | — | — | — |
| Continuing care retirement community | 36 | 36 | 36 | — | — | — | — |
| ESRD I | 9 | 9 | 9 | — | — | — | — |
| ESRD II | 3 | 3 | 3 | — | — | — | — |
| Employer/union only direct contract PFFS | 2 | 2 | — | — | — | — | — |
| HMO | 2,155 | 2,136 | 1,691 | 1,691 | 1,637 | 1,580 | 1,575 |
| HMO POS | 319 | 319 | 279 | 279 | 265 | 253 | 253 |
| MSA | 25 | 25 | 14 | 14 | 14 | 14 | 3 |
| National PACE | 116 | 116 | 116 | — | — | — | — |
| PFFS | 1,026 | 1,008 | 838 | 838 | 792 | 787 | 771 |
| Local PPO | 803 | 803 | 501 | 501 | 478 | 471 | 457 |
| PSO (state license) | 30 | 30 | 24 | 24 | 24 | 24 | 23 |
| Regional PPO | 172 | 172 | 84 | 84 | 84 | 84 | 82 |
| **SNPs, total** | 782 | 782 | 770 | 751 | 695 | 661 | 654 |
| Chronic-condition plans | 252 | 252 | 241 | 228 | 220 | 212 | 211 |
| Dual-eligible plans | 441 | 441 | 440 | 440 | 409 | 384 | 379 |
| Institutional plans | 89 | 89 | 89 | 83 | 66 | 65 | 64 |

NOTE:

1. There are no contracts with only Part B only plans, so this exclusion does not exclude any contracts.

SOURCE: RTI analysis of the July 2008 HPMS file.

## Table 2-3
## Enrollment (HPMS and MIIR) in analysis sample of MA plans, 2008

| Enrollment, by plan type | HPMS **Original sample** enrollment file, July 2008 | HPMS Not present in HPMS plan information file exclusions | HPMS Part B only plans exclusions | HPMS Employer-only plans exclusions | HPMS "1876 Cost" "continuing care retirement community," "ESRD I," "ESRD II," "national PACE" exclusions | HPMS Not present in section D HPMS file exclusions [1] | HPMS Puerto Rico plans exclusions | HPMS **Final analysis sample** Plan status not "Active" exclusions | MIIR **Final analysis sample** |
|---|---|---|---|---|---|---|---|---|---|
| MA total | 10,119,339 | 9,934,506 | 9,929,475 | 8,211,276 | 7,998,565 | 7,998,377 | 7,654,203 | 7,621,340 | 7,735,237 |
| Missing hpms_plan_type | 184,833 | — | — | — | — | — | — | — | — |
| 1876 Cost | 240,459 | 240,459 | 240,458 | 193,762 | — | — | — | — | — |
| Continuing care retirement community | 3,394 | 3,394 | 3,394 | 3,394 | — | — | — | — | — |
| ESRD I | 528 | 528 | 528 | 528 | — | — | — | — | — |
| ESRD II | 597 | 597 | 597 | 597 | — | — | — | — | — |
| Employer/union only direct contract PFF | 13,008 | 13,008 | 13,008 | — | — | — | — | — | — |
| HMO | 5,943,010 | 5,943,010 | 5,940,441 | 4,999,254 | 4,999,254 | 4,999,066 | 4,701,845 | 4,692,530 | 4,760,572 |
| HMO POS | 488,527 | 488,527 | 488,527 | 453,340 | 453,340 | 453,340 | 428,289 | 428,289 | 433,215 |
| MSA | 3,552 | 3,552 | 3,552 | 3,552 | 3,552 | 3,552 | 3,552 | 469 | 473 |
| National PACE | 14,430 | 14,430 | 14,430 | 14,430 | — | — | — | — | — |
| PFFS | 2,260,364 | 2,260,364 | 2,257,903 | 1,668,847 | 1,668,847 | 1,668,847 | 1,668,481 | 1,650,019 | 1,671,830 |
| Local PPO | 659,575 | 659,575 | 659,575 | 574,606 | 574,606 | 574,606 | 553,070 | 552,449 | 564,692 |
| PSO (state license) | 18,246 | 18,246 | 18,246 | 18,246 | 18,246 | 18,246 | 18,246 | 18,242 | 18,614 |
| Regional PPO | 288,816 | 288,816 | 288,816 | 280,720 | 280,720 | 280,720 | 280,720 | 279,342 | 285,841 |
| SNP total | 1,218,895 | 1,218,895 | 1,218,895 | 1,218,413 | 1,216,023 | 1,216,023 | 982,188 | 972,868 | 1,002,334 |
| Chronic or disabling condition | 217,281 | 217,281 | 217,281 | 217,281 | 215,097 | 215,097 | 184,884 | 180,420 | 194,497 |
| Dual-eligibles | 868,824 | 868,824 | 868,824 | 868,342 | 868,342 | 868,342 | 665,436 | 660,593 | 675,110 |
| Institutional | 132,790 | 132,790 | 132,790 | 132,790 | 132,584 | 132,584 | 131,868 | 131,855 | 132,727 |

[1] Did not have full benefit/cost sharing information.

NOTES:

1. Other plan types (e.g., HMOs) include SNPs.
2. MIIR is Management Integrated Information Repository.

SOURCE: RTI analysis of the July 2008 HPMS file.

plans in each contract, not just the lowest premium plan. The ability to analyze all plans weighted by enrollment gave us a more accurate picture of the premiums paid and benefits received by the average MA enrollee. This is increasingly important as the number of plan types and options proliferates and provides a basis for examining MA trends from 2006 to 2008 in project Phase II.

As a consequence of including all plans in our premiums and benefits analysis, our 2006 through 2008 premiums and benefits data are not comparable to premiums and benefits for basic HMO plans from our earlier work (Pope et al., 2006). Hence, our 2008 premiums and benefits analysis is limited to a cross-sectional analysis of 2008 and changes from 2006 to 2008.

Even if we had not made the change in enrollment weighting, comparison of 2006 through 2008 premiums and benefits to earlier premiums and benefits would have been problematic because of the introduction of Part D in 2006. With the advent of Part D, MA plans' prescription drug benefit is separately priced (through the Part D premium); the Part C premium now covers only medical benefits. Previously, the drug benefit, if any, was covered by the single Part C premium. Thus, the benefit package covered by the Part C premium has changed, and the Part C premium time trends pre- and post-2006 are not comparable. Part D premiums, of course, did not exist before 2006.

### 2.5 Geographic Areas

In our analysis of plan availability, number and percentage of counties are key measures of the availability of types of plans. We have data on approximately 3,120 counties throughout our time period (2000 to 2008). The number of counties may vary slightly for different tables, analyses, or years because of availability of data for several counties. One issue is Broomfield County, Colorado, which was created in 2003, and thus did not exist throughout our study period. Another issue involves counties in Alaska that were not coded consistently across different data sources. To address the latter, we created a single aggregate "county" for "rest of Alaska," which comprises Alaska excluding Anchorage, Juneau, and Fairbanks. Data were not always available for these Alaska "counties" that we created. The Social Security Administration county codes that we used include two county codes for Los Angeles County in California. We combined these into a single Los Angeles County code.

We excluded Puerto Rico and the U.S. territories (i.e., the Virgin Islands, Northern Marianas, American Samoa, and Guam) from all of our analyses.

In addition to national- and county-level analyses, we grouped counties by urbanicity and region to examine aggregated impacts by type and location of county. We defined five categories of urbanicity based on the "Beale" codes created by the U.S. Department of Agriculture for the year 2003 based on the 2000 Census. The categories included the following:

- Large urban: Counties in Metropolitan Statistical Areas of 1 million or more
- Medium urban: Counties in Metropolitan Statistical Areas of 250,000 to 1 million
- Small urban: Counties in Metropolitan Statistical Areas of less than 250,000

- Rural–urban-adjacent: Non-metropolitan counties adjacent to at least one metropolitan county

- Rural–nonadjacent: Non-metropolitan counties not adjacent to any metropolitan counties.

Our regional definition was the four U.S. census regions: Northeast, Midwest, South, and West.

## 2.6 Beneficiary Sample

Our analysis focuses on options available to Medicare beneficiaries; however, because individuals diagnosed with end-stage renal disease are excluded from enrolling in an MA plan (they can, however, remain in a plan if they are diagnosed after enrollment), we have excluded this population from our analyses that look at penetration and Medicare-eligible populations.

## 2.7 Timing of Data

In our earlier work studying the period 2000 to 2005, we were unable to obtain a consistent month of the year for trend analyses because of data limitations (see research from Pope and colleagues [2006] for more details). For 2006 through 2008, we chose to obtain data for July of each year, which was the midpoint of the year. In 2006, July was after the special initial open-enrollment period for Part D plans ended in May 2006. Our data represent a point-in-time sample for July 2008, July 2007, and July 2006, not an "ever enrolled" in 2007 or in the 2006 sample.

## 2.8 Pre-2006 Trends

For our analysis of plan availability in Section 3, because the necessary data were consistent over time, we were able to build on our earlier work for 2000 to 2005 by adding results for 2006 through 2008 and analyzing trends for 2000 to 2008. For the premiums and benefits analysis of Section 4 and the enrollment analysis of Section 5, pre-2006 trend analysis was problematic, and we did not attempt it for this report. The premiums, benefits, and enrollment analyses evaluate 2008 and changes from 2006 to 2008.

We discussed in Section 2.4 that 2000 to 2008 trend analysis of premiums and benefits proved to be infeasible for two reasons: (1) inclusion of all MA plans in the 2006 analysis versus only basic HMO plans prior to 2006 and (2) the introduction of Part D in 2006, which changed the premium and benefit structure of MA plans. Our premiums and benefits analysis is a cross-sectional study of 2008 and of changes from 2006 to 2008.

Trend analysis of MA enrollment also proved to be difficult. Our 2000 to 2005 enrollment analyses used the Medicare Enrollment Database (EDB). In 2006, we began using the MIIR (described in more detail below). Enrollment trends from the two databases were inconsistent. In part, the incomparability between the EDB and MIIR enrollments was due to our ability to perfectly exclude employer-only plan enrollment in 2006 through 2008 with the MIIR, compared to our imperfect exclusion for 2000 to 2005 with the EDB. For this report, we use the MIIR to analyze 2008 MA enrollment and changes in enrollment from 2006 to 2008.

## 2.9 Data Sources

**CMS Health Plan Management System**—The primary data source used in our analyses was CMS' HPMS, which collects service area, premium, and benefit information for MA plans and certain other plan types. This information is submitted by plans annually, or more frequently if the data change. The HPMS Plan Benefit Package (PBP) data sets are available for each month and contain information describing the benefit package provided by each plan, including information on premiums, co-payments, co-insurance and deductible amounts, and drug and other benefit descriptions. The HPMS data were used for the plan availability and plan premiums and benefits analyses. We used July 2006, July 2007, and July 2008 HPMS PBP extracts.

**HPMS Plan Enrollment Data Extract**—Because of delays in obtaining the MIIR enrollment data, RTI International completed 2006, 2007, and 2008 national-level premiums and benefits analyses using plan enrollment weights from the Plan Enrollment Data Extract from the HPMS. Like the MIIR, the HPMS data include enrollment at the individual-plan level, rather than just the contract level. But they are not available at the contract/plan/county level; thus, the MIIR was used to develop an enrollment weight for analyses including a geographic component (e.g., urbanicity, region). For most plans, the HPMS and MIIR enrollment data are very similar, but differences are larger for a few plans, perhaps because of differences in the timing of when data feeds from plans are reflected in the two data sources. Thus, premiums and benefits results, using an HPMS enrollment weight versus an MIIR enrollment weight, are very similar and consistent, but are not identical.

**Management Information Integrated Repository**—The MIIR is a beneficiary-level CMS database that contains extensive information about Medicare beneficiaries, including Medicare program enrollment information, Medicare health plan enrollment, Part D enrollment, and beneficiary demographic characteristics. The MIIR was used to obtain a contract/plan/county enrollment weight for premium and benefit analyses by urbanicity and region. The MIIR was also used for the 2006 through 2008 enrollment analyses in Section 5.

**Medicare Denominator File**—The Medicare Denominator File was used to calculate counts of Medicare beneficiaries eligible to enroll in MA. Eligibility counts were needed for several of our analyses, including descriptive analyses of a number of Medicare beneficiaries with access to MA plans and the percentage of Medicare beneficiaries enrolled in MA plans (MA penetration).

**Out-of-Pocket Cost Estimates—**CMS/Fu Associates Ltd. simulated average OOP costs for beneficiaries of various ages and health statuses as if they were enrolled in each MA plan in 2007 and in 2008 (Fu Associates, 2006 and 2007). Using Medicare Current Beneficiary Survey data, CMS/Fu Associates developed an average medical services utilization profile for beneficiaries in each age and health status cell. CMS/Fu Associates then applied the benefit rules of each MA plan to estimate expenses for each utilization profile. Benefit coverage and cost sharing were combined with premiums to simulate total enrollee OOP costs by age and health status.

We used the age and health status cell sizes reported by Fu Associates (2006 and 2007) as relative weights to combine data for multiple cells into a single weighted average. We reported

data for all ages for any health status, excellent health status, and poor health status. Any health status was reported as an overall summary measure. Excellent versus good health status contrast costs for plan enrollees in the best versus the worst health status to show how much OOP costs rise with poorer health and increased utilization of medical care, and which plans are better for healthy versus sick enrollees. We report simulated total average OOP costs and estimates for the following major categories of OOP costs: premiums, outpatient prescription drugs, inpatient care, dental care, and all other services.

## 2.10 Data Consistency and Quality Issues

Developing the analytical data files for this report required merging multiple data sources from the HPMS, MIIR, and other data sources. The data from different source files were not always fully consistent (e.g., a small number of plans or counties might not match between data files). We merged files and reconciled data as completely as possible, and merges were usually perfect or nearly so, but because of a small number of non-merges in some instances, the sample (number) of plans, counties, or enrollees may differ slightly among some tables, years, variables, or analyses in this report. These minor inconsistencies should not have any material effect on the results that we report.

In some cases, we found that variables were not reported accurately in the source data. For example, not all MA plans may have responded to certain items on the HPMS/PBP, and certain MIIR fields did not contain usable data. If data fields did not appear to be substantially complete and accurate, we did not use them in our analyses.

There were also data consistency issues over time. The major ones were previously discussed in this section. There were also minor inconsistencies in some of the HPMS files over time (e.g., in certain variables related to aspects of plan benefits). Our methods of drawing the sample of MA plans and analyzing the data evolved to some extent over the course of this project. The 2006 to 2008 trends presented in this report were entirely recalculated with our latest procedures, data, and methods in a consistent manner. This recalculation may cause them to differ from data presented in our earlier reports. Generally these differences are minor, but where there are discrepancies, the data presented in this report supersedes earlier reports.

# SECTION 3
# PLAN AVAILABILITY

## 3.1 Introduction

One collective goal of recent Medicare legislative initiatives has been to expand the number and type of Medicare health plans available to Medicare beneficiaries, particularly in geographic areas (such as rural counties) that have traditionally been underserved by managed care. Therefore, in this section, we describe changes in plan availability between 2000 (after the Balanced Budget Act (BBA) and Balanced Budget Refinement Act (BBRA) were implemented) and 2008 (3 years after initial Medicare Modernization Act [MMA] provisions were implemented), focusing on trends in the most recent 2 years post MMA. We examined changes in total number of contracts participating in Medicare Advantage (MA), contract availability by urban-rural and regional areas, and beneficiary access to different numbers and types of MA contracts.

## 3.2 Medicare Advantage Contracts by Plan Type: 2000 to 2008

### 3.2.1 Number of Contracts

Our initial analysis evaluated the number of Medicare contracts, in total and by contract type, by year. Findings are presented in Table 3-1. In this analysis, we counted the number of contracts, not individual plans offered under these contracts.[16]

Looking at the overall trend in number of MA contracts, the sharp post-2004 gain in contracts contrasts sharply with declines earlier in the decade. In 2000, there were a total of 264 MA contracts. By 2002, driven by Congressionally mandated payment rate reductions, contracts declined to the lowest point in our analysis period, at 154 MA contracts nationally. In 2005, when MMA-mandated payment changes had been implemented, the total number of contracts rose sharply from the previous year—by approximately 62 percent. By June 2005, the number of MA contracts exceeded the number of contracts at the beginning of our analysis period (2000).

The sharp increase in the number of contracts that began in 2005 continued through 2008, with the total number of MA contracts rising to 556. The gain in total contracts from 2006 to 2007 did slow to 50, down from approximately 100 more total contracts per year in 2005 and in 2006. However, between 2007 and 2008, the number of contracts increased again by approximately 100 (rising from 458 to 556). Private fee-for-service (PFFS) contracts again showed the largest proportional growth in 2008, increasing in number by approximately 50 percent (from 41 to 63) between 2007 and 2008. PFFS plans tend to cover very large service areas with single contracts, so the relatively small number of contracts should not be equated with lesser impact on the MA program.

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16 A contract is an agreement between an MA organization and Centers for Medicare & Medicaid Services to offer Medicare health plans in an area. A plan is a specific benefit package offered by the MA organization. One or more plans may be offered under a single contract, but each contract is limited to one plan type (except special needs plans) (e.g., health maintenance organizations, local preferred provider organizations).

**Table 3-1**
**Number of MA contracts, by plan type**

| Plan type | Nov-00 | Jun-01 | Apr-02 | Apr-03 | Feb-04 | Jun-05 | Jul-06 | Jul-07 | Jul-08 |
|---|---|---|---|---|---|---|---|---|---|
| Total MA contracts | 264 | 179 | 154 | 178 | 178 | 289 | 408 | 458 | 556 |
| Total coordinated care contracts | 263 | 178 | 152 | 175 | 175 | 275 | 387 | 414 | 491 |
| HMO[1] | 259 | 173 | 147 | 137 | 132 | 176 | 256 | 293 | 348 |
| Local PPO[2] | 1 | 2 | 3 | 35 | 40 | 93 | 120 | 107 | 130 |
| Regional PPO | — | — | — | — | — | — | 11 | 14 | 13 |
| MSA[3, 4] | — | — | — | — | — | — | — | 3 | 2 |
| PFFS | 1 | 1 | 2 | 3 | 3 | 14 | 21 | 41 | 63 |

[1] HMO includes HMO point of service (POS); 2006–2008 also include provider-sponsored organization (PSO).

[2] Includes PPO demonstration contracts from 2003 to 2005.

[3] Includes MSA demonstration contracts.

[4] There were nine MSA contracts in 2008, but only two of them had active contract status in July.

NOTES:

1. Special needs plans (SNPs) incorporated by plan type.

2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data.

Still, health maintenance organizations (HMOs) continue to be the dominate plan type within the MA program. By July 2008, the number of HMOs continued their trend of adding new contracts each year (55 new in 2008). Following the expiration of the MMA moratorium on new local preferred provider organizations (PPOs), local PPO contracts increased by 23 contracts during 2008. The number of regional PPO and medical savings account (MSA) contracts decreased between 2007 and 2008, suggesting these plan types were not particularly attractive to sponsoring organizations.

### 3.2.2 Percentage of Counties with at Least One Medicare Contract

Because one of the goals of the legislative changes was to improve Medicare beneficiary access to Medicare healthcare plans, we also analyzed for each year between 2000 and 2008 the percentage of counties in which at least one Medicare contract was available. Our findings are shown in Table 3-2, which maps the contracts to counties served and presents data on the proportion of counties with access by each type of plan.[17] Continuing the trend from the past several years, most plan types were available in more counties in 2008 than in earlier years.

In 2008, HMO availability continued to increase significantly to include at least one plan in 47.4 percent of counties. This followed 2007, during which HMO availability rose moderately, and beneficiaries had access to HMOs in more than one-third of all counties. Recent HMO growth contrasts sharply with the beginning of the decade, when from 2000 to 2003 the percentage of counties with at least one Medicare HMO contract fell from nearly 26 percent to 17.8 percent. The percentage of counties with access to an HMO rose slightly to 18.5 percent in 2004. In 2005, there was a sizeable increase (29.5 percent) in the percentage of counties with at least one HMO contract.

In 2008, 1 year after the moratorium on new plans, local PPO availability increased slightly (from 28.5 percent access to 34.3 percent of counties). This continues the earlier trend of upward local PPO availability in 2005 and 2006. In 2005, 22.7 percent of counties had access to a PPO, the first year in which the number of counties with a PPO approached the number of counties with an HMO. In 2006, 29.5 percent of counties had access to a local PPO, as even more PPOs entered or expanded in the MA program in late 2005 before the PPO moratorium for 2006 and 2007 took effect. Earlier in the decade, the percentage of counties with a local PPO contract remained low until the start of the PPO demonstration in 2003 and increased from that point. In 2003, 6.3 percent of counties had access to a local PPO, increasing from less than 1 percent the year before.

Regional PPOs represented a small percentage of the number of contracts, but because of large service areas, they offered accessibility to a large proportion of the Medicare population. Still, this contract type has not grown as expected by some policy makers. In their first year (2006), regional PPOs accounted for only 11 contracts but were available in nearly 90 percent of all counties. Regional PPO access remained unchanged between 2006 and 2009, with these larger contracts reaching a large proportion of counties despite the relatively few number of contracts.

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[17] In general, each contract contains plans of a single type (e.g., HMO, PPO). The exception is SNPs (see Section 2).

**Table 3-2**
**Percent of counties with at least one MA contract, by plan type**

| Plan type | Nov-00 (%) | Jun-01 (%) | Apr-02 (%) | Apr-03 (%) | Feb-04 (%) | Jun-05 (%) | Jul-06 (%) | Jul-07 (%) | Jul-08 (%) |
|---|---|---|---|---|---|---|---|---|---|
| Coordinated care plans | | | | | | | | | |
| HMO[1] | 25.9 | 20.3 | 19.1 | 17.8 | 18.5 | 29.0 | 34.5 | 40.3 | 47.4 |
| Local PPO[2] | 0.2 | 0.2 | 0.4 | 6.3 | 7.6 | 22.7 | 29.5 | 28.5 | 34.3 |
| Regional PPO | — | — | — | — | — | — | 89.9 | 89.9 | 89.9 |
| Non-coordinated care plans | | | | | | | | | |
| MSA[3, 4] | — | — | — | — | — | — | — | 71.3 | 3.1 |
| PFFS | 52.7 | 52.7 | 51.6 | 54.9 | 40.6 | 92.9 | 96.0 | 99.9 | 100.0 |

[1] HMO includes HMO POS; 2006–2008 data also include PSO.

[2] Includes PPO demonstration contracts from 2003 to 2005.

[3] Includes MSA demonstration contracts.

[4] There were nine MSA contracts in 2008, but only two of them had active contract status in July; nine contracts would cover 100% of the counties, and two active contracts would cover only 3%.

NOTES:

1. SNPs incorporated by plan type.

2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data.

By 2008, all counties had access to at least one PFFS option, driven by a more than doubling of PFFS contracts between 2006 and 2008. In 2005, 92.9 percent of counties had access to a PFFS plan, making PFFS options already the most accessible MA option for Medicare beneficiaries. This trend continued in 2006, where with 21 contracts, PFFS plans were available in 96 percent of counties. The number of counties with access to a PFFS plan is quite large, particularly considering the relatively small number of PFFS contracts. In 2000, although there was only one PFFS contract, through this contract, 52.7 percent of counties had access to a PFFS plan. The structure of the PFFS option appeared to favor large service areas under a single contract umbrella, possibly because of the lack of the need to establish local provider networks under PFFS plans. Although the number of PFFS contracts increased to three by 2004, the number of counties with access to a PFFS plan actually decreased that year to 40.6 percent, suggesting that PFFS plans had reduced the number of counties in their service areas. However, by 2005, both the number of PFFS contracts and the number of counties with access to a PFFS plan increased significantly. This growth has continued, with now universal access to Medicare beneficiaries.

MSAs were available in only 3.1 percent of counties in 2008, which is a sharp contrast to 2007 (their first year) where MSA were available in 71.3 percent of contracts. A net exit of MSA contracts (with large service areas) explains this trend. During 2008, nine additional MSA contracts initially were given Medicare approval and entered the marketplace, but they did not remain active as of July 2009, bringing the final number of active contracts down to two. Given this sharp decline in access, the future viability of MSAs under MA seems in doubt.

### 3.2.3 Number and Percentage of Beneficiaries with Access to a Medicare Contract

In addition to the percentage of counties with access to a Medicare plan, we considered the number and percentage of Medicare beneficiaries with access to a contract. Just as counting the number of contracts can give an incomplete picture, counting counties does not take into account the number of beneficiaries residing in each county. Table 3-3 addresses this by counting the number of Medicare-eligible individuals in each county and calculating the proportion of eligibles that have access to each contract type. In looking at the trends in Table 3-3, it is important to note that the data source changes after 2004. The results for 2000 to 2004 were drawn from data that were formerly posted on the Centers for Medicare & Medicaid Services (CMS) Web site; results for 2005 to 2007 were drawn from the CMS Denominator files.[18]

Considering the entire analysis period, we found that the percentage of beneficiaries with access to HMOs and local PPOs was much higher than the percentage of counties with access to HMOs and local PPOs. This is because offerings of HMOs and local PPOs have limited service areas and are concentrated in populous urban counties.

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[18] The data source was changed because these data were not published by CMS for 2006 and 2007 (and, in fact, data for previous years were removed from the CMS Web site). To facilitate a comparison of 2006 data to 2005, the results for 2005 were recalculated using the CMS Denominator file; as a result, the 2005 results reported here differ from earlier tables reported by Pope and colleagues (2006).

## Table 3-3
## Number and percentage of Medicare beneficiaries with access to an MA plan, by plan type

| I. Number<br>Plan type | Nov-00 | Jun-01 | Apr-02 | Apr-03 | Feb-04 | Jun-05 | Jul-06 | Jul-07 | Jul-08 |
|---|---|---|---|---|---|---|---|---|---|
| MA plans | 33,300,258 | 32,958,996 | 32,305,226 | 32,841,281 | 31,774,507 | 37,334,895 | 38,766,667 | 39,606,108 | 40,314,930 |
| HMO[1] | 27,233,843 | 25,646,057 | 24,754,752 | 24,042,140 | 25,160,074 | 26,713,737 | 28,235,418 | 30,381,360 | 33,024,885 |
| Local PPO[2] | 598,318 | 864,952 | 1,693,642 | 9,625,333 | 10,660,896 | 21,382,705 | 25,083,176 | 25,157,693 | 26,227,579 |
| Regional PPO | — | — | — | — | — | — | 34,426,846 | 35,019,154 | 35,652,268 |
| PFFS | 15,223,535 | 15,443,348 | 14,862,682 | 15,490,096 | 13,037,695 | 28,681,100 | 31,570,787 | 39,446,169 | 40,314,930 |
| MSA[3] | — | — | — | — | — | — | — | 31,119,087 | 40,314,930 |
| **II. Percent**<br>**Plan type** | | | | | | | | | |
| MA plans | 83.3% | 80.9% | 78.3% | 78.5% | 74.8% | 97.7% | 99.6% | 99.9% | 100.0% |
| HMO[1] | 68.1% | 62.9% | 60.0% | 57.4% | 59.2% | 69.9% | 72.3% | 76.6% | 81.9% |
| Local PPO[2] | 1.5% | 2.1% | 4.1% | 23.0% | 25.1% | 56.0% | 64.5% | 63.5% | 65.1% |
| Regional PPO | — | — | — | — | — | — | 88.5% | 88.4% | 88.4% |
| PFFS | 38.1% | 37.9% | 36.0% | 37.0% | 30.7% | 75.0% | 81.1% | 99.6% | 100.0% |
| MSA[3] | — | — | — | — | — | — | — | 78.6% | 8.6% |

[1] HMO includes HMO POS; 2005 to 2008 data also include PSO.

[2] Includes PPO demonstration contracts from 2003 to 2005.

[3] Includes MSA demonstration contracts.

NOTES:
1. End-stage renal disease (ESRD) beneficiaries are not included

2. Medicare beneficiaries by county prior to 2005 were obtained from the CMS Web site, and beneficiaries from 2005 through 2008 were obtained from the Medicare Denominator file. Beneficiaries include those eligible to enroll in an MA plan. SNPs are incorporated by plan type. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and the U.S. territories.

SOURCE: RTI analysis of CMS Web site, Denominator file, and Health Plan Management System data.

Conversely, the percentage of beneficiaries with access to PFFS plans has historically been lower than the percentage of counties with access because PFFS service areas were concentrated in less-populous rural counties. However, as PFFS became available in virtually all counties as of 2007, these differences in access as measured by the percentage of counties versus percentage of beneficiaries are erased. For regional PPOs, the percentages of beneficiaries and counties are almost the same because regional PPOs must be offered throughout entire regions comprising both urban and rural areas. Considering all types of MA plans together, more than three-quarters of beneficiaries had access to at least one MA plan throughout the 2000 to 2004 period, although the percentage with access declined from 2000 to 2004. In 2005, the pattern of declining access reversed dramatically, and virtually all beneficiaries (97.7 percent) had access to at least one MA contract. This trend continued in 2006 and 2007 (when virtually all beneficiaries had access to at least one contract). These high percentages found, beginning in 2005 and continuing through 2008, were driven by the availability of PFFS plans (whose relatively limited number of contracts provided access through very large service areas per contract) followed by the addition of regional PPOs in 2006.

In 2008, all MA plan types except MSAs were available to a majority of Medicare beneficiaries. Approximately 82 percent of Medicare beneficiaries had access to an HMO in 2008—above the level in any other year. All beneficiaries had access to PFFS plans. Access to local PPOs decreased slightly in 2007 relative to 2006 with the MMA moratorium on new local PPOs, but rebounded somewhat in 2008; a majority of beneficiaries retained access to these options. Access to regional PPOs remained fairly constant, owing largely to the large service areas typical of these contracts.

### 3.2.4 Plan Availability by Urbanicity

To further study how the legislated payment changes impacted access to Medicare plans, including the goal of increased access to Medicare plans for beneficiaries in rural and small urban areas, we analyzed plan participation by county urbanicity. In this analysis, we returned to the percentage of counties as the measure of access rather than the percentage of beneficiaries. We looked at data from 2000 to 2008, specifically the percentage of counties with at least one HMO, local PPO, regional PPO, or PFFS contract by a range of urban/rural categories. Our results are shown in Table 3-4, which stratifies counties by a measure of urbanicity (Beale Codes) developed by the U.S. Department of Agriculture. The total values (aggregated across all counties) differ in some instances from the results in Table 3-2 because special needs plans (SNPs) have been broken out separately; in the categories in which there are no SNPs (i.e., PFFS) the results are the same as in Table 3-2.

At the time the BBA was enacted, MA-type options were generally more widely available to beneficiaries in larger urban areas and were often not available to those in rural and smaller urban areas. The BBA of 1997 created minimum payment, or "floor," rates which, by 2006, became the rates used to determine benchmarks in most rural and small urban areas. In addressing the creation of floor rates and the new plan types, such as PFFS plans, the BBA conference report indicates that these changes were intended to make MA-type options "available to beneficiaries nationwide, not just to those in select geographic areas." Table 3-4 shows the importance of the PFFS option in making MA options widely available to those in rural and small urban areas.

**Table 3-4**
**Percentage of counties with at least one MA contract, by plan type and urbanicity**

| Urbanicity | Number of counties | Nov-00 (%) | Jun-01 (%) | Apr-02 (%) | Apr-03 (%) | Feb-04 (%) | Jun-05 (%) | Jul-06 (%) | Jul-07 (%) | Jul-08 (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 3,120 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.6 | 100.0 | 100.0 |
| HMO[1] | — | 25.9 | 20.3 | 19.1 | 17.7 | 18.5 | 29.0 | 30.6 | 36.5 | 44.1 |
| Local PPO[2] | — | 0.2 | 0.2 | 0.4 | 6.3 | 7.6 | 22.7 | 28.5 | 27.3 | 32.8 |
| Regional PPO | — | — | — | — | — | — | — | 89.9 | 89.9 | 89.9 |
| MSA | — | — | — | — | — | — | — | — | 71.3 | 3.1 |
| PFFS | — | 52.7 | 52.7 | 51.6 | 54.9 | 40.6 | 92.9 | 96.0 | 99.9 | 100.0 |
| Special needs plan[3] | — | — | — | — | — | — | — | 25.4 | 46.5 | 81.5 |
| Urban | 1,089 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.4 | 100.0 | 100.0 |
| HMO[1] | — | 51.8 | 44.1 | 39.5 | 36.4 | 38.1 | 52.0 | 55.4 | 61.2 | 68.4 |
| Local PPO[2] | — | 0.5 | 0.6 | 1.0 | 14.6 | 17.4 | 43.5 | 51.1 | 48.4 | 55.1 |
| Regional PPO | — | — | — | — | — | — | — | 90.0 | 90.0 | 89.9 |
| MSA | — | — | — | — | — | — | — | — | 66.7 | 7.4 |
| PFFS | — | 42.9 | 42.9 | 41.3 | 43.4 | 34.9 | 88.0 | 92.0 | 99.8 | 100.0 |
| Special needs plan[3] | — | — | — | — | — | — | — | 43.0 | 62.3 | 94.4 |
| Large urban | 414 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.8 | 100.0 | 100.0 |
| HMO[1] | — | 75.8 | 64.3 | 58.5 | 52.4 | 55.3 | 63.3 | 66.4 | 70.5 | 74.9 |
| Local PPO[2] | — | 1.2 | 1.7 | 2.4 | 22.7 | 27.3 | 57.0 | 65.2 | 60.4 | 64.0 |
| Regional PPO | — | — | — | — | — | — | — | 91.5 | 91.5 | 91.3 |
| MSA | — | — | — | — | — | — | — | — | 58.7 | 12.6 |
| PFFS | — | 33.6 | 33.6 | 31.6 | 29.7 | 25.8 | 81.2 | 86.7 | 100.0 | 100.0 |
| Special needs plan[3] | — | — | — | — | — | — | — | 55.1 | 69.8 | 99.0 |

(continued)

**Table 3-4 (continued)**
**Percentage of counties with at least one MA contract, by plan type and urbanicity**

| Urbanicity | Number of counties | Nov-00 (%) | Jun-01 (%) | Apr-02 (%) | Apr-03 (%) | Feb-04 (%) | Jun-05 (%) | Jul-06 (%) | Jul-07 (%) | Jul-08 (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| Medium urban | 324 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.7 | 100.0 | 100.0 |
| HMO[1] | — | 49.1 | 44.4 | 37.7 | 37.0 | 39.5 | 58.6 | 63.6 | 71.3 | 78.7 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.3 | 13.9 | 16.4 | 46.3 | 57.7 | 54.9 | 64.8 |
| Regional PPO | — | — | — | — | — | — | — | 88.6 | 88.6 | 88.6 |
| MSA | — | — | — | — | — | — | — | — | 75.6 | 7.1 |
| PFFS | — | 50.3 | 50.3 | 48.5 | 51.5 | 41.7 | 92.0 | 95.7 | 99.7 | 100.0 |
| Special needs plan[3] | — | — | — | — | — | — | — | 48.1 | 66.0 | 95.1 |
| Small urban | 351 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 98.6 | 100.0 | 100.0 |
| HMO[1] | — | 25.9 | 19.9 | 18.8 | 16.8 | 16.5 | 32.5 | 34.8 | 40.7 | 51.3 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 5.7 | 6.6 | 25.1 | 28.5 | 28.2 | 35.6 |
| Regional PPO | — | — | — | — | — | — | — | 89.5 | 89.5 | 89.5 |
| MSA | — | — | — | — | — | — | — | — | 67.8 | 1.7 |
| PFFS | — | 47.0 | 47.0 | 46.2 | 52.1 | 39.3 | 92.3 | 94.9 | 99.7 | 100.0 |
| Special needs plan[3] | — | — | — | — | — | — | — | 23.9 | 49.9 | 88.3 |

(continued)

**Table 3-4 (continued)**
**Percentage of counties with at least one MA contract, by plan type and urbanicity**

| Urbanicity | Number of counties | Nov-00 (%) | Jun-01 (%) | Apr-02 (%) | Apr-03 (%) | Feb-04 (%) | Jun-05 (%) | Jul-06 (%) | Jul-07 (%) | Jul-08 (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| Rural | 2,031 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.6 | 100.0 | 100.0 |
| HMO[1] | — | 12.0 | 7.5 | 8.2 | 7.7 | 8.0 | 16.6 | 17.3 | 23.3 | 31.1 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 1.9 | 2.3 | 11.5 | 16.4 | 16.1 | 20.8 |
| Regional PPO | — | — | — | — | — | — | — | 89.9 | 89.9 | 89.9 |
| MSA | — | — | — | — | — | — | — | — | 73.8 | 0.7 |
| PFFS | — | 57.9 | 57.9 | 57.1 | 61.1 | 43.7 | 95.5 | 98.1 | 100.0 | 100.0 |
| Special needs plan[3] | — | — | — | — | — | — | — | 16.0 | 38.1 | 74.5 |
| Rural—urban adjacent | 1,061 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.5 | 100.0 | 100.0 |
| HMO[1] | — | 18.9 | 12.0 | 11.0 | 12.1 | 12.6 | 25.1 | 24.9 | 32.7 | 41.8 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 3.6 | 4.3 | 15.1 | 22.1 | 21.6 | 28.7 |
| Regional PPO | — | — | — | — | — | — | — | 90.9 | 90.9 | 90.9 |
| MSA | — | — | — | — | — | — | — | — | 69.4 | 1.1 |
| PFFS | — | 57.0 | 57.0 | 55.8 | 61.1 | 44.3 | 94.9 | 97.4 | 100.0 | 100.0 |
| Special needs plan[3] | — | — | — | — | — | — | — | 20.1 | 46.4 | 85.2 |

(continued)

**Table 3-4 (continued)**
**Percentage of counties with at least one MA contract, by plan type and urbanicity**

| Urbanicity | Number of counties | Nov-00 (%) | Jun-01 (%) | Apr-02 (%) | Apr-03 (%) | Feb-04 (%) | Jun-05 (%) | Jul-06 (%) | Jul-07 (%) | Jul-08 (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| Rural–not urban adjacent | 970 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.7 | 100.0 | 100.0 |
| HMO[1] | — | 4.3 | 2.7 | 5.1 | 3.0 | 2.9 | 7.4 | 9.0 | 13.1 | 19.4 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 7.5 | 10.1 | 10.0 | 12.2 |
| Regional PPO | — | — | — | — | — | — | — | 88.9 | 88.9 | 88.9 |
| MSA | — | — | — | — | — | — | — | — | 78.7 | 0.3 |
| PFFS | — | 58.9 | 58.9 | 58.6 | 61.0 | 43.1 | 96.1 | 99.0 | 99.9 | 100.0 |
| Special needs plan[3] | — | — | — | — | — | — | — | 11.5 | 29.0 | 62.9 |



[1] HMO includes HMO POS, 2006/2008 data also include PSO.

[2] Includes PPO demonstration contracts from 2003 to 2005.

[3] Includes MSA demonstration contracts.

NOTES:

1. SNP are listed as a separate category, and not by plan type (e.g., an SNP HMO would be listed as SNP and not counted as an HMO).
2. Excludes employer-only and non-Part A/B plans. Excludes Puerto Rico, the Virgin Islands, and Guam.

SOURCE: RTI analysis of CMS Health Plan Management System data.

The PFFS option is available to 100 percent of beneficiaries in all counties. This contrasts with the availability of the HMO option in larger urban versus rural and smaller urban geographic areas. In 2008, the HMO option was available to beneficiaries in only 31.1 percent and 51.3 percent of rural and small urban counties, respectively. This compares to HMO access to beneficiaries in more than 70 percent of large and medium urban counties.

SNPs exhibited a pattern similar to HMOs and local PPOs, albeit at a slightly reduced overall level of availability. In 2008, SNPs were more common in urban areas (94.4 percent of counties) than rural areas (74.5 percent of counties). The rapid growth in SNPs during 2008 is narrowing county-based disparities. Within urban areas, the availability of SNPs was associated with the size of the urban area, and in rural areas, SNPs were more likely to be offered in urban-adjacent counties.

We also noted interesting patterns among open-access HMOs, which remained the dominant plan type through 2008 despite the continued growth of PFFS and SNPs. A larger proportion of large urban counties had at least one HMO every year between 2002 and 2008 compared to any other county type. However, between 2000 and 2006, the percentage of large urban counties with at least one Medicare HMO declined from 75.8 percent to 70.5 percent. Some of the decline likely arose from a substitution of newer plan options in large urban counties. Conversely, the percentage of medium urban counties with an HMO rose from 2000 to 2007 because of a large increase from 2004 to 2005 that continued into 2007. By July 2007, a larger percentage of medium than large urban counties had access to an HMO. HMO access also continued to rise in 2007 in small urban counties to a far greater level than in 2000. Despite these increases in availability in urban counties, HMO availability in small urban counties remained limited, well below availability in larger urban counties and with only a minority of counties served by HMOs.

A number of interesting trends emerged looking across urbanicity categories. From 2007 to 2008, access to HMOs, local PPOs, and SNPs continued to grow across all urbanicity categories, whereas access to regional PPOs leveled off or slightly declined. Increased access to SNPs across all urbanicity categories was particularly striking between 2007 and 2008. Access to PFFS plans, already nearly universal in most areas in 2007, improved in 2008 to essentially 100 percent of in all counties and remained more available to beneficiaries residing in rural and small urban counties than either HMO or local PPO options. MSA plans, initially available in a majority of counties of all urbanicity classifications in their 2007 introductory year, were only available in limited counties by 2008 due to the withdrawal of contracts. The availability of SNPs grew the fastest of any plan category from 2007 to 2008. Nationally, in 2007, SNPs were available in 46.5 percent of counties and concentrated mostly in urban counties. This increased markedly to availability in 81.5 percent of counties by 2008, suggesting that SNPs continue to gain popularity rapidly.

### 3.2.5 Plan Availability by Census Region

To detect plan participation trends in different areas of the country, we analyzed plan availability by census region. Table 3-5 is a complement to Table 3-4 in the sense that counties are stratified by census region rather than urbanicity. Table 3-5 shows the percentage of counties with different contract types in the Northeast, Midwest, South, and West.

## Table 3-5
## Percentage of counties with at least one MA contract, by plan type and region

| Census region | Number of counties | Nov-00 (%) | Jun-01 (%) | Apr-02 (%) | Apr-03 (%) | Feb-04 (%) | Jun-05 (%) | Jul-06 (%) | Jul-07 (%) | Jul-08 (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| Northeast | 217 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 94.5 | 100.0 | 100.0 |
| HMO[1] | — | 69.1 | 60.4 | 58.1 | 57.1 | 58.1 | 63.1 | 66.4 | 71.0 | 75.1 |
| Local PPO[2] | — | 2.3 | 2.3 | 2.3 | 32.7 | 34.1 | 56.7 | 71.9 | 69.1 | 74.7 |
| Regional PPO | — | — | — | — | — | — | — | 69.1 | 69.1 | 69.1 |
| MSA[3] | — | — | — | — | — | — | — | — | 84.8 | 16.6 |
| PFFS | — | 30.9 | 30.9 | 30.9 | 30.9 | 30.9 | 46.1 | 74.7 | 98.6 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 60.4 | 70.5 | 82.9 |
| Midwest | 1,056 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 100.0 | 100.0 | 100.0 |
| HMO[1] | — | 17.4 | 16.0 | 16.6 | 14.4 | 14.9 | 27.8 | 30.6 | 35.3 | 41.9 |
| Local PPO[2] | — | 0.0 | 0.2 | 0.4 | 3.7 | 5.1 | 13.1 | 19.6 | 19.6 | 24.0 |
| Regional PPO | — | — | — | — | — | — | — | 100.0 | 100.0 | 100.0 |
| MSA[3] | — | — | — | — | — | — | — | — | 65.2 | 1.9 |
| PFFS | — | 49.3 | 49.3 | 49.3 | 57.8 | 48.9 | 100.0 | 100.0 | 100.0 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 23.2 | 33.0 | 73.4 |

(continued)

**Table 3-5 (continued)**
**Percentage of counties with at least one MA contract, by plan type and region**

| Census region | Number of counties | Nov-00 (%) | Jun-01 (%) | Apr-02 (%) | Apr-03 (%) | Feb-04 (%) | Jun-05 (%) | Jul-06 (%) | Jul-07 (%) | Jul-08 (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| South | 1,425 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 100.0 | 100.0 | 100.0 |
| HMO[1] | — | 24.8 | 16.4 | 13.2 | 11.6 | 12.9 | 23.4 | 24.1 | 31.4 | 41.0 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.1 | 4.6 | 6.0 | 21.0 | 25.5 | 23.6 | 29.8 |
| Regional PPO | — | — | — | — | — | — | — | 100.0 | 100.0 | 100.0 |
| MSA[3] | — | — | — | — | — | — | — | — | 70.9 | 2.7 |
| PFFS | — | 58.9 | 58.9 | 52.7 | 53.7 | 33.4 | 98.2 | 98.5 | 100.0 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 23.6 | 57.5 | 99.6 |
| West | 423 | — | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.3 | 100.0 | 100.0 |
| HMO[1] | — | 28.1 | 23.4 | 25.3 | 26.4 | 26.2 | 33.3 | 33.8 | 39.0 | 44.4 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 5.2 | 5.2 | 34.9 | 38.5 | 37.6 | 43.5 |
| Regional PPO | — | — | — | — | — | — | — | 41.4 | 41.4 | 41.1 |
| MSA[3] | — | — | — | — | — | — | — | — | 81.1 | 0.2 |
| PFFS | — | 51.3 | 51.3 | 64.3 | 64.2 | 49.3 | 80.7 | 88.7 | 100.0 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 19.1 | 30.7 | 39.5 |

[1] HMO includes HMO POS, 2006/2008 data also include PSO.

[2] Includes PPO demonstration contracts from 2003 to 2005.

[3] Includes MSA demonstration contracts.

[4] SNPs are listed as a separate category and not by plan type (e.g., an SNP HMO would be listed as SNP and not counted as an HMO).

NOTE:

1. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data.

Of particular note is that virtually all Medicare eligibles in all regions continued to have access to at least one plan in 2008, due largely to the existence of PFFS. PFFS plans were available in every county in 2008. From 2007 to 2008, HMO availability rose in every region. HMOs were most widely available in the Northeast (more than 75 percent of counties in 2008 compared to approximately 40 percent in other regions). From 2004 to 2005, HMO availability nearly doubled in the Midwest and South, rising from low levels, but growth has since moderated in 2006 and 2007 in these regions. HMO availability had been stable in the West in 2005 and 2006 but showed some growth in 2007. Consistent with national trends, local PPO access increased in all regions from 2007 to 2008. In 2008, local PPOs were available in a substantially higher proportion of counties in the Northeast than other regions (approximately 75 percent versus 24 to 44 percent elsewhere).

MSAs, widely available in 2007, became scarce and scattered by 2008. Regional PPO availability remained largely unchanged between 2006 and 2008. Regional PPOs, per their intended design, also covered large service areas and therefore offered access to a large proportion of beneficiaries in most census regions. In the Midwest and South, regional PPOs were available in 100 percent of counties, followed by the Northeast where this option was offered in 69 percent of counties. By contrast, regional PPOs were available in only 41 percent of Western counties.[19] By mandate, the service areas of regional PPOs must include all states in each defined MA region, making the decision to offer (or not) this option more complex for managed care organizations. The stable service areas, and little expansion of this option since its inception, suggest that organizations have determined the regional PPO option may not be as viable in certain geographic areas.

Between 2006 and 2008, SNP access rose significantly, indicating particular interest in this option. SNPs were only moderately available in the South in 2006, but their penetration nearly doubled to nearly 100 percent by 2008. SNP availability rose strongly in the Midwest from 2007 to 2008. In 2008, SNPs were available in majority of counties in the Northeast, Midwest, and South. Only in the West are SNPs unavailable in many counties.

### 3.3 Plan Choices Available to Beneficiaries in 2008

Tables 3-1 through 3-5 defined access to MA plans in the most basic way: if a single contract was available in a given county, then a Medicare-eligible person was considered to have access to that type of plan. Our analyses focused on changes in this basic definition of access between 2000 and 2008.

In this next set of analyses (presented in Tables 3-6 through 3-10), we broaden our focus beyond this most basic definition of access and consider the range and combinations of multiple plan choices available to beneficiaries in 2008. It generally is believed that the broader the set of MA choices available to a beneficiary, the more likely he or she can find a plan closely suited to his or her preferences. One aspect of the availability of choices is the degree to which alternative plan types are available to a beneficiary. For example, the availability of a single HMO plan and

[19] Regional PPOs were not available in the following five MA regions: 1 (Maine, New Hampshire); 2 (Connecticut, Massachusetts, Rhode Island, Vermont); 20 (Colorado, New Mexico); 23 (Idaho, Oregon, Utah, Washington); and 26 (Alaska).

a single PFFS plan may comprise a greater degree of plan choice than the availability of two HMO plans without access to a PFFS plan. Tables 3-6 through 3-8 examine the range of choices available to beneficiaries in 2008 by looking at the various combinations of the major MA categories: HMO, PPO, and PFFS. In these tables, local and regional PPOs are combined because although they have different service area requirements, to beneficiaries, they offer a single type of benefit structure. In Tables 3-9a and 3-9b and Tables 3-10a and 3-10b, we considered yet another aspect of access, the numbers of contracts available to beneficiaries in various types of counties.

### 3.3.1 Choice Among Medicare Advantage Plan Types

Table 3-6a displays the number and percentage of beneficiaries facing each combination of plan choices and the number and percentage of counties in which the particular combinations were offered in 2008, 2007, and 2006. Percentage point changes over this period are shown in Table 3-6b. Increasing relative to 2007, in 2008, approximately 81 percent of all Medicare beneficiaries lived in counties where HMOs, PPOs, and PFFS were all offered; these counties represented 46 percent of all counties. At least one PPO and one PFFS plan, with no HMO, were available to another 17 percent of beneficiaries (in 49 percent of counties)—decreases relative to 2007. Fewer than 2 percent of beneficiaries had access to only one of these three plan types. As of 2007 and continuing into 2008, all Medicare beneficiaries had access to at least one of these three plan types. Put another way, more than 98 percent of beneficiaries have access to two or more plan types, including at least one coordinated care plan option. Looking at the goal of increasing the range of options available to Medicare beneficiaries, this analysis suggests that most Medicare beneficiaries had at least some choice among multiple plan types.

### 3.3.2 Choice Among Plan Types by County Urbanicity

One focus of the MMA was to increase beneficiary choices of MA plan types in rural and other underserved areas. Table 3-7a (with percentage point changes in Table 3-7b) examines how access to combinations of plan types varied with county urbanicity in 2006 through 2008. The percentages in the table are row percentages; that is, the proportion of beneficiaries in the specific urbanicity category who have access to a particular combination of plan types. Note that the PPO category combines local and regional PPOs; generally, from the perspective of the beneficiary, the two types are interchangeable.

As of 2008, very few beneficiaries, particularly in large and medium urban locations, had access to only a single plan type. In urban regions, 91 percent of beneficiaries had access to all three major plan types; 45 percent of rural beneficiaries had access to all three plan types. The lower proportion of rural beneficiaries with access to all three major MA plan types is due primarily to the relative paucity of HMO offerings in rural areas. Beneficiaries in small urban areas were less likely to have access to all three plan types than residents of larger urban areas. This resulted from HMOs being less prevalent in lower population urban areas than in higher population ones as shown in Table 3-4. Although availability of all three (HMO, PPO, and PFFS) options was not as commonly found in small urban and rural areas, beneficiaries residing in these county types often had a choice between at least PPO and PFFS options. Post-MMA growth of PPO options through the regional PPO program may explain this finding.

**Table 3-6a**
**Percentage of beneficiaries and counties with access to MA plan types, 2008–2006**

| Plan types | 2008 Beneficiaries (%) | 2008 Counties (%) | 2007 Beneficiaries (%) | 2007 Counties (%) | 2006 Beneficiaries (%) | 2006 Counties (%) |
|---|---|---|---|---|---|---|
| No MA plans[1] | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 | 0.5 |
| HMO only[2] | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.1 |
| PPO only[3] | 0.0 | 0.0 | 0.0 | 0.0 | 0.9 | 1.1 |
| PFFS only | 1.4 | 3.6 | 1.6 | 4.2 | 1.3 | 4.4 |
| HMO and PPO[2, 3] | 0.0 | 0.0 | 0.4 | 0.1 | 17.5 | 2.3 |
| HMO and PFFS[2] | 0.6 | 1.1 | 1.0 | 1.3 | 0.6 | 0.6 |
| PPO and PFFS[3] | 17.1 | 49.1 | 22.1 | 55.4 | 24.9 | 59.5 |
| HMO and PPO and PFFS[2, 3] | 80.9 | 46.2 | 75.0 | 38.9 | 54.3 | 31.5 |

[1] Beneficiaries with no access to HMO, PPO, or PFFS contracts.

[2] HMO includes HMO POS and PSO plans.

[3] PPO includes local and regional PPOs.

NOTES:
1. SNPs incorporated by plan type.
2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006/2008.

**Table 3-6b**
**Change in percentage of beneficiaries and counties with access to MA plan types, 2008–2006**

| Plan types | Change, 2007 to 2008, Beneficiaries (%) | Change, 2007 to 2008, Counties (%) | Change, 2006 to 2007, Beneficiaries (%) | Change, 2006 to 2007, Counties (%) | Change, 2006 to 2008, Beneficiaries (%) | Change, 2006 to 2008, Counties (%) |
|---|---|---|---|---|---|---|
| No MA plans[1] | 0.0 | 0.0 | −0.4 | −0.5 | −0.4 | −0.5 |
| HMO only[2] | 0.0 | 0.0 | −0.2 | −0.1 | −0.2 | −0.1 |
| PPO only[3] | 0.0 | 0.0 | −0.9 | −1.1 | −0.9 | −1.1 |
| PFFS only | −0.2 | −0.6 | 0.2 | −0.2 | 0.1 | −0.8 |
| HMO and PPO[2, 3] | −0.4 | −0.1 | −17.1 | −2.3 | −17.5 | −2.3 |
| HMO and PFFS[2] | −0.4 | −0.2 | 0.4 | 0.7 | 0.0 | 0.5 |
| PPO and PFFS[3] | −5.0 | −6.4 | −2.8 | −4.1 | −7.8 | −10.4 |
| HMO and PPO and PFFS[2, 3] | 5.9 | 7.3 | 20.7 | 7.4 | 26.6 | 14.7 |

[1] Beneficiaries with no access to HMO, PPO, or PFFS contracts.
[2] HMO includes HMO POS and PSO plans.
[3] PPO includes local and regional PPOs.

NOTES:
1. SNPs incorporated by plan type.
2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006/2008.

**Table 3-7a**
**Percentage of beneficiaries with access to MA plan types, by urbanicity, 2008–2006**

| Urbanicity | No plans[1] (%) | HMO only[2] (%) | PPO only[3] (%) | PFFS only (%) | HMO and PPO[2, 3] (%) | HMO and PFFS[2] (%) | PPO and PFFS[3] (%) | HMO and PPO and PFFS[2, 3] (%) |
|---|---|---|---|---|---|---|---|---|
| 2008 | | | | | | | | |
| Urban | 0.0 | 0.0 | 0.0 | 0.6 | 0.0 | 0.4 | 8.1 | 90.9 |
| Large urban | 0.0 | 0.0 | 0.0 | 0.3 | 0.0 | 0.2 | 2.5 | 97.0 |
| Medium urban | 0.0 | 0.0 | 0.0 | 0.8 | 0.0 | 0.5 | 7.1 | 91.6 |
| Small urban | 0.0 | 0.0 | 0.0 | 1.8 | 0.0 | 0.8 | 34.0 | 63.4 |
| Rural | 0.0 | 0.0 | 0.0 | 3.8 | 0.0 | 1.4 | 49.7 | 45.1 |
| Rural–urban adjacent | 0.0 | 0.0 | 0.0 | 2.8 | 0.0 | 1.5 | 42.1 | 53.5 |
| Rural–not urban adjacent | 0.0 | 0.0 | 0.0 | 5.8 | 0.0 | 1.1 | 64.2 | 28.9 |
| 2007 | | | | | | | | |
| Urban | 0.0 | 0.0 | 0.0 | 0.7 | 0.5 | 0.6 | 11.9 | 86.3 |
| Large urban | 0.0 | 0.0 | 0.0 | 0.3 | 0.0 | 0.3 | 4.8 | 94.6 |
| Medium urban | 0.0 | 0.0 | 0.0 | 0.8 | 1.3 | 0.5 | 11.5 | 86.0 |
| Small urban | 0.0 | 0.0 | 0.0 | 2.0 | 1.3 | 2.3 | 43.1 | 51.3 |
| Rural | 0.0 | 0.0 | 0.0 | 4.5 | 0.0 | 2.2 | 58.8 | 34.6 |
| Rural–urban adjacent | 0.0 | 0.0 | 0.0 | 3.5 | 0.0 | 2.9 | 52.4 | 41.2 |
| Rural–not urban adjacent | 0.0 | 0.0 | 0.0 | 6.3 | 0.0 | 0.8 | 71.0 | 22.0 |

(continued)

**Table 3-7a (continued)**
**Percentage of beneficiaries with access to MA plan types, by urbanicity, 2008–2006**

| Urbanicity | No plans[1] (%) | HMO only[2] (%) | PPO only[3] (%) | PFFS only (%) | HMO and PPO[2, 3] (%) | HMO and PFFS[2] (%) | PPO and PFFS[3] (%) | HMO and PPO and PFFS[2, 3] (%) |
|---|---|---|---|---|---|---|---|---|
| 2006 | | | | | | | | |
| Urban | 0.4 | 0.2 | 0.7 | 0.3 | 22.1 | 0.5 | 14.3 | 61.7 |
| Large urban | 0.2 | 0.1 | 0.1 | 0.1 | 31.8 | 0.2 | 6.2 | 61.2 |
| Medium urban | 0.2 | 0.5 | 0.5 | 0.0 | 9.4 | 0.6 | 15.6 | 73.2 |
| Small urban | 1.3 | 0.0 | 3.3 | 1.6 | 4.1 | 1.4 | 46.3 | 41.9 |
| Rural | 0.5 | 0.2 | 1.6 | 4.8 | 0.8 | 1.0 | 63.0 | 28.0 |
| Rural–urban adjacent | 0.6 | 0.3 | 1.9 | 3.9 | 1.0 | 1.5 | 56.9 | 33.8 |
| Rural–not urban adjacent | 0.4 | 0.0 | 0.8 | 6.6 | 0.5 | 0.1 | 74.8 | 16.8 |

[1] Beneficiaries with no access to HMO, PPO, or PFFS contracts.

[2] HMO includes HMO POS and PSO plans.

[3] PPO includes local and regional PPOs.

NOTES:
1. SNPs incorporated by plan type.
2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006/2008.

**Table 3-7b**
**Change in percentage of beneficiaries with access to MA plan types, by urbanicity, 2008–2006**

| Urbanicity | No plans[1] (%) | HMO only[2] (%) | PPO only[3] (%) | PFFS only (%) | HMO and PPO[2, 3] (%) | HMO and PFFS[2] (%) | PPO and PFFS[3] (%) | HMO and PPO and PFFS[2, 3] (%) |
|---|---|---|---|---|---|---|---|---|
| Percentage point difference, 2007 to 2008 | | | | | | | | |
| Urban | 0.0 | 0.0 | 0.0 | 0.0 | −0.5 | −0.3 | −3.8 | 4.6 |
| Large urban | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | −0.1 | −2.3 | 2.4 |
| Medium urban | 0.0 | 0.0 | 0.0 | 0.0 | −1.3 | 0.0 | −4.4 | 5.6 |
| Small urban | 0.0 | 0.0 | 0.0 | −0.2 | −1.3 | −1.5 | −9.1 | 12.1 |
| Rural | 0.0 | 0.0 | 0.0 | −0.6 | 0.0 | −0.7 | −9.1 | 10.5 |
| Rural–urban adjacent | 0.0 | 0.0 | 0.0 | −0.7 | 0.0 | −1.3 | −10.3 | 12.3 |
| Rural–not urban adjacent | 0.0 | 0.0 | 0.0 | −0.5 | 0.0 | 0.4 | −6.7 | 6.9 |
| Percentage point difference, 2006 to 2007 | | | | | | | | |
| Urban | −0.4 | −0.2 | −0.7 | 0.4 | −21.6 | 0.1 | −2.3 | 24.6 |
| Large urban | −0.2 | −0.1 | −0.1 | 0.2 | −31.8 | 0.1 | −1.4 | 33.3 |
| Medium urban | −0.2 | −0.5 | −0.5 | 0.8 | −8.1 | −0.1 | −4.1 | 12.8 |
| Small urban | −1.3 | 0.0 | −3.3 | 0.4 | −2.8 | 0.9 | −3.2 | 9.4 |
| Rural | −0.5 | −0.2 | −1.6 | −0.3 | −0.8 | 1.1 | −4.3 | 6.6 |
| Rural–urban adjacent | −0.6 | −0.3 | −1.9 | −0.4 | −1.0 | 1.3 | −4.5 | 7.4 |
| Rural–not urban adjacent | −0.4 | 0.0 | −0.8 | −0.3 | −0.5 | 0.7 | −3.8 | 5.1 |

(continued)

**Table 3-7b (continued)**
**Change in percentage of beneficiaries with access to MA plan types, by urbanicity, 2008–2006**

| Urbanicity | No plans[1] (%) | HMO only[2] (%) | PPO only[3] (%) | PFFS only (%) | HMO and PPO[2, 3] (%) | HMO and PFFS[2] (%) | PPO and PFFS[3] (%) | HMO and PPO and PFFS[2, 3] (%) |
|---|---|---|---|---|---|---|---|---|
| Percentage point difference, 2006 to 2008 | | | | | | | | |
| Urban | −0.4 | −0.2 | −0.7 | 0.4 | −22.1 | −0.1 | −6.1 | 29.2 |
| Large urban | −0.2 | −0.1 | −0.1 | 0.2 | −31.8 | 0.0 | −3.7 | 35.8 |
| Medium urban | −0.2 | −0.5 | −0.5 | 0.8 | −9.4 | −0.1 | −8.5 | 18.4 |
| Small urban | −1.3 | 0.0 | −3.3 | 0.2 | −4.1 | −0.6 | −12.3 | 21.4 |
| Rural | −0.5 | −0.2 | −1.6 | −1.0 | −0.8 | 0.4 | −13.4 | 17.1 |
| Rural−urban adjacent | −0.6 | −0.3 | −1.9 | −1.1 | −1.0 | 0.0 | −14.8 | 19.7 |
| Rural−not urban adjacent | −0.4 | 0.0 | −0.8 | −0.8 | −0.5 | 1.0 | −10.6 | 12.0 |

[1] Beneficiaries with no access to HMO, PPO, or PFFS contracts.

[2] HMO includes HMO POS and PSO plans.

[3] PPO includes local and regional PPOs.

NOTES:
1. SNPs incorporated by plan type.
2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006/2008.

### 3.3.3 Choice Among Plan Types by Census Region

Table 3-8a (with percentage point changes in Table 3-8b) examines how access to MA plan type varied by census region in 2006 through 2008. By 2008, approximately three-quarters or more of beneficiaries were able to choose among each of the major plan types, which was a substantial improvement since 2006 when the MMA provisions began full implementation. In all regions, beneficiaries had access to at least one MA plan in 2008. In the Northeast and West, 88 percent or more of beneficiaries had access to all three plan types. In the Midwest and South, a lower percentage (approximately 75 percent) had access to all three types because of the lesser availability of HMOs in those regions. We observed relatively few changes between 2007 and 2008, suggesting that plan availability by geographic region may have stabilized.

### 3.3.4 Choice of Multiple Medicare Advantage Contracts

Tables 3-6a and 3-6b through Tables 3-8a and 3-8b present findings on the combinations of different plan types available to a beneficiary, consistent with the idea that an important aspect of "choice" of MA plans is the availability of different plan types that offer different provider access structures. However, another aspect of choice may relate to the number of different contracts available in an area (each of which may offer more than one plan). Choice among different contracts in an area may reflect both the sheer number of offerings available and the presence of multiple competing organizations (e.g., insurance companies) offering these options. Tables 3-9a and 3-9b through Tables 3-10a and 3-10b use the number of contracts in a county as an alternative way to evaluate "choice" to beneficiaries in that county in 2007.

Table 3-9a (with percentage point changes in Table 3-9b) stratifies the number of contracts available in a county by urbanicity. Results are weighted by the number of MA-eligible Medicare beneficiaries residing in each county and, therefore, show the percentage of beneficiaries with access to the number of contracts. The number of contracts available to beneficiaries was, on average, larger in 2008 compared to 2007 across all the geographic strata. On average, beneficiaries could choose from 16.2 contracts in 2008, substantially increasing from 11.9 contracts in 2007 and 7.7 contracts in 2006. Eighty-six percent of beneficiaries could choose from 10 or more contracts in 2008, versus 27 percent in 2006.

Consistent with the results from earlier years, findings from 2008 continue to show that the number of contracts was related to county urbanicity, with urban areas as a whole having more total contract options than rural areas though these difference have narrow substantially between 2007 and 2008. By 2008, more than 95 percent of large and medium urban counties had access to 10 or more contracts, although 73 percent of small urban counties enjoyed the same high level of access. Unlike prior years, the majority of even rural beneficiaries had access to 10 or more contracts. By 2008, even rural non-urban-adjacent beneficiaries had access to a mean of 9.7 contracts, representing a substantial improvement in access compared to 2006.

**Table 3-8a**
**Percentage of beneficiaries with access to MA plan types, by region, 2008–2006**

| Region | No plans[1] (%) | HMO only[2] (%) | PPO only[3] (%) | PFFS only (%) | HMO and PPO[2, 3] (%) | HMO and PFFS[2] (%) | PPO and PFFS[3] (%) | HMO and PPO and PFFS[2, 3] (%) |
|---|---|---|---|---|---|---|---|---|
| 2008 | | | | | | | | |
| Northeast | 0.0 | 0.0 | 0.0 | 4.5 | 0.0 | 1.7 | 2.6 | 91.2 |
| Midwest | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 23.9 | 76.1 |
| South | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 25.1 | 74.9 |
| West | 0.0 | 0.0 | 0.0 | 2.6 | 0.0 | 1.3 | 8.2 | 87.9 |
| 2007 | | | | | | | | |
| Northeast | 0.0 | 0.0 | 0.0 | 5.1 | 2.1 | 2.1 | 3.0 | 87.6 |
| Midwest | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 30.1 | 69.9 |
| South | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 33.8 | 66.2 |
| West | 0.0 | 0.0 | 0.0 | 2.8 | 0.0 | 2.7 | 9.2 | 85.2 |
| 2006 | | | | | | | | |
| Northeast | 1.7 | 0.9 | 0.0 | 3.2 | 46.9 | 1.4 | 4.8 | 41.1 |
| Midwest | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 32.7 | 67.3 |
| South | 0.0 | 0.0 | 0.7 | 0.0 | 3.5 | 0.0 | 40.2 | 55.7 |
| West | 0.4 | 0.0 | 3.1 | 3.5 | 35.2 | 1.6 | 6.7 | 49.5 |

[1] Beneficiaries with no access to HMO, PPO, or PFFS contracts.

[2] HMO includes HMO POS and PSO plans.

[3] PPO includes local and regional PPOs.

NOTES:
1. SNPs incorporated by plan type.
2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006/2008.

**Table 3-8b**
**Change in percentage of beneficiaries with access to MA plan types, by region, 2008–2006**

| Region | No plans[1] (%) | HMO only[2] (%) | PPO only[3] (%) | PFFS only (%) | HMO and PPO[2, 3] (%) | HMO and PFFS[2] (%) | PPO and PFFS[3] (%) | HMO and PPO and PFFS[2, 3] (%) |
|---|---|---|---|---|---|---|---|---|
| Change in percentage points, 2007 to 2008 | | | | | | | | |
| Northeast | 0.0 | 0.0 | 0.0 | −0.6 | −2.1 | −0.5 | −0.4 | 3.6 |
| Midwest | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | −6.2 | 6.2 |
| South | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | −8.7 | 8.7 |
| West | 0.0 | 0.0 | 0.0 | −0.2 | 0.0 | −1.4 | −1.0 | 2.6 |
| Change in percentage points, 2006 to 2007 | | | | | | | | |
| Northeast | −1.7 | −0.9 | 0.0 | 1.9 | −44.8 | 0.7 | −1.8 | 46.5 |
| Midwest | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | −2.6 | 2.6 |
| South | 0.0 | 0.0 | −0.7 | 0.0 | −3.5 | 0.0 | −6.3 | 10.5 |
| West | −0.4 | 0.0 | −3.1 | −0.7 | −35.2 | 1.1 | 2.6 | 35.7 |
| Change in percentage points, 2006 to 2008 | | | | | | | | |
| Northeast | −1.7 | −0.9 | 0.0 | 1.3 | −46.9 | 0.2 | −2.2 | 50.1 |
| Midwest | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | −8.8 | 8.8 |
| South | 0.0 | 0.0 | −0.7 | 0.0 | −3.5 | 0.0 | −15.1 | 19.2 |
| West | −0.4 | 0.0 | −3.1 | −0.9 | −35.2 | −0.3 | 1.6 | 38.3 |

[1] Beneficiaries with no access to HMO, PPO, or PFFS contracts.

[2] HMO includes HMO POS and PSO plans.

[3] PPO includes local and regional PPOs.

NOTES:
1. SNPs incorporated by plan type.
2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006/2008.

**Table 3-9a**
**Percentage of beneficiaries with access to MA plan types, by number of contracts and urbanicity, 2008–2006**

| Urbanicity | 0 contracts (%) | 1–3 contracts (%) | 4–6 contracts (%) | 7–9 contracts (%) | 10+ contracts (%) | Mean number contracts/ county[1] |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Total | 0.0 | 0.1 | 2.4 | 11.3 | 86.2 | 16.2 |
| Urban | 0.0 | 0.1 | 0.9 | 6.5 | 92.5 | 17.6 |
| Large urban | 0.0 | 0.0 | 0.4 | 4.1 | 95.5 | 19.2 |
| Medium urban | 0.0 | 0.3 | 0.3 | 3.6 | 95.8 | 17.1 |
| Small urban | 0.0 | 0.1 | 3.7 | 22.7 | 73.4 | 12.0 |
| Rural | 0.0 | 0.0 | 8.1 | 28.5 | 63.3 | 11.0 |
| Rural–urban adjacent | 0.0 | 0.0 | 6.2 | 24.3 | 69.5 | 11.7 |
| Rural–not urban adjacent | 0.0 | 0.1 | 11.9 | 36.6 | 51.3 | 9.7 |
| 2007 | | | | | | |
| Total | 0.0 | 0.7 | 10.7 | 23.9 | 64.7 | 11.9 |
| Urban | 0.0 | 0.4 | 6.0 | 17.9 | 75.7 | 13.0 |
| Large urban | 0.0 | 0.1 | 2.8 | 13.1 | 84.0 | 14.2 |
| Medium urban | 0.0 | 0.9 | 3.9 | 17.6 | 77.5 | 12.4 |
| Small urban | 0.0 | 1.2 | 23.7 | 38.9 | 36.1 | 8.7 |
| Rural | 0.0 | 1.7 | 27.3 | 45.7 | 25.3 | 8.1 |
| Rural–urban adjacent | 0.0 | 1.8 | 23.2 | 43.3 | 31.8 | 8.5 |
| Rural–not urban adjacent | 0.0 | 1.6 | 35.3 | 50.3 | 12.8 | 7.3 |
| 2006 | | | | | | |
| Total | 0.4 | 17.6 | 33.4 | 21.2 | 27.4 | 7.7 |
| Urban | 0.4 | 9.9 | 31.3 | 24.1 | 34.4 | 8.6 |
| Large urban | 0.2 | 3.4 | 25.9 | 26.2 | 44.4 | 10.2 |
| Medium urban | 0.2 | 8.7 | 39.1 | 24.9 | 27.0 | 7.3 |
| Small urban | 1.3 | 40.2 | 40.0 | 13.5 | 5.0 | 4.5 |
| Rural | 0.5 | 45.2 | 40.9 | 10.8 | 2.6 | 4.2 |
| Rural–urban adjacent | 0.6 | 40.8 | 42.4 | 13.2 | 3.0 | 4.4 |
| Rural–not urban adjacent | 0.4 | 53.4 | 38.2 | 6.2 | 1.8 | 3.8 |

[1] Weighted by eligibles in county.

NOTE:
1. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2008/2006.

**Table 3-9b**
**Change in percentage of beneficiaries with access to MA plan types, by number of contracts and urbanicity, 2008–2006**

| Urbanicity | 0 contracts (%) | 1–3 contracts (%) | 4–6 contracts (%) | 7–9 contracts (%) | 10+ contracts (%) | Difference, Mean number contracts/county[1] |
|---|---|---|---|---|---|---|
| Percentage point difference, 2007 to 2008 | | | | | | |
| Total | 0.0 | −0.6 | −8.2 | −12.6 | 21.5 | 4.3 |
| Urban | 0.0 | −0.4 | −5.2 | −11.3 | 16.9 | 4.6 |
| Large urban | 0.0 | −0.1 | −2.4 | −9.0 | 11.5 | 4.9 |
| Medium urban | 0.0 | −0.7 | −3.7 | −14.0 | 18.3 | 4.7 |
| Small urban | 0.0 | −1.1 | −20.0 | −16.2 | 37.3 | 3.3 |
| Rural | 0.0 | −1.7 | −19.2 | −17.1 | 38.0 | 2.9 |
| Rural–urban adjacent | 0.0 | −1.8 | −17.0 | −18.9 | 37.8 | 3.2 |
| Rural–not urban adjacent | 0.0 | −1.5 | −23.4 | −13.7 | 38.5 | 2.3 |
| Percentage point difference, 2006 to 2007 | | | | | | |
| Total | −0.4 | −16.8 | −22.7 | 2.7 | 37.3 | 4.2 |
| Urban | −0.4 | −9.4 | −25.3 | −6.2 | 41.3 | 4.3 |
| Large urban | −0.2 | −3.3 | −23.0 | −13.1 | 39.6 | 4.0 |
| Medium urban | −0.2 | −7.8 | −35.1 | −7.3 | 50.5 | 5.1 |
| Small urban | −1.3 | −39.0 | −16.3 | 25.4 | 31.2 | 4.2 |
| Rural | −0.5 | −43.4 | −13.6 | 34.9 | 22.7 | 3.9 |
| Rural–urban adjacent | −0.6 | −39.0 | −19.2 | 30.0 | 28.8 | 4.1 |
| Rural–not urban adjacent | −0.4 | −51.9 | −2.9 | 44.1 | 11.0 | 3.6 |
| Percentage point difference, 2006 to 2008 | | | | | | |
| Total | −0.4 | −17.5 | −31.0 | −9.9 | 58.7 | 8.5 |
| Urban | −0.4 | −9.8 | −30.4 | −17.5 | 58.1 | 8.9 |
| Large urban | −0.2 | −3.4 | −25.4 | −22.1 | 51.1 | 8.9 |
| Medium urban | −0.2 | −8.4 | −38.8 | −21.3 | 68.8 | 9.8 |
| Small urban | −1.3 | −40.1 | −36.3 | 9.2 | 68.5 | 7.5 |
| Rural | −0.5 | −45.1 | −32.8 | 17.7 | 60.7 | 6.8 |
| Rural–urban adjacent | −0.6 | −40.8 | −36.2 | 11.1 | 66.5 | 7.3 |
| Rural–not urban adjacent | −0.4 | −53.3 | −26.2 | 30.4 | 49.5 | 5.9 |

[1] Weighted by eligibles in county.

NOTE:
1. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2008/2006.

Table 3-10a (with percentage point changes in Table 3-10b) stratifies the number of contracts per county by census region. By 2008, more than 80 percent of beneficiaries in all regions had access to at least 10 contracts (weighted by MA-eligible Medicare beneficiaries residing in each county). The West and the Northeast regions had the highest level of mean contracts per county in 2008, and the Midwest had the fewest. This finding is in sharp contrast to 2006, when at no more than 38 percent of beneficiaries in a region had access to 10 or more contract options. Policy changes under MMA clearly have increased access to competing contract options for a wider range of beneficiaries.

## 3.4 Special Needs Plans in 2008

Section 3 generally presents information on the availability of MA options to beneficiaries in terms of contracts. However, SNPs are defined by their targeted population and are not defined by a contract type. Table 3-11a (with changes in Table 3-11b) identifies the number of contracts offering at least one SNP, and contracts offering only SNPs by plan type between 2006 and 2008. Overall, we found a large increase in the availability of SNPs. This can be explained in part due to some legislative changes. The original MMA language establishing SNPs under the MA program was set initially to expire as of December 2008. However, the Medicare, Medicaid, and SCHIP extension Act of 2007 extended the SNP program through December 31, 2009, and authorization for these options was again extended under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) through December 31, 2010. The MIPPA legislation also created limitations on new chronic-condition SNPs, increasing their focus on care for a specified set of chronic conditions. Managed care organizations that wanted to establish these options therefore continue to operate under a time limited and potentially uncertain future, possibly prompting them to enter the market prior to any additional changes.

The analysis shows that in 2008, SNPs were offered through both HMO and PPO contracts, including eight regional PPOs that offered SNPs. However, HMOs continue to be by far the most common contract type for SNP plans–approximately 87 percent of contracts offering SNPs were HMOs similar to the proportion in 2007. Slightly more than one-third of the contracts offering at least one SNP in 2008 specialized in offering SNPs only, which is also similar to findings from 2007. A significant number of these contractors were Medicaid-only HMOs that, upon passage of the MMA, applied to be SNPs to keep their populations served intact. The total number of MA contracts offering SNPs rose from 139 in 2006 to 285 in 2008, which is an increase of nearly 50 percent in total contracts over just 2 years. MSA and PFFS contracts do not offer SNPs.

Table 3-12a (with changes in Table 3-12b) shows the number of SNPs by plan type and target population between 2006 and 2008. There was growth in all three types of SNPs: institutional, dual Medicare/Medicaid eligible, and chronic condition. However, consistent with the MIPPA requirements, the number of chronic-condition SNPs increased from only 10 in 2006 to 211 by 2008, far surpassing the number of institutional SNPs and exceeding half of the dominant dual-eligible plan type. Despite growth in the other two types, dual-eligible SNPs still comprised 58 percent of total SNPs in 2008. The HMO plan type was the most common for all three types of SNPs in 2008, but approximately one-fifth of institutional SNPs were local PPOs, and approximately one-third of chronic-condition SNPs were offered through either a regional or local PPO contract. Overall, 58 percent of 2008 SNPs were HMOs targeted at dual-eligible beneficiaries.

**Table 3-10a**
**Percentage of beneficiaries with access to MA contracts, by number of contracts and region, 2008–2006**

| Urbanicity | 0 contracts (%) | 1–3 contracts (%) | 4–6 contracts (%) | 7–9 contracts (%) | 10+ contracts (%) | Mean number contracts/county[1] |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Northeast | 0.0 | 0.0 | 2.0 | 10.9 | 87.2 | 17.0 |
| Midwest | 0.0 | 0.0 | 2.1 | 12.6 | 85.3 | 14.4 |
| South | 0.0 | 0.0 | 3.6 | 13.0 | 83.4 | 16.0 |
| West | 0.0 | 0.7 | 1.0 | 7.1 | 91.2 | 17.7 |
| 2007 | | | | | | |
| Northeast | 0.0 | 1.3 | 12.7 | 22.6 | 63.5 | 12.5 |
| Midwest | 0.0 | 0.1 | 10.5 | 29.0 | 60.4 | 10.4 |
| South | 0.0 | 0.7 | 11.2 | 27.4 | 60.7 | 11.8 |
| West | 0.0 | 1.2 | 8.0 | 12.6 | 78.3 | 13.2 |
| 2006 | | | | | | |
| Northeast | 1.7 | 12.6 | 23.5 | 23.7 | 38.6 | 8.7 |
| Midwest | 0.0 | 17.3 | 32.2 | 27.5 | 23.0 | 6.9 |
| South | 0.0 | 22.0 | 39.7 | 18.7 | 19.6 | 7.0 |
| West | 0.4 | 14.6 | 32.7 | 15.9 | 36.5 | 8.9 |

[1] Weighted by eligibles in county.

NOTE:
1. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2008/2006.

**Table 3-10b**
**Change in percentage of beneficiaries with access to MA contracts, by number of contracts and region, 2008–2006**

| Urbanicity | 0 contracts (%) | 1–3 contracts (%) | 4–6 contracts (%) | 7–9 contracts (%) | 10+ contracts (%) | Mean number contracts/county[1] |
|---|---|---|---|---|---|---|
| Change in percentage points, 2007 to 2008 | | | | | | |
| Northeast | 0.0 | −1.3 | −10.7 | −11.8 | 23.7 | 4.5 |
| Midwest | 0.0 | −0.1 | −8.4 | −16.4 | 24.9 | 4.0 |
| South | 0.0 | −0.7 | −7.6 | −14.4 | 22.7 | 4.1 |
| West | 0.0 | −0.5 | −7.0 | −5.5 | 13.0 | 4.5 |
| Change in percentage points, 2006 to 2007 | | | | | | |
| Northeast | −1.7 | −11.3 | −10.8 | −1.1 | 24.9 | 3.8 |
| Midwest | 0.0 | −17.2 | −21.7 | 1.6 | 37.4 | 3.6 |
| South | 0.0 | −21.3 | −28.5 | 8.7 | 41.2 | 4.8 |
| West | −0.4 | −13.4 | −24.7 | −3.3 | 41.8 | 4.3 |
| Change in percentage points, 2006 to 2008 | | | | | | |
| Northeast | −1.7 | −12.6 | −21.5 | −12.8 | 48.6 | 8.4 |
| Midwest | 0.0 | −17.3 | −30.1 | −14.9 | 62.3 | 7.6 |
| South | 0.0 | −22.0 | −36.1 | −5.8 | 63.9 | 9.0 |
| West | −0.4 | −14.0 | −31.6 | −8.8 | 54.8 | 8.8 |

[1] Weighted by eligibles in county.

NOTE:
1. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2008/2006.

**Table 3-11a**
**Number of contracts offering special needs plans, by plan type, 2006–2008**

| Plan type | 2008 Total[1] | 2008 SNP only[2] | 2007 Total[1] | 2007 SNP only[2] | 2006 Total[1] | 2006 SNP only[2] |
|---|---|---|---|---|---|---|
| Total | 285 | 99 | 215 | 90 | 158 | 67 |
| HMO[3] | 247 | 82 | 190 | 77 | 136 | 58 |
| Local PPO | 30 | 14 | 19 | 10 | 19 | 9 |
| Regional PPO | 8 | 3 | 6 | 3 | 3 | 0 |
| MSA[4] | 0 | 0 | 0 | 0 | — | — |
| PFFS | 0 | 0 | 0 | 0 | 0 | 0 |

[1] Offering at least one SNP.

[2] Offering only SNPs.

[3] HMO includes HMO POS and PSO plans.

[4] Includes MSA demonstration contracts.

NOTE:
1. Excludes employer-only and non-Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006/2008.

**Table 3-11b**
**Change in number of contracts offering special needs plans, by plan type, 2006–2008**

| Plan type | 2008–2007 Total[1] | 2008–2007 SNP only[2] | 2007–2006 Total[1] | 2007–2006 SNP only[2] | 2008–2006 Total[1] | 2008–2006 SNP only[2] |
|---|---|---|---|---|---|---|
| Total | 70 | 9 | 57 | 23 | 127 | 32 |
| HMO[3] | 57 | 5 | 54 | 19 | 111 | 24 |
| Local PPO | 11 | 4 | 0 | 1 | 11 | 5 |
| Regional PPO | 2 | 0 | 3 | 3 | 5 | 3 |
| MSA[4] | 0 | 0 | — | — | — | — |
| PFFS | 0 | 0 | 0 | 0 | 0 | 0 |

[1] Offering at least one SNP.

[2] Offering only SNPs.

[3] HMO includes HMO POS and PSO plans.

[4] Includes MSA demonstration contracts.

NOTE:
1. Excludes employer-only and non-Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006/2008.

**Table 3-12a**
**Number of special needs plans, by plan type and target beneficiaries, 2006–2008**

| Plan type | Total | Institutional | Dual eligible | Chronic condition |
|---|---|---|---|---|
| 2008 | | | | |
| Total | 654 | 64 | 379 | 211 |
| HMO[1] | 540 | 50 | 351 | 139 |
| Local PPO | 73 | 13 | 25 | 35 |
| Regional PPO | 41 | 1 | 3 | 37 |
| MSA[2] | 0 | 0 | 0 | 0 |
| PFFS | 0 | 0 | 0 | 0 |
| 2007 | 381 | 58 | 266 | 57 |
| Total | | | | |
| HMO[1] | 318 | 42 | 248 | 28 |
| Local PPO | 39 | 16 | 15 | 8 |
| Regional PPO | 24 | 0 | 3 | 21 |
| MSA[2] | 0 | 0 | 0 | 0 |
| PFFS | 0 | 0 | 0 | 0 |
| 2006 | | | | |
| Total | 262 | 40 | 212 | 10 |
| HMO[1] | 230 | 27 | 193 | 10 |
| Local PPO | 29 | 13 | 16 | 0 |
| Regional PPO | 3 | 0 | 3 | 0 |
| MSA[2] | — | — | — | — |
| PFFS | 0 | 0 | 0 | 0 |

[1] HMO includes HMO POS and PSO plans.

[2] Includes MSA demonstration contracts

NOTE:

1. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from 2008–2006.

**Table 3-12b**
**Change in number of special needs plans, by plan type and target beneficiaries, 2006–2008**

| Plan type | Total | Institutional | Dual eligible | Chronic condition |
|---|---|---|---|---|
| Change, 2008–2007 | | | | |
| Total | 273 | 6 | 113 | 154 |
| HMO[1] | 222 | 8 | 103 | 111 |
| Local PPO | 34 | -3 | 10 | 27 |
| Regional PPO | 17 | 1 | 0 | 16 |
| MSA[2] | 0 | 0 | 0 | 0 |
| PFFS | 0 | 0 | 0 | 0 |
| Change, 2007–2006 | | | | |
| Total | 119 | 18 | 54 | 47 |
| HMO[1] | 88 | 15 | 55 | 18 |
| Local PPO | 10 | 3 | -1 | 8 |
| Regional PPO | 21 | 0 | 0 | 21 |
| MSA[2] | — | — | — | — |
| PFFS | 0 | 0 | 0 | 0 |
| Change, 2008–2006 | | | | |
| Total | 392 | 24 | 167 | 201 |
| HMO[1] | 310 | 23 | 158 | 129 |
| Local PPO | 44 | 0 | 9 | 35 |
| Regional PPO | 38 | 1 | 0 | 37 |
| MSA[2] | — | — | — | — |
| PFFS | 0 | 0 | 0 | 0 |

[1] HMO includes HMO POS and PSO plans.

[2] Includes MSA demonstration contracts

NOTE:
1. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from 2008–2006.

## SECTION 4
## PREMIUMS AND BENEFITS

This section analyzes the premiums and benefits of Medicare Advantage (MA) plans in 2008, including changes from 2006 to 2008. We begin this section with an analysis of MA plan premiums in Section 4.1. Section 4.2 analyzes the structure of MA plans' Part D prescription drug benefits. Section 4.3 then considers other benefits and cost sharing of MA plans. Section 4.4 analyzes simulated out-of-pocket (OOP) costs of MA plans.[20]

### 4.1 Premiums

With the introduction of Part D in 2006, MA plans offering prescription drug benefits began charging two premiums, for Part C benefits (corresponding to Medicare fee-for-service [FFS] Parts A and B benefits) and for Part D prescription drug coverage. Some MA plans offer only Part C benefits and only have a Part C premium (which may be zero). A beneficiary enrolling in MA does not have to take Part D coverage, but if the person does enroll in Part D, it must be through his or her plan. The only exceptions are if the beneficiary is enrolled in a private fee-for-service (PFFS) plan not offering Part D or in a medical savings account (MSA) plan (MSA plans do not offer Part D), in which case the beneficiary can obtain Part D through a stand-alone prescription drug plan (PDP). As described in more detail later, nearly 90 percent of MA enrollees take up Part D through their MA plans.

We discuss Part C, Part D, and Parts C + D (total) premiums. The latter two premiums are tabulated for the subset of plans that incorporate the Part D benefit. Because the sample of plans differs, the sum of the Part C and Part D premiums does not equal the Parts C + D premium. Most premiums we present are weighted by plan enrollment and reflect average premiums charged to enrollees. We also discuss national unweighted average premiums by plan type, which reflect plan offers not taking account of plan enrollment. Some enrollees receive assistance in paying MA premiums (e.g., the Part D low-income subsidies). Thus, the premium amounts reflect plan charges, not necessarily enrollee OOP payments.

In addition to discussing MA premiums in 2008, we consider changes in premiums from 2006 to 2008. Changes in average premiums can be affected by several factors. Changes in average unweighted premiums can arise from changes in the premiums of plans offered in all years or from changes in the mix of plans offered across years. For example, even if the premiums of all plans offered in all years were unchanged, if new, higher premium plans were first offered in 2008, the average plan premium could rise from 2006 or 2007 to 2008. Changes in average enrollment-weighted premiums can arise from changes in the premiums paid by beneficiaries who remain in the same plan in both years, from changes in the mix of plans offered in the 2 years and from changes in the proportion of enrollment across plans in the 2 years. For example, even if plan premiums were unchanged from 2006 to 2008, if enrollment shifted toward higher-premium plans in 2008, enrollment-weighted premiums could rise. Plan types with relatively few plans offered and/or limited enrollment, such as regional preferred provider organizations (PPOs) and institutional and chronic-condition special needs plans

[20] For a summary of the MA payment structure and how it relates to plan premiums and benefits, please see two documents by Pope and colleagues (2007, Section 1.3) and MedPAC (2007).

(SNPs), are likely to have more volatile average premiums from year to year as relatively small shifts in plans offered or in enrollment can have large effects on average premiums. Average enrollment-weighted premiums of plan types with substantial and stable enrollment, such as health maintenance organizations (HMOs), are likely to be dominated by changes in the premiums of beneficiaries who remain in the same plan for multiple years.

We first discuss premiums by plan type in Section 4.1.1 and then the range of premiums paid by MA enrollees in Section 4.1.2. We examine geographic variation in premiums in Section 4.1.3. Section 4.1.4 considers plans that reduce the Medicare Part B premium.

### 4.1.1 By Plan Type

Table 4-1a presents national average enrollment-weighted and unweighted Part C, Part D, and combined Parts C + D 2006–2008 monthly premiums by MA plan type. Table 4-1b shows percentage changes in premiums 2007 to 2008, 2006 to 2007, and 2006 to 2008. MA total (Parts C + D) monthly premiums for open-access (non-SNP) plan types, weighted by enrollment, averaged between $30 and $40 in 2008, with the exception of local PPOs, which were notably more expensive than other plan types. SNP premiums, which averaged approximately $20, were lower than non-SNP premiums. MSA plans do not offer Part D coverage and thus do not have a total (combined Part C and Part D) premium.

The average total premium paid by or on behalf of MA enrollees (the enrollment-weighted average) increased from 2007 to 2008 by 1.1 percent, from $32.35 to $32.72. The average premium for non-SNP plans rose by 2.2 percent, and there was a 1 percent decline in the average SNP premium. Among non-SNP plans, HMO, local PPO, and regional PPO average premiums fell by 4 to 10 percent from 2007 to 2008, but PFFS plan average premiums rose by 36 percent.

From 2006 to 2008, average MA total premiums rose by 10.3 percent, which was a combination of a 13.5 percent increase in non-SNP premiums and a 2.3 percent increase in SNP premiums. PFFS premiums more than doubled in these 2 years, and HMO premiums rose a modest 3.2 percent. The result was that after considerably underpricing HMOs in 2006, by 2008, PFFS total premiums had reached parity with HMO total premiums. PFFS Part C premiums were still lower than HMO Part C premiums in 2008, but PFFS Part D premiums were higher.

The average Parts C + D premium charged by MA plans (the unweighted plan average) fell from $44.19 in 2007 to $40.20 in 2008. Unweighted premiums are considerably higher for PFFS plans and for regional PPOs, indicating that beneficiaries are enrolling in the lower priced offerings of these types of plans. From 2006 to 2008, open-access plan unweighted premiums fell by more than 9 percent, but enrollment-weighted premiums rose. This may indicate that lower-priced plans were raising their premiums more aggressively over this period.

## Table 4-1a
## Mean monthly premiums of MA plans, by plan type, 2006–2008

| Plan type | Enrollment-weighted (Average enrollee premium) Parts C + D[1] ($) | Enrollment-weighted (Average enrollee premium) Part C ($) | Enrollment-weighted (Average enrollee premium) Part D[1] ($) | Unweighted (Average plan offer) Parts C + D[1] ($) | Unweighted (Average plan offer) Part C ($) | Unweighted (Average plan offer) Part D[1] ($) |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Total | 32.72 | 20.24 | 12.62 | 40.20 | 22.62 | 18.26 |
| Open-access plans | 34.85 | 22.66 | 11.93 | 45.28 | 26.70 | 18.10 |
| HMO[2] | 31.64 | 22.45 | 9.70 | 32.68 | 19.48 | 12.71 |
| Local PPO | 70.70 | 46.26 | 25.55 | 66.00 | 40.61 | 26.38 |
| Regional PPO | 36.69 | 23.00 | 12.05 | 61.38 | 33.54 | 20.96 |
| MSA[3] | N/A | 0.00 | N/A | N/A | 0.00 | N/A |
| PFFS | 31.61 | 16.44 | 15.14 | 56.23 | 31.77 | 23.45 |
| SNP | 20.37 | 3.72 | 16.66 | 25.69 | 6.98 | 18.71 |
| Dual | 23.21 | 1.81 | 21.40 | 23.18 | 1.80 | 21.38 |
| Institutional | $6.75 | 0.02 | 6.73 | 27.74 | 4.36 | 23.38 |
| Chronic | 19.94 | 13.39 | 6.55 | 29.56 | 17.08 | 12.48 |
| 2007 | | | | | | |
| Total | 32.35 | 20.72 | 11.49 | 44.19 | 26.08 | 18.33 |
| Open-access plans | 34.10 | 23.08 | 10.45 | 48.72 | 30.18 | 17.66 |
| HMO[2] | 33.11 | 24.74 | 9.25 | 36.06 | 22.30 | 14.00 |
| Local PPO | 76.58 | 50.81 | 26.07 | 71.42 | 45.16 | 25.96 |
| Regional PPO | 40.10 | 23.17 | 15.08 | 68.89 | 37.59 | 24.86 |
| MSA[3] | N/A | 0.00 | N/A | N/A | 0.00 | N/A |
| PFFS | 23.20 | 12.12 | 10.19 | 62.59 | 39.77 | 20.28 |
| SNP | 20.58 | 1.59 | 18.99 | 26.99 | 5.52 | 21.47 |
| Dual | 24.29 | 1.18 | 23.11 | 22.16 | 1.40 | 20.76 |
| Institutional | 6.23 | 0.01 | 6.22 | 36.32 | 12.50 | 23.82 |
| Chronic | 22.85 | 9.64 | 13.20 | 40.01 | 17.63 | 22.38 |
| 2006 | | | | | | |
| Total | 29.67 | 19.16 | 11.45 | 44.39 | 26.04 | 18.83 |
| Open-access plans | 30.70 | 20.88 | 10.65 | 48.43 | 29.39 | 18.45 |
| HMO[2] | 30.65 | 21.52 | 10.31 | 39.98 | 24.06 | 15.52 |
| Local PPO | 68.33 | 45.83 | 23.43 | 71.69 | 44.53 | 27.11 |
| Regional PPO | 26.85 | 13.48 | 12.81 | 66.88 | 40.66 | 20.87 |
| PFFS | 14.80 | 9.96 | 7.28 | 48.46 | 30.48 | 18.70 |
| SNP | 19.91 | 0.88 | 19.03 | 23.13 | 2.26 | 20.87 |
| Dual | 24.93 | 1.15 | 23.78 | 21.50 | 1.53 | 19.98 |
| Institutional | 4.95 | 0.00 | 4.95 | 20.17 | 0.00 | 20.17 |
| Chronic | 41.33 | 8.32 | 33.02 | 65.46 | 24.54 | 40.91 |

[1] For plans offering Part D.

[2] HMO includes HMO point-of-service (POS) and provider-sponsored organization (PSO) plans.

[3] Includes MSA demonstration contracts.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of Centers for Medicare & Medicaid Services (CMS) Health Plan Management System data from July 2006 through July 2008.

**Table 4-1b**
**Percentage change in mean monthly premiums of MA plans, by plan type, 2006–2008**

| Plan type | Enrollment-weighted (Average enrollee premium) Parts C + D[1] (%) | Enrollment-weighted (Average enrollee premium) Part C (%) | Enrollment-weighted (Average enrollee premium) Part D[1] (%) | Unweighted (Average plan offer) Parts C + D[1] (%) | Unweighted (Average plan offer) Part C (%) | Unweighted (Average plan offer) Part D[1] (%) |
|---|---|---|---|---|---|---|
| 2007 to 2008 | | | | | | |
| Total | 1.1 | −2.3 | 9.8 | −9.0 | −13.3 | −0.4 |
| Open-access plans | 2.2 | −1.8 | 14.2 | −7.1 | −11.5 | 2.5 |
| HMO[2] | −4.4 | −9.3 | 4.9 | −9.4 | −12.6 | −9.2 |
| Local PPO | −7.7 | −9.0 | −2.0 | −7.6 | −10.1 | 1.6 |
| Regional PPO | −8.5 | −0.7 | −20.1 | −10.9 | −10.8 | −15.7 |
| PFFS | 36.3 | 35.6 | 48.6 | −10.2 | −20.1 | 15.6 |
| SNP | −1.0 | 134.0 | −12.3 | −4.8 | 26.4 | −12.9 |
| Dual | −4.4 | 53.4 | −7.4 | 4.6 | 28.6 | 3.0 |
| Institutional | 8.3 | 100.0 | 8.2 | −23.6 | −65.1 | −1.8 |
| Chronic | −12.7 | 38.9 | −50.4 | −26.1 | −3.1 | −44.2 |
| 2006 to 2007 | | | | | | |
| Total | 9.0 | 8.1 | 0.3 | −0.5 | 0.2 | −2.7 |
| Open-access plans | 11.1 | 10.5 | −1.9 | 0.6 | 2.7 | −4.3 |
| HMO[2] | 8.0 | 15.0 | −10.3 | −9.8 | −7.3 | −9.8 |
| Local PPO | 12.1 | 10.9 | 11.3 | −0.4 | 1.4 | −4.2 |
| Regional PPO | 49.3 | 71.9 | 17.7 | 3.0 | −7.6 | 19.1 |
| PFFS | 56.8 | 21.7 | 40.0 | 29.2 | 30.5 | 8.4 |
| SNP | 3.4 | 80.7 | −0.2 | 16.7 | 144.2 | 2.9 |
| Dual | −2.6 | 2.6 | −2.8 | 3.1 | −8.5 | 3.9 |
| Institutional | 25.9 | — | 25.7 | 80.1 | — | 18.1 |
| Chronic | −44.7 | 15.9 | −60.0 | −38.9 | −28.2 | −45.3 |
| 2006 to 2008 | | | | | | |
| Total | 10.3 | 5.6 | 10.2 | −9.4 | −13.1 | −3.0 |
| Open-access plans | 13.5 | 8.5 | 12.0 | −6.5 | −9.2 | −1.9 |
| HMO[2] | 3.2 | 4.3 | −5.9 | −18.3 | −19.0 | −18.1 |
| Local PPO | 3.5 | 0.9 | 9.0 | −7.9 | −8.8 | −2.7 |
| Regional PPO | 36.6 | 70.6 | −5.9 | −8.2 | −17.5 | 0.4 |
| PFFS | 113.6 | 65.1 | 108.0 | 16.0 | 4.2 | 25.4 |
| SNP | 2.3 | 322.7 | −12.5 | 11.1 | 208.8 | −10.3 |
| Dual | −6.9 | 57.4 | −10.0 | 7.8 | 17.6 | 7.0 |
| Institutional | 36.4 | — | 36.0 | 37.5 | — | 15.9 |
| Chronic | −51.8 | 60.9 | −80.2 | −54.8 | −30.4 | −69.5 |

[1] For plans offering Part D.
[2] HMO includes HMO POS and PSO plans.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

Table 4-2a shows the percentage of enrollees in zero-premium plans by MA plan type 2006–2008, with percentage point changes in Table 4-2b. In 2008, just under half (49.1 percent) of MA enrollees received their Part C and Part D benefits at no extra charge beyond the Medicare Part B premium. The proportion of enrollees in open-access plans paying neither a Part C nor a Part D premium varied from a high of 59 percent for HMO plans to a low of 22 percent for local PPOs. Very few SNP enrollees were charged a Part C premium, but most were charged a Part D premium. Part D low-income assistance presumably defrayed some or all of many SNP enrollees' Part D premiums.

In 2008, the percentage of MA enrollees in zero total premium plans continued to decline slightly. Consistent with the increase in overall premiums, the decline was most marked for PFFS enrollees. However, the percentage of SNP enrollees in zero total premium plans rose from 23 percent in 2007 to 25 percent in 2008. This difference was due to an increase in SNP enrollees with no Part D premium.

### 4.1.2 Enrollment by Premium Range

Table 4-3a shows the distribution of MA enrollees in open-enrollment (non-SNP) plans by Part C, Part D, and Parts C + D premium range 2006–2008, with percentage point changes in Table 4-3b. Among open-access plans in 2008, there was a large concentration of enrollment at zero total premium with 53 percent of enrollees in plans with Part C and D coverage, and 58 percent of enrollees with Part C coverage, in zero premium plans. There was a fairly uniform distribution of enrollees among the other premium ranges. Almost all the Part D enrollment was in plans with premiums below $50. A significant fraction of MA enrollees were paying a substantial total (Parts C + D) premium. More than one-fifth were paying a monthly total premium of $75 or greater, and more than 10 percent were paying $100 or more each month.

Compared to 2007, there was a mixed pattern of gains and losses in 2008 across the premium categories in the percentage of total enrollees. In terms of total premiums, in addition to the drop in percentage of enrollees at zero, fewer enrollees were in the $75–$100 range. The $50–$75 range showed the largest gains. Fewer Part C enrollees had premiums of zero and in the highest ranges, with the largest gains in the $1–$25 range. The percentage of enrollees with Part D premiums of less than $25 decreased, but those with premiums of $25–$50 increased. From 2006 to 2008, the most striking changes were the drop in percentage of enrollees with a zero Part D premium and a corresponding decline in percentage of enrollees with a total premium of zero, as well as an increase in the percentage with a total premium of $50–$75.

### 4.1.3 By Urbanicity and Region

Table 4-4a shows enrollment-weighted 2006–2008 average MA premiums by urbanicity, with percentage point changes in Table 4-4b. Premiums in urban and rural categories may be affected by several factors, including MA benchmark amounts, differences in plan types or benefits offered and chosen, the payment discounts plans can obtain from providers, beneficiary income levels and the demand for extra benefits, plan costs, and degree of competition among plans. Urban premiums were somewhat lower than rural premiums in 2008. The average total (Parts C + D) urban premium was $31.88 compared to $40.11 in rural areas.

**Table 4-2a**
**Percentage of MA enrollees in zero premium plans, by plan type, 2006–2008**

| Plan type | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2008 | | | |
| Total | 49.1 | 62.7 | 50.3 |
| Open-access plans | 53.2 | 58.2 | 54.0 |
| HMO[2] | 58.5 | 60.7 | 59.3 |
| Local PPO | 21.6 | 24.4 | 22.7 |
| Regional PPO | 38.1 | 48.9 | 38.1 |
| MSA[3] | N/A | 100.0 | N/A |
| PFFS | 48.4 | 62.5 | 49.2 |
| SNP | 24.8 | 93.2 | 28.6 |
| Dual | 4.9 | 97.6 | 4.9 |
| Institutional | 75.1 | 99.9 | 75.1 |
| Chronic | 60.8 | 72.3 | 81.1 |
| 2007 | | | |
| Total | 51.4 | 64.0 | 52.3 |
| Open-access plans | 55.3 | 60.0 | 56.3 |
| HMO[2] | 58.0 | 60.2 | 59.1 |
| Local PPO | 14.3 | 16.6 | 14.9 |
| Regional PPO | 43.6 | 51.5 | 43.6 |
| MSA[3] | N/A | 100.0 | N/A |
| PFFS | 58.3 | 69.6 | 59.0 |
| SNP | 22.8 | 96.7 | 23.4 |
| Dual | 3.7 | 97.2 | 3.7 |
| Institutional | 76.1 | 100.0 | 76.1 |
| Chronic | 65.1 | 83.6 | 72.1 |
| 2006 | | | |
| Total | 53.8 | 63.1 | 57.9 |
| Open-access plans | 57.1 | 59.8 | 61.7 |
| HMO[2] | 58.8 | 60.1 | 63.7 |
| Local PPO | 15.7 | 18.2 | 23.1 |
| Regional PPO | 35.8 | 50.4 | 37.5 |
| PFFS | 65.3 | 72.4 | 66.4 |
| SNP | 22.1 | 98.7 | 22.1 |
| Dual | 1.8 | 98.4 | 1.8 |
| Institutional | 82.0 | 100.0 | 82.0 |
| Chronic | 9.2 | 85.7 | 9.2 |

[1] For plans offering Part D.

[2] HMO includes HMO POS and PSO plans.

[3] Includes MSA demonstration contracts.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-2b**
**Change in percentage points of MA enrollees in zero premium plans, by plan type, 2006–2008**

| Plan type | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2007 to 2008 | | | |
| Total | −2.3 | −1.3 | −2.0 |
| Open-access plans | −2.1 | −1.8 | −2.3 |
| HMO[2] | 0.5 | 0.5 | 0.2 |
| Local PPO | 7.3 | 7.8 | 7.8 |
| Regional PPO | −5.5 | −2.6 | −5.5 |
| PFFS | −9.9 | −7.1 | −9.8 |
| SNP | 2.0 | −3.5 | 5.2 |
| Dual | 1.2 | 0.4 | 1.2 |
| Institutional | −1.0 | −0.1 | −1.0 |
| Chronic | −4.3 | −11.3 | 9.0 |
| 2006 to 2007 | | | |
| Total | −2.4 | 0.9 | −5.6 |
| Open-access plans | −1.8 | 0.2 | −5.4 |
| HMO[2] | −0.8 | 0.1 | −4.6 |
| Local PPO | −1.4 | −1.6 | −8.2 |
| Regional PPO | 7.8 | 1.1 | 6.1 |
| PFFS | −7.0 | −2.8 | −7.4 |
| SNP | 0.7 | −2.0 | 1.3 |
| Dual | 1.9 | −1.2 | 1.9 |
| Institutional | −5.9 | 0.0 | −5.9 |
| Chronic | 55.9 | −2.1 | 62.9 |
| 2006 to 2008 | | | |
| Total | −4.7 | −0.4 | −7.6 |
| Open-access plans | −3.9 | −1.6 | −7.7 |
| HMO[2] | −0.3 | 0.6 | −4.4 |
| Local PPO | 5.9 | 6.2 | −0.4 |
| Regional PPO | 2.3 | −1.5 | 0.6 |
| PFFS | −16.9 | −9.9 | −17.2 |
| SNP | 2.7 | −5.5 | 6.5 |
| Dual | 3.1 | −0.8 | 3.1 |
| Institutional | −6.9 | −0.1 | −6.9 |
| Chronic | 51.6 | −13.4 | 71.9 |

[1] For plans offering Part D.

[2] HMO includes HMO POS and PSO plans.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-3a**
**Percentage of enrollees in MA open-access (non-SNP) plans, by premium range, 2006–2008**

| Monthly premium | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2008 | | | |
| $0 | 53.2 | 58.4 | 55.1 |
| >$0–24.99 | 5.1 | 8.9 | 23.4 |
| $25–49.99 | 9.4 | 11.3 | 19.1 |
| $50–74.99 | 11.7 | 9.2 | 2.3 |
| $75–99.99 | 9.9 | 10.1 | 0.1 |
| $100+ | 10.7 | 2.2 | 0.0 |
| 2007 | | | |
| $0 | 55.4 | 60.3 | 56.3 |
| >$0–24.99 | 4.2 | 5.6 | 26.1 |
| $25–49.99 | 9.3 | 12.6 | 16.8 |
| $50–74.99 | 8.9 | 8.1 | 0.7 |
| $75–99.99 | 11.8 | 11.4 | 0.2 |
| $100+ | 10.5 | 2.1 | 0.0 |
| 2006 | | | |
| $0 | 57.1 | 59.8 | 61.7 |
| >$0–24.99 | 4.5 | 9.0 | 19.5 |
| $25–49.99 | 10.2 | 10.5 | 17.0 |
| $50–74.99 | 7.3 | 11.0 | 1.4 |
| $75–99.99 | 12.9 | 8.0 | 0.2 |
| $100+ | 8.0 | 1.7 | 0.3 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Excludes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-3b**
**Change in percentage points of MA enrollees in open-access (non-SNP) plans, by premium range, 2006–2008**

| Monthly premium | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2007 to 2008 | | | |
| $0 | –2.1 | –1.9 | –1.2 |
| >$0–24.99 | 0.9 | 3.4 | –2.7 |
| $25–49.99 | 0.1 | –1.2 | 2.4 |
| $50–74.99 | 2.8 | 1.1 | 1.6 |
| $75–99.99 | –1.9 | –1.3 | –0.1 |
| $100+ | 0.2 | 0.0 | 0.0 |
| 2006 to 2007 | | | |
| $0 | –1.8 | 0.5 | –5.4 |
| >$0–24.99 | –0.4 | –3.5 | 6.6 |
| $25–49.99 | –0.9 | 2.1 | –0.3 |
| $50–74.99 | 1.6 | –2.9 | –0.7 |
| $75–99.99 | –1.1 | 3.4 | 0.0 |
| $100+ | 2.6 | 0.4 | –0.2 |
| 2006 to 2008 | | | |
| $0 | –3.9 | –1.4 | –6.6 |
| >$0–24.99 | 0.5 | –0.1 | 3.9 |
| $25–49.99 | –0.8 | 0.8 | 2.1 |
| $50–74.99 | 4.4 | –1.9 | 0.9 |
| $75–99.99 | –3.0 | 2.1 | 0.0 |
| $100+ | 2.8 | 0.4 | –0.2 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Excludes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-4a**
**Mean monthly premiums of MA plans, by urbanicity, 2006–2008**

| Urbanicity | Parts C + D[1] ($) | Part C ($) | Part D[1] ($) |
|---|---|---|---|
| 2008 | | | |
| Urban | 31.88 | 19.82 | 12.22 |
| Large urban | 29.33 | 18.67 | 11.03 |
| Medium urban | 34.68 | 20.11 | 13.92 |
| Small urban | 49.06 | 28.58 | 18.80 |
| Rural | 40.11 | 22.76 | 16.45 |
| Rural–urban adjacent | 40.82 | 22.92 | 17.21 |
| Rural–not urban adjacent | 37.95 | 22.29 | 14.17 |
| 2007 | | | |
| Urban | 32.08 | 20.77 | 11.28 |
| Large urban | 30.26 | 20.41 | 10.24 |
| Medium urban | 33.76 | 19.44 | 13.25 |
| Small urban | 48.16 | 28.50 | 16.45 |
| Rural | 36.85 | 19.98 | 14.98 |
| Rural–urban adjacent | 37.66 | 20.44 | 15.57 |
| Rural–not urban adjacent | 34.36 | 18.59 | 13.18 |
| 2006 | | | |
| Urban | 29.40 | 18.90 | 11.21 |
| Large urban | 26.64 | 17.16 | 10.17 |
| Medium urban | 35.26 | 21.85 | 13.52 |
| Small urban | 46.38 | 29.49 | 17.23 |
| Rural | 35.06 | 21.25 | 15.29 |
| Rural–urban adjacent | 36.84 | 22.29 | 16.42 |
| Rural–not urban adjacent | 29.08 | 17.75 | 11.50 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Weighted by contract/plan/county enrollment. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-4b**
**Percentage change in mean monthly premiums of MA plans, by urbanicity, 2006–2008**

| Urbanicity | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2007 to 2008 | | | |
| Urban | –0.6 | –4.5 | 8.3 |
| Large urban | –3.1 | –8.5 | 7.7 |
| Medium urban | 2.7 | 3.4 | 5.0 |
| Small urban | 1.9 | 0.3 | 14.3 |
| Rural | 8.9 | 13.9 | 9.8 |
| Rural–urban adjacent | 8.4 | 12.2 | 10.5 |
| Rural–not urban adjacent | 10.5 | 19.9 | 7.5 |
| 2006 to 2007 | | | |
| Urban | 9.1 | 9.9 | 0.6 |
| Large urban | 13.6 | 18.9 | 0.8 |
| Medium urban | –4.2 | –11.0 | –2.0 |
| Small urban | 3.8 | –3.3 | –4.5 |
| Rural | 5.1 | –6.0 | –2.0 |
| Rural–urban adjacent | 2.2 | –8.3 | –5.2 |
| Rural–not urban adjacent | 18.2 | 4.7 | 14.6 |
| 2006 to 2008 | | | |
| Urban | 8.4 | 4.9 | 9.0 |
| Large urban | 10.1 | 8.8 | 8.5 |
| Medium urban | –1.6 | –8.0 | 2.9 |
| Small urban | 5.8 | –3.1 | 9.1 |
| Rural | 14.4 | 7.1 | 7.6 |
| Rural–urban adjacent | 10.8 | 2.8 | 4.8 |
| Rural–not urban adjacent | 30.5 | 25.6 | 23.2 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Weighted by contract/plan/county enrollment. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

Within urban areas, enrollees in medium and smaller urban areas paid higher premiums than enrollees in large urban areas. Total premiums in small urban areas were the highest of any urban or rural category. Within rural areas, enrollees in counties adjacent to urban counties paid slightly higher average premiums than enrollees in nonadjacent counties.

From 2007 to 2008, the urban-rural premium gap widened as urban total premiums decreased, whereas rural premiums increased. Total premiums in large urban areas decreased by 3 percent; in all other urban-rural categories total premiums increased. From 2006 to 2008, total premiums rose more rapidly in rural than urban areas, with the largest increases in rural areas not adjacent to urban areas.

Findings from Tables 4-5a and 4-5b regarding the percentage of MA enrollees in zero-premium plans by urbanicity largely mirror those of Tables 4-4a and 4-4b. Only 38 percent of rural residents are in zero total premium plans compared to 50 percent of urban residents. The percentage of rural residents in zero premium plans fell from 43 percent in 2007 to 38 percent in 2008.

Table 4-6a shows enrollment-weighted average premiums by census region, and Table 4-7a presents the percentage of enrollees in zero-premium plans by region for 2006 to 2008. Tables 4-6b and 4-7b show the corresponding changes over time. Regional premium differences continued to be pronounced in 2008, but were compressed slightly from 2007. Average 2008 total premiums were highest in the Northeast ($56) and lowest in the South ($16). More than 6 in 10 Southern MA enrollees paid no total premium, and less than 1 in 4 of Northeast MA enrollees were in zero total premium plans. The Northeast had an unusually low percentage of enrollees in zero-premium Medicare Advantage Prescription Drug Plans (MA-PDs), only 25 percent, compared to at least 49 percent in the other regions (Table 4-7a).

From 2007 to 2008, total premiums fell in the Northeast and West, but rose in the Midwest and South. Part C premiums showed the same regional pattern, but Part D premiums rose in all regions except in the Midwest. From 2006 to 2008, total premiums rose significantly in the Midwest and the South, modestly in the West, and very little in the Northeast. This had the effect of somewhat compressing the regional premium differences that existed in 2006.

### 4.1.4 Part B Premium Reductions

Since 2003, plans have been allowed to reduce the Medicare Part B premium as an added benefit to their enrollees. Enrollees in Part B premium reduction plans pay a lower Medicare Part B premium than they would pay if they stayed in the traditional Medicare FFS program. The Medicare Part B premium was $96.40 in 2008, it was $93.50 in 2007, and it was $88.50 in 2006.

Table 4-8a shows the percentage of MA enrollees who had a Part B premium reduction 2006–2008, with changes over time shown in Table 4-8b. Overall, 2.7 percent of MA enrollees had their Part B premium reduced in 2008, and the average Part B premium reduction among enrollees with a reduction was $38.88. HMO enrollees and enrollees in urban areas and in the South, were most likely to have their Part B premium reduced. Six percent of Southern enrollees and 3.5 percent of HMO enrollees had their Part B premium reduced.

**Table 4-5a**
**Percent of Medicare Advantage enrollees in zero premium plans, by urbanicity, 2008–2006**

| Urbanicity | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2008 | | | |
| Urban | 50.2 | 64.0 | 51.3 |
| Large urban | 53.8 | 67.0 | 54.9 |
| Medium urban | 45.0 | 61.3 | 46.1 |
| Small urban | 29.4 | 46.6 | 31.3 |
| Rural | 37.9 | 54.0 | 40.4 |
| Rural–urban adjacent | 36.3 | 52.4 | 38.6 |
| Rural–not urban adjacent | 42.9 | 58.8 | 45.9 |
| 2007 | | | |
| Urban | 51.8 | 64.3 | 52.7 |
| Large urban | 55.2 | 66.5 | 55.8 |
| Medium urban | 45.9 | 62.8 | 47.8 |
| Small urban | 32.6 | 48.4 | 33.4 |
| Rural | 43.3 | 60.5 | 44.0 |
| Rural–urban adjacent | 41.1 | 58.5 | 41.6 |
| Rural–not urban adjacent | 50.1 | 66.5 | 51.4 |
| 2006 | | | |
| Urban | 54.3 | 63.8 | 58.6 |
| Large urban | 58.4 | 67.1 | 62.7 |
| Medium urban | 44.8 | 57.9 | 49.2 |
| Small urban | 33.0 | 44.5 | 37.2 |
| Rural | 43.2 | 55.4 | 44.6 |
| Rural–urban adjacent | 39.9 | 51.8 | 41.3 |
| Rural–not urban adjacent | 54.6 | 67.6 | 55.8 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-5b**
**Change in percentage points of MA enrollees in zero premium plans, by urbanicity, 2006–2008**

| Urbanicity | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2007 to 2008 | | | |
| Urban | −1.6 | −0.4 | −1.4 |
| Large urban | −1.3 | 0.5 | −0.9 |
| Medium urban | −0.9 | −1.5 | −1.7 |
| Small urban | −3.3 | −1.9 | −2.1 |
| Rural | −5.4 | −6.5 | −3.6 |
| Rural–urban adjacent | −4.8 | −6.1 | −3.0 |
| Rural–not urban adjacent | −7.3 | −7.7 | −5.5 |
| 2006 to 2007 | | | |
| Urban | −2.5 | 0.6 | −5.9 |
| Large urban | −3.2 | −0.6 | −6.8 |
| Medium urban | 1.1 | 5.0 | −1.4 |
| Small urban | −0.3 | 3.9 | −3.8 |
| Rural | 0.1 | 5.1 | −0.6 |
| Rural–urban adjacent | 1.2 | 6.7 | 0.3 |
| Rural–not urban adjacent | −4.4 | −1.1 | −4.4 |
| 2006 to 2008 | | | |
| Urban | −4.2 | 0.2 | −7.3 |
| Large urban | −4.6 | −0.1 | −7.8 |
| Medium urban | 0.2 | 3.5 | −3.1 |
| Small urban | −3.6 | 2.0 | −5.9 |
| Rural | −5.3 | −1.4 | −4.2 |
| Rural–urban adjacent | −3.5 | 0.6 | −2.7 |
| Rural–not urban adjacent | −11.7 | −8.7 | −9.9 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-6a**
**Mean monthly premiums of MA plans, by region, 2006–2008**

| Census region | Parts C + D[1] ($) | Part C ($) | Part D[1] ($) |
|---|---|---|---|
| 2008 | | | |
| Northeast | $56.29 | $32.58 | $22.88 |
| Midwest | 35.03 | 21.32 | 13.68 |
| South | 16.05 | 8.28 | 8.54 |
| West | 33.33 | 24.01 | 9.46 |
| 2007 | | | |
| Northeast | 58.51 | 36.13 | 21.15 |
| Midwest | 33.01 | 18.42 | 14.34 |
| South | 13.49 | 6.99 | 6.97 |
| West | 33.98 | 25.37 | 8.54 |
| 2006 | | | |
| Northeast | 55.31 | 32.23 | 23.20 |
| Midwest | 29.54 | 18.33 | 11.97 |
| South | 12.26 | 5.64 | 7.16 |
| West | 29.78 | 22.71 | 7.83 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Weighted by contract/plan/county enrollment. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-6b**
**Percentage change in mean monthly premiums of MA plans, by region, 2006–2008**

| Census region | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2007 to 2008 | | | |
| Northeast | −3.8 | −9.8 | 8.2 |
| Midwest | 6.1 | 15.8 | −4.6 |
| South | 19.0 | 18.6 | 22.5 |
| West | −1.9 | −5.3 | 10.8 |
| 2006 to 2007 | | | |
| Northeast | 5.8 | 12.1 | −8.9 |
| Midwest | 11.8 | 0.5 | 19.8 |
| South | 10.0 | 23.9 | −2.6 |
| West | 14.1 | 11.7 | 9.0 |
| 2006 to 2008 | | | |
| Northeast | 1.8 | 1.1 | −1.4 |
| Midwest | 18.6 | 16.3 | 14.3 |
| South | 31.0 | 46.9 | 19.4 |
| West | 11.9 | 5.8 | 20.7 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Weighted by contract/plan/county enrollment. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-7a**
**Percent of MA enrollees**
**in zero premium plans, by region, 2006–2008**

| Census region | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2008 | | | |
| Northeast | 24.1 | 45.3 | 24.6 |
| Midwest | 49.0 | 60.8 | 50.4 |
| South | 64.6 | 78.1 | 67.1 |
| West | 49.1 | 59.1 | 49.4 |
| 2007 | | | |
| Northeast | 24.0 | 42.6 | 24.1 |
| Midwest | 50.1 | 63.8 | 50.9 |
| South | 71.4 | 83.6 | 73.3 |
| West | 49.2 | 58.3 | 49.7 |
| 2006 | | | |
| Northeast | 25.3 | 40.7 | 25.5 |
| Midwest | 53.9 | 63.2 | 57.1 |
| South | 71.1 | 82.6 | 72.8 |
| West | 55.3 | 60.6 | 64.4 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

**Table 4-7b**
**Change in percentage points of MA enrollees in zero premium plans, by region, 2006–2008**

| Census region | Parts C + D[1] (%) | Part C (%) | Part D[1] (%) |
|---|---|---|---|
| 2007 to 2008 | | | |
| Northeast | 0.1 | 2.8 | 0.5 |
| Midwest | −1.1 | −3.0 | −0.5 |
| South | −6.8 | −5.5 | −6.2 |
| West | −0.1 | 0.7 | −0.3 |
| 2006 to 2007 | | | |
| Northeast | −1.3 | 1.8 | −1.4 |
| Midwest | −3.8 | 0.6 | −6.2 |
| South | 0.3 | 1.0 | 0.5 |
| West | −6.1 | −2.3 | −14.7 |
| 2006 to 2008 | | | |
| Northeast | −1.2 | 4.6 | −0.8 |
| Midwest | −4.9 | −2.4 | −6.7 |
| South | −6.5 | −4.5 | −-5.7 |
| West | −6.2 | −1.5 | −15.0 |

[1] For plans offering Part D.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

**Table 4-8a**
**Part B premium reduction by MA plan type, urbanicity, and region, 2006–2008 (Percentage of enrollees)**

| Plan type/ urbanicity/ region | With any reduction, 2008 (%) | Mean reduction[1] 2008 ($) | With any reduction, 2007 (%) | Mean reduction[1] 2007 ($) | With any reduction, 2006 (%) | Mean reduction[1] 2006 ($) |
|---|---|---|---|---|---|---|
| Total | 2.7 | 38.88 | 3.4 | 52.71 | 3.5 | 35.72 |
| Plan type | | | | | | |
| HMO[2] | 3.5 | 41.01 | 3.5 | 41.51 | 4.0 | 35.32 |
| Local PPO | 0.9 | 10.36 | 1.3 | 56.23 | 1.3 | 87.70 |
| Regional PPO | 0.0 | N/A | 0.0 | N/A | 0.0 | N/A |
| MSA[3] | 0.0 | N/A | 0.0 | N/A | N/A | N/A |
| PFFS | 1.4 | 28.59 | 4.1 | 84.46 | 1.4 | 25.05 |
| Urbanicity | | | | | | |
| Urban | 2.9 | 39.40 | 3.6 | 53.34 | 3.7 | 36.41 |
| Rural | 1.2 | 29.97 | 1.6 | 41.31 | 1.7 | 20.21 |
| Census region | | | | | | |
| Northeast | 0.5 | 12.83 | 0.6 | 21.12 | 1.2 | 5.16 |
| Midwest | 1.4 | 26.80 | 1.0 | 31.72 | 0.8 | 25.12 |
| South | 6.0 | 45.63 | 7.2 | 65.89 | 5.2 | 57.32 |
| West | 1.3 | 18.89 | 2.6 | 23.34 | 4.7 | 19.51 |

[1] Among enrollees with a reduction.

[2] HMO includes HMO POS and PSO plans.

[3] Includes MSA demonstration contracts.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

**Table 4-8b**
**Change in Part B premium reduction by MA plan type, urbanicity, and region, 2006–2008**

| Plan type/ urbanicity/ region | Change, 2007 to 2008, With any reduction[1] (%) | Change, 2007 to 2008, Mean reduction[2] ($) | Change, 2006 to 2007, With any reduction[1] (%) | Change, 2006 to 2007, Mean reduction[2] ($) | Change, 2006 to 2008, With any reduction[1] (%) | Change, 2006 to 2008, Mean reduction[2] ($) |
|---|---|---|---|---|---|---|
| Total | −0.7 | −13.83 | −0.1 | 16.99 | −0.8 | 3.16 |
| Plan type | | | | | | |
| HMO[3] | 0.0 | −0.50 | −0.6 | 6.20 | −0.6 | 5.70 |
| Local PPO | −0.4 | −45.87 | 0.0 | −31.47 | −0.5 | −77.34 |
| Regional PPO | 0.0 | N/A | 0.0 | N/A | 0.0 | N/A |
| MSA[4] | 0.0 | N/A | N/A | N/A | N/A | N/A |
| PFFS | −2.6 | −55.87 | 2.7 | 59.41 | 0.0 | 3.54 |
| Urbanicity | | | | | | |
| Urban | −0.7 | −13.94 | 0.0 | 16.93 | −0.7 | 2.99 |
| Rural | −0.4 | −11.34 | −0.2 | 21.09 | −0.5 | 9.76 |
| Census region | | | | | | |
| Northeast | −0.1 | −8.29 | −0.6 | 15.96 | −0.7 | 7.66 |
| Midwest | 0.4 | −4.92 | 0.2 | 6.61 | 0.6 | 1.69 |
| South | −1.2 | −20.26 | 1.9 | 8.57 | 0.8 | −11.69 |
| West | −1.3 | −4.44 | −2.1 | 3.83 | −3.4 | −0.61 |

[1] Change in percentage points.

[2] Among enrollees with a reduction.

[3] HMO includes HMO POS and PSO plans.

[4] Includes MSA demonstration contracts.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

The percentage of MA enrollees with a premium reduction fell from 3.4 percent in 2007 to 2.7 percent in 2008. The average amount of the reduction also decreased. Reductions were most marked among PFFS enrollees.

## 4.2 Prescription Drug Benefits

The implementation of the Medicare Part D drug benefit in 2006, including the establishment of MA-PDs, was the most significant change in Medicare in many years. This section characterizes the prescription drug benefits that MA-PDs provided in 2008, including changes 2006–2008.

MA-PDs had the flexibility to offer four types of Part D benefits:

- Defined standard
- Actuarially equivalent
- Basic alternative
- Enhanced alternative.

We use these categories (merging "basic alternative" into "actuarially equivalent") as one important descriptor of drug benefits offered. We also use the category of "basic" coverage, which includes defined standard, actuarially equivalent, and basic alternative plans, as a descriptor.

The defined standard Part D benefit in 2008 had a $275 deductible ($265 in 2007 and $250 in 2006) and 25 percent enrollee cost sharing until the enrollee reached an "initial coverage limit" (or ICL) of $2,510 ($2,400 in 2007 and $2,250 in 2006) in total covered drug expenses. There was no coverage (other than discounted prices) in the "coverage" gap from the ICL to the OOP threshold of $4,050 ($3,850 in 2007 and $3,600 in 2006). Catastrophic coverage reimbursed most expenditures above $4,050 in OOP costs.

The two types of basic coverage that are actuarially equivalent to defined standard plans are (1) standard coverage with actuarially equivalent cost sharing and (2) basic alternative coverage. In the first variant, plans have a similar overall structure to the defined standard benefit, but the cost sharing differs from the 25 percent co-insurance under the standard defined benefit. These "actuarially equivalent" plans tend to have tiered co-payments of a low dollar amount for a generic drug and higher amounts for preferred brand-name drugs and for non-preferred brand-name drugs. Under the second variant, termed "basic alternative coverage," plans have a different overall structure of the benefit, although they must be actuarially equivalent to the standard benefit. In a basic alternative coverage design, features such as a reduction in the deductible, changes in cost sharing, and a modification of the ICL can be combined and still provide coverage with an actuarial value equal to standard coverage.

In addition to the defined standard plans and its two actuarially equivalent variants, plans were able to offer enhanced alternative prescription coverage that exceeds standard coverage by

offering supplemental benefits such as an increase in the ICL, coverage in the gap, or reduced cost sharing.

This section is organized as follows. We begin in Section 4.2.1 by analyzing MA-PDs by plan type. Section 4.2.2 discusses drug benefits by urbanicity and region. Section 4.2.3 presents data on MA-PDs' cost sharing before the ICL, Section 4.2.4 on their ICL, and Section 4.2.5 on their coverage if any in the coverage gap.

### 4.2.1 By Plan Type

Table 4-9a shows the type of prescription drug benefit by MA plan type 2006–2008, with percentage point changes in Table 4-9b. Approximately 13 percent of MA enrollees were in plans without a drug benefit in 2008 and 2007, which is up from 10 percent in 2006. These beneficiaries may have prescription drug coverage from another source, such as a former employer, or may have declined Part D coverage. The proportion of enrollees in plans without Part D coverage is small for all plan types except MSA and PFFS plans. MSA enrollees, and PFFS enrollees in plans not offering drug coverage, are allowed to enroll in stand-alone Part D plans (PDPs). SNPs are required to provide Part D and so have no enrollees without it.

Only 12 percent of MA enrollees were in MA-PDs offering basic coverage in 2008, which is down from 22 percent in 2007 and 27 percent in 2006. The majority of basic coverage continued to be an actuarially equivalent variant rather than defined standard, but actuarially equivalent coverage fell from 20 percent of MA enrollees in 2006 to 8 percent in 2008. Basic coverage was especially prevalent among SNP dual-eligible plan enrollees, but the Part D low-income subsidy generally exempted most enrollees from the cost sharing and coverage gap in these plans except for the statutorily mandated co-payment amounts.

Enhanced coverage was the most common Part D benefit in all plan types except dual-eligible SNPs (MSAs do not offer Part D coverage). A majority of enrollees in each non-dual-SNP plan type had enhanced coverage. Overall, 75 percent of MA enrollees enjoyed enhanced coverage in 2008, which is up from 65 percent in 2007 and 63 percent in 2006.

### 4.2.2 By Urbanicity and Region

Table 4-10a shows the type of prescription drug benefit by urbanicity with percentage point changes in Table 4-10b. A much higher percentage of rural than urban MA enrollees were in plans without a Part D benefit. This reflects the prevalence of PFFS plans in rural areas, which were not required to offer a prescription drug benefit. Also, rural enrollees in MA-PDs were more likely than urban enrollees to have only a basic Part D benefit. Basic coverage was replaced by enhanced coverage at a more rapid rate in urban areas from 2007 to 2008 and from 2006 to 2008.

Table 4-11a shows Part D benefit type by census region with percentage point changes in Table 4-11b. MA enrollees in the Midwest were most likely to be in a plan without a drug benefit, and Western MA enrollees were least likely to be in such a plan. Northeastern enrollees were more likely to have only basic drug coverage, whereas Western enrollees were most likely to have enhanced coverage. The proportion of MA enrollees with enhanced MA-PD coverage rose substantially in the Northeast and in the West from 2007 to 2008.

**Table 4-9a**
**Prescription drug benefits, by MA plan type, 2006–2008**
**(Percentage of enrollees with Part D benefit type for each MA plan type)**

| Plan type | Total (%) | None (%) | Basic[1] total (%) | Defined standard (%) | Actuarially equivalent[2] (%) | Enhanced alternative (%) |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Total | 100.0 | 13.1 | 12.2 | 4.3 | 7.9 | 74.8 |
| Open-access plans | 100.0 | 15.0 | 5.8 | 0.7 | 5.1 | 79.1 |
| HMO[3] | 100.0 | 5.8 | 6.2 | 1.0 | 5.2 | 88.0 |
| Local PPO | 100.0 | 6.4 | 17.2 | 0.1 | 17.1 | 76.5 |
| Regional PPO | 100.0 | 6.7 | 10.0 | 0.0 | 10.0 | 83.3 |
| MSA[4] | 100.0 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| PFFS | 100.0 | 42.6 | 1.2 | 0.3 | 0.9 | 56.3 |
| SNP | 100.0 | 0.0 | 55.3 | 29.0 | 26.3 | 44.7 |
| Dual | 100.0 | 0.0 | 72.6 | 41.9 | 30.6 | 27.4 |
| Institutional | 100.0 | 0.0 | 14.7 | 2.1 | 12.6 | 85.3 |
| Chronic | 100.0 | 0.0 | 21.7 | 1.1 | 20.6 | 78.3 |
| 2007 | | | | | | |
| Total | 100.0 | 13.3 | 22.1 | 5.2 | 16.9 | 64.6 |
| Open-access plans | 100.0 | 14.9 | 17.2 | 1.0 | 16.2 | 68.0 |
| HMO[3] | 100.0 | 6.3 | 19.2 | 1.2 | 18.0 | 74.4 |
| Local PPO | 100.0 | 7.4 | 33.8 | 1.2 | 32.7 | 58.8 |
| Regional PPO | 100.0 | 7.5 | 29.9 | 0.0 | 29.9 | 62.6 |
| MSA[4] | 100.0 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| PFFS | 100.0 | 42.7 | 6.2 | 0.3 | 5.9 | 51.1 |
| SNP | 100.0 | 0.0 | 63.1 | 40.1 | 23.0 | 36.9 |
| Dual | 100.0 | 0.0 | 77.6 | 54.2 | 23.4 | 22.4 |
| Institutional | 100.0 | 0.0 | 13.8 | 3.3 | 10.5 | 86.2 |
| Chronic | 100.0 | 0.0 | 54.4 | 2.5 | 51.9 | 45.6 |
| 2006 | | | | | | |
| Total | 100.0 | 10.2 | 26.7 | 6.3 | 20.4 | 63.0 |
| Open-access plans | 100.0 | 11.2 | 22.8 | 1.9 | 20.9 | 66.1 |
| HMO[3] | 100.0 | 7.1 | 25.8 | 2.1 | 23.8 | 67.1 |
| Local PPO | 100.0 | 10.0 | 36.9 | 0.6 | 36.3 | 53.1 |
| Regional PPO | 100.0 | 7.7 | 12.4 | 8.4 | 4.0 | 79.9 |
| PFFS | 100.0 | 35.0 | 1.9 | 0.2 | 1.7 | 63.1 |
| SNP | 100.0 | 0.1 | 69.0 | 53.9 | 15.1 | 30.9 |
| Dual | 100.0 | 0.0 | 86.5 | 71.7 | 14.7 | 13.6 |
| Institutional | 100.0 | 0.0 | 18.0 | 1.9 | 16.2 | 82.0 |
| Chronic | 100.0 | 23.0 | 60.5 | 40.7 | 19.8 | 16.5 |

[1] Basic includes defined standard and actuarially equivalent.

[2] Includes actuarially equivalent and basic alternative plan types.

[3] HMO includes HMO POS and PSO plans.

[4] Includes MSA demonstration contracts.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes integrated plan drug benefits only.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

## Table 4-9b
## Change in prescription drug benefits, by MA plan type, 2006–2008
## (Change in percentage points of enrollees with Part D benefit type for each MA plan type)

| Plan type | Total (%) | None (%) | Basic[1] total (%) | Defined standard (%) | Actuarially equivalent[2] (%) | Enhanced alternative (%) |
|---|---|---|---|---|---|---|
| 2007 to 2008 | | | | | | |
| Total | 0.0 | −0.2 | −10.0 | −0.9 | −9.1 | 10.2 |
| Open-access plans | 0.0 | 0.1 | −11.3 | −0.3 | −11.1 | 11.2 |
| HMO[3] | 0.0 | −0.5 | −13.0 | −0.2 | −12.8 | 13.5 |
| Local PPO | 0.0 | −1.1 | −16.6 | −1.1 | −15.6 | 17.7 |
| Regional PPO | 0.0 | −0.8 | −19.9 | 0.0 | −19.9 | 20.7 |
| PFFS | 0.0 | −0.1 | −5.1 | 0.0 | −5.0 | 5.2 |
| SNP | 0.0 | 0.0 | −7.8 | −11.1 | 3.3 | 7.8 |
| Dual | 0.0 | 0.0 | −5.0 | −12.2 | 7.3 | 5.0 |
| Institutional | 0.0 | 0.0 | 0.9 | −1.2 | 2.1 | −0.9 |
| Chronic | 0.0 | 0.0 | −32.7 | −1.5 | −31.2 | 32.7 |
| 2006 to 2007 | | | | | | |
| Total | 0.0 | 3.1 | −4.6 | −1.1 | −3.5 | 1.6 |
| Open-access plans | 0.0 | 3.7 | −5. | −0.9 | −4.7 | 1.9 |
| HMO[3] | 0.0 | −0.8 | −6.6 | −0.9 | −5.7 | 7.4 |
| Local PPO | 0.0 | −2.6 | −3.1 | 0.5 | −3.6 | 5.7 |
| Regional PPO | 0.0 | −0.3 | 17.5 | −8.4 | 26.0 | −17.3 |
| PFFS | 0.0 | 7.7 | 4.3 | 0.1 | 4.2 | −12.0 |
| SNP | 0.0 | −0.1 | −6.0 | −13.8 | 7.9 | 6.0 |
| Dual | 0.0 | 0.0 | −8.9 | −17.5 | 8.6 | 8.9 |
| Institutional | 0.0 | 0.0 | −4.3 | 1.4 | −5.7 | 4.3 |
| Chronic | 0.0 | −23.0 | −6.1 | -38.2 | 32.0 | 29.1 |
| 2006 to 2008 | | | | | | |
| Total | — | 2.9 | −14.6 | −2.0 | −12.6 | 11.7 |
| Open-access plans | — | 3.8 | −16.9 | −1.2 | −15.8 | 13.1 |
| HMO[3] | — | −1.3 | −19.6 | −1.1 | −18.5 | 20.9 |
| Local PPO | — | −3.7 | −19.7 | −0.5 | −19.2 | 23.4 |
| Regional PPO | — | −1.0 | −2.4 | −8.4 | 6.1 | 3.4 |
| PFFS | — | 7.6 | −0.8 | 0.0 | −0.8 | −6.8 |
| SNP | — | −0.1 | −13.8 | −25.0 | 11.2 | 13.8 |
| Dual | — | 0.0 | −13.9 | −29.8 | 15.9 | 13.9 |
| Institutional | — | 0.0 | −3.4 | 0.2 | −3.6 | 3.4 |
| Chronic | — | −23.0 | −38.8 | −39.7 | 0.8 | 61.8 |

[1] Basic includes defined standard and actuarially equivalent.

[2] Includes actuarially equivalent and basic alternative plan types.

[3] HMO includes HMO POS and PSO plans.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes integrated plan drug benefits only.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

**Table 4-10a**
**Prescription drug benefits of MA enrollees, by urbanicity, 2006–2008**
**(Percentage of enrollees with Part D benefit type for each urbanicity category)**

| Urbanicity | Total (%) | None (%) | Basic[1] total (%) | Defined standard (%) | Actuarially equivalent[2] (%) | Enhanced alternative (%) |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Urban | 100.0 | 10.5 | 12.1 | 4.2 | 7.9 | 77.4 |
| Large urban | 100.0 | 6.8 | 11.9 | 4.6 | 7.3 | 81.3 |
| Medium urban | 100.0 | 15.1 | 12.2 | 3.5 | 8.8 | 72.7 |
| Small urban | 100.0 | 27.2 | 13.0 | 3.6 | 9.5 | 59.7 |
| Rural | 100.0 | 30.7 | 12.8 | 5.1 | 7.8 | 56.4 |
| Rural–urban adjacent | 100.0 | 30.6 | 13.5 | 5.1 | 8.4 | 55.9 |
| Rural–not urban adjacent | 100.0 | 31.2 | 10.9 | 5.2 | 5.7 | 57.9 |
| 2007 | | | | | | |
| Urban | 100.0 | 11.1 | 22.7 | 5.3 | 17.4 | 66.3 |
| Large urban | 100.0 | 7.3 | 23.9 | 6.0 | 17.9 | 68.8 |
| Medium urban | 100.0 | 16.2 | 19.9 | 4.0 | 15.9 | 63.9 |
| Small urban | 100.0 | 29.7 | 20.2 | 2.7 | 17.5 | 50.2 |
| Rural | 100.0 | 34.4 | 17.9 | 4.2 | 13.7 | 47.7 |
| Rural–urban adjacent | 100.0 | 34.4 | 19.2 | 4.1 | 15.1 | 46.4 |
| Rural–not urban adjacent | 100.0 | 34.6 | 13.9 | 4.6 | 9.3 | 51.5 |
| 2006 | | | | | | |
| Urban | 100.0 | 8.5 | 27.4 | 6.2 | 21.3 | 64.0 |
| Large urban | 100.0 | 6.1 | 26.7 | 6.9 | 19.8 | 67.2 |
| Medium urban | 100.0 | 12.8 | 28.6 | 4.0 | 24.5 | 58.6 |
| Small urban | 100.0 | 22.7 | 32.2 | 5.3 | 26.9 | 45.0 |
| Rural | 100.0 | 28.8 | 23.5 | 7.3 | 16.2 | 47.6 |
| Rural–urban adjacent | 100.0 | 29.0 | 25.2 | 7.2 | 18.0 | 45.8 |
| Rural–not urban adjacent | 100.0 | 28.5 | 17.8 | 7.8 | 10.0 | 53.8 |

[1] Basic includes defined standard and actuarially equivalent.

[2] Includes actuarially equivalent and basic alternative plan types.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes integrated plan drug benefits only. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

**Table 4-10b**
**Change in prescription drug benefits of MA enrollees, by urbanicity, 2006–2008**
**(Change in percentage points of enrollees with Part D benefit type for each urbanicity category)**

| Urbanicity | Total (%) | None (%) | Basic[1] total (%) | Defined standard (%) | Actuarially equivalent[2] (%) | Enhanced alternative (%) |
|---|---|---|---|---|---|---|
| 2007 to 2008 | | | | | | |
| Urban | 0.0 | −0.6 | −10.6 | −1.1 | −9.5 | 11.1 |
| Large urban | 0.0 | −0.5 | −12.0 | −1.4 | −10.6 | 12.5 |
| Medium urban | 0.0 | −1.1 | −7.7 | −0.6 | −7.1 | 8.8 |
| Small urban | 0.0 | −2.4 | −7.2 | 0.9 | −8.0 | 9.6 |
| Rural | 0.0 | −3.7 | −5.0 | 0.9 | −5.9 | 8.7 |
| Rural–urban adjacent | 0.0 | −3.8 | −5.7 | 1.0 | −6.7 | 9.5 |
| Rural–not urban adjacent | 0.0 | −3.3 | −3.0 | 0.5 | −3.5 | 6.4 |
| 2006 to 2007 | | | | | | |
| Urban | 0.0 | 2.5 | −4.8 | −0.9 | −3.9 | 2.2 |
| Large urban | 0.0 | 1.2 | −2.8 | −0.9 | −1.9 | 1.6 |
| Medium urban | 0.0 | 3.4 | −8.6 | 0.0 | -8.6 | 5.3 |
| Small urban | 0.0 | 6.9 | −12.1 | −2.6 | −9.4 | 5.2 |
| Rural | 0.0 | 5.6 | −5.6 | −3.1 | −2.5 | 0.1 |
| Rural–urban adjacent | 0.0 | 5.4 | −6.0 | −3.2 | −2.9 | 0.6 |
| Rural–not urban adjacent | 0.0 | 6.1 | −3.9 | −3.1 | −0.8 | −2.3 |
| 2006 to 2008 | | | | | | |
| Urban | 0.0 | 2.0 | −15.3 | −1.9 | −13.4 | 13.4 |
| Large urban | 0.0 | 0.7 | −14.8 | −2.3 | −12.5 | 14.1 |
| Medium urban | 0.0 | 2.3 | −16.4 | −0.6 | −15.8 | 14.1 |
| Small urban | 0.0 | 4.5 | −19.2 | −1.8 | −17.5 | 14.7 |
| Rural | 0.0 | 1.9 | −10.7 | −2.3 | −8.4 | 8.8 |
| Rural–urban adjacent | 0.0 | 1.6 | −11.7 | −2.2 | −9.6 | 10.1 |
| Rural–not urban adjacent | 0.0 | 2.8 | −6.9 | −2.6 | −4.3 | 4.1 |

[1] Basic includes defined standard and actuarially equivalent.

[2] Includes actuarially equivalent and basic alternative plan types.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes integrated plan drug benefits only. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

**Table 4-11a**
**Prescription drug benefits of MA enrollees, by region, 2006–2008**
**(Percentage of enrollees with Part D benefit type for each region)**

| Census region | Total (%) | None (%) | Basic[1] total (%) | Defined standard (%) | Actuarially equivalent[2] (%) | Enhanced (%) |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Northeast | 100.0 | 14.7 | 17.0 | 6.2 | 10.7 | 68.4 |
| Midwest | 100.0 | 19.3 | 9.7 | 4.3 | 5.5 | 70.9 |
| South | 100.0 | 12.9 | 11.1 | 3.8 | 7.3 | 76.1 |
| West | 100.0 | 8.1 | 11.4 | 3.7 | 7.8 | 80.5 |
| 2007 | | | | | | |
| Northeast | 100.0 | 16.4 | 29.1 | 6.8 | 22.2 | 54.5 |
| Midwest | 100.0 | 19.9 | 11.5 | 4.9 | 6.7 | 68.6 |
| South | 100.0 | 14.3 | 15.8 | 2.9 | 12.9 | 70.0 |
| West | 100.0 | 7.7 | 29.7 | 6.6 | 23.1 | 62.6 |
| 2006 | | | | | | |
| Northeast | 100.0 | 16.9 | 40.6 | 8.8 | 31.8 | 42.5 |
| Midwest | 100.0 | 14.4 | 22.5 | 6.6 | 15.9 | 63.1 |
| South | 100.0 | 8.3 | 15.0 | 4.1 | 10.9 | 76.7 |
| West | 100.0 | 5.5 | 30.9 | 6.3 | 24.6 | 63.6 |

[1] Basic includes defined standard and actuarially equivalent.

[2] Includes actuarially equivalent standard and basic alternative plan type.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes integrated plan drug benefits only. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

**Table 4-11b**
**Change in prescription drug benefits of MA enrollees, by region, 2006–2008**
**(Change in percentage points of enrollees with Part D benefit type for each region)**

| Census region | Total (%) | None (%) | Basic[1] total (%) | Defined standard (%) | Actuarially equivalent[2] (%) | Enhanced (%) |
|---|---|---|---|---|---|---|
| 2007 to 2008 | | | | | | |
| Northeast | 0.0 | −1.7 | −12.1 | −0.6 | −11.5 | 13.8 |
| Midwest | 0.0 | −0.6 | −1.8 | −0.6 | −1.2 | 2.4 |
| South | 0.0 | −1.4 | −4.7 | 0.9 | −5.6 | 6.1 |
| West | 0.0 | 0.4 | −18.3 | −2.9 | −15.4 | 17.9 |
| 2006 to 2007 | | | | | | |
| Northeast | 0.0 | −0.4 | −11.6 | −2.0 | −9.6 | 12.0 |
| Midwest | 0.0 | 5.6 | −11.0 | -1.8 | −9.3 | 5.5 |
| South | 0.0 | 5.9 | 0.8 | −1.2 | 2.0 | −6.8 |
| West | 0.0 | 2.1 | −1.2 | 0.3 | −1.4 | −1.0 |
| 2006 to 2008 | | | | | | |
| Northeast | 0.0 | −2.2 | −23.7 | −2.6 | −21.1 | 25.9 |
| Midwest | 0.0 | 5.0 | −12.8 | −2.4 | −10.5 | 7.8 |
| South | 0.0 | 4.6 | -3.9 | −0.3 | −3.6 | −0.7 |
| West | 0.0 | 2.6 | −19.5 | −2.7 | −16.8 | 16.9 |

[1] Basic includes defined standard and actuarially equivalent.

[2] Includes actuarially equivalent standard and basic alternative plan type.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes integrated plan drug benefits only. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

### 4.2.3 Cost Sharing Before the Initial Coverage Limit

Table 4-12a shows the cost-sharing structure of MA-PDs before the ICL, by type of drug benefit, with percentage point changes in Table 4-12b. The vast majority (90 percent in 2008) of MA-PD enrollees paid no deductible. Virtually no enrollees in enhanced alternative plans paid a deductible, and approximately half in actuarially equivalent plans did not. The proportion of enrollees in actuarially equivalent plans with a deductible rose substantially from 2007 to 2008, but the overall proportion of MA-PD enrollees in actuarially equivalent plans declined significantly. All enrollees in defined standard coverage were charged the $275 (2008) deductible, but they were a small minority of MA-PD enrollees.

## Table 4-12a
## Cost sharing before the ICL, by type of MA prescription drug plan, 2006–2008
## (Percentage of enrollees in each Part D benefit type with specified cost sharing)

| Characteristic | 2008 Total (%) | 2008 Defined standard (%) | 2008 Actuarially equivalent[1] (%) | 2008 Enhanced (%) | 2007 Total (%) | 2007 Defined standard (%) | 2007 Actuarially equivalent[1] (%) | 2007 Enhanced (%) | 2006 Total (%) | 2006 Defined standard (%) | 2006 Actuarially equivalent[1] (%) | 2006 Enhanced (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deductible | | | | | | | | | | | | |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Zero | 89.8 | 0.0 | 49.5 | 99.2 | 90.3 | 0.0 | 84.5 | 99.1 | 85.8 | 0.0 | 71.1 | 99.1 |
| Reduced | 2.6 | 0.0 | 22.4 | 0.6 | 1.4 | 0.0 | 3.8 | 0.9 | 2.3 | 0.0 | 9.5 | 0.2 |
| Defined standard[2] | 7.7 | 100.0 | 28.1 | 0.2 | 8.3 | 100.0 | 11.8 | 0.0 | 11.9 | 100.0 | 19.4 | 0.6 |
| Cost-sharing structure before the ICL | | | | | | | | | | | | |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| No cost sharing | 0.3 | 0.0 | 0.0 | 0.3 | 0.7 | 0.0 | 0.0 | 0.9 | 0.8 | 0.0 | 0.0 | 1.1 |
| 25% Co-insurance amount | 5.0 | 100.0 | 0.0 | 0.0 | 6.5 | 100.0 | 2.7 | 0.0 | 7.1 | 100.0 | 0.0 | 0.0 |
| One or more groups of cost sharing | 94.8 | 0.0 | 100.0 | 99.7 | 92.8 | 0.0 | 97.3 | 99.1 | 92.2 | 0.0 | 100.0 | 98.9 |
| # of Co-payment tiers | | | | | | | | | | | | |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| None | 5.8 | 100.0 | 5.5 | 0.4 | 7.7 | 100.0 | 4.4 | 1.2 | 8.9 | 100.0 | 1.2 | 2.2 |
| 1 | 0.2 | 0.0 | 1.2 | 0.1 | 0.4 | 0.0 | 0.6 | 0.3 | 3.6 | 0.0 | 2.3 | 4.3 |
| 2 | 11.0 | 0.0 | 17.6 | 11.0 | 15.1 | 0.0 | 46.3 | 8.1 | 40.4 | 0.0 | 40.0 | 44.6 |
| 3 | 76.7 | 0.0 | 64.9 | 82.4 | 70.8 | 0.0 | 41.9 | 84.0 | 43.5 | 0.0 | 49.2 | 46.1 |
| 4 | 5.7 | 0.0 | 10.7 | 5.5 | 5.4 | 0.0 | 6.8 | 5.5 | 3.0 | 0.0 | 6.4 | 2.2 |
| 5+ | 0.6 | 0.0 | 0.0 | 0.7 | 0.7 | 0.0 | 0.1 | 0.9 | 0.7 | 0.0 | 0.9 | 0.7 |
| # of Co-insurance tiers | | | | | | | | | | | | |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| None | 6.2 | 0.0 | 17.7 | 5.4 | 18.4 | 0.0 | 55.0 | 10.1 | 25.7 | 0.0 | 50.4 | 20.4 |
| 1 | 77.9 | 100.0 | 62.8 | 78.2 | 67.0 | 100.0 | 33.1 | 72.7 | 46.8 | 100.0 | 25.2 | 48.5 |
| 2 | 15.1 | 0.0 | 12.7 | 16.2 | 14.5 | 0.0 | 9.8 | 16.8 | 27.0 | 0.0 | 24.1 | 30.6 |
| 3+ | 0.9 | 0.0 | 6.7 | 0.3 | 0.1 | 0.0 | 2.1 | 0.3 | 0.5 | 0.0 | 0.4 | 0.6 |

[1] Includes actuarially equivalent and basic alternative.

[2] $275 (2008) or $265 (2007) or $250 (2006).

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

## Table 4-12b
## Change in cost sharing before the ICL, by type of MA prescription drug plan, 2006–2008
## (Change in percentage points of enrollees in each Part D benefit type with specified cost sharing)

| Characteristic | 2007 to 2008 Total (%) | 2007 to 2008 Defined standard (%) | 2007 to 2008 Actuarially equivalent[1] (%) | 2007 to 2008 Enhanced (%) | 2006 to 2007 Total (%) | 2006 to 2007 Defined standard (%) | 2006 to 2007 Actuarially equivalent[1] (%) | 2006 to 2007 Enhanced (%) | 2006 to 2008 Total (%) | 2006 to 2008 Defined standard (%) | 2006 to 2008 Actuarially equivalent[1] (%) | 2006 to 2008 Enhanced (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deductible | | | | | | | | | | | | |
| Total | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Zero | −0.5 | 0.0 | −35.0 | 0.1 | 4.5 | 0.0 | 13.3 | −0.1 | 4.0 | 0.0 | −21.6 | 0.0 |
| Reduced | 1.1 | 0.0 | 18.6 | −0.3 | −0.9 | 0.0 | −5.7 | 0.7 | 0.2 | 0.0 | 12.9 | 0.4 |
| Defined standard[2] | −0.6 | 0.0 | 16.4 | 0.2 | −3.6 | 0.0 | −7.6 | −0.6 | −4.2 | 0.0 | 8.8 | −0.4 |
| Cost-sharing structure before the ICL | | | | | | | | | | | | |
| Total | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| No cost sharing | −0.4 | 0.0 | 0.0 | −0.6 | −0.1 | 0.0 | 0.0 | −0.1 | −0.5 | 0.0 | 0.0 | −0.8 |
| 25% Co-insurance amount | −1.5 | 0.0 | −2.7 | 0.0 | −0.5 | 0.0 | 2.7 | 0.0 | −2.1 | 0.0 | 0.0 | 0.0 |
| One or more groups of cost sharing | 2.0 | 0.0 | 2.7 | 0.6 | 0.6 | 0.0 | −2.7 | 0.1 | 2.6 | 0.0 | 0.0 | 0.8 |
| # of Co-payment tiers | | | | | | | | | | | | |
| Total | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| None | −1.9 | 0.0 | 1.1 | −0.8 | −1.2 | 0.0 | 3.1 | −1.1 | −3.1 | 0.0 | 4.3 | −1.9 |
| 1 | −0.2 | 0.0 | 0.7 | −0.2 | −3.2 | 0.0 | −1.7 | −4.0 | −3.4 | 0.0 | −1.0 | −4.2 |
| 2 | −4.0 | 0.0 | −28.6 | 2.9 | −25.3 | 0.0 | 6.3 | −36.5 | −29.3 | 0.0 | −22.4 | −33.6 |
| 3 | 5.9 | 0.0 | 23.0 | −1.6 | 27.3 | 0.0 | −7.2 | 37.9 | 33.2 | 0.0 | 15.8 | 36.3 |
| 4 | 0.3 | 0.0 | 3.9 | 0.0 | 2.5 | 0.0 | 0.3 | 3.4 | 2.7 | 0.0 | 4.3 | 3.3 |
| 5+ | −0.1 | 0.0 | −0.1 | −0.2 | 0.0 | 0.0 | −0.8 | 0.2 | −0.1 | 0.0 | −0.9 | 0.0 |
| # of Co-insurance tiers | | | | | | | | | | | | |
| Total | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| None | −12.2 | 0.0 | −37.3 | −4.8 | −7.4 | 0.0 | 4.6 | −10.2 | −19.5 | 0.0 | −32.7 | −15.0 |
| 1 | 10.8 | 0.0 | 29.7 | 5.4 | 20.2 | 0.0 | 7.9 | 24.3 | 31.1 | 0.0 | 37.7 | 29.7 |
| 2 | 0.5 | 0.0 | 2.9 | −0.6 | −12.4 | 0.0 | −14.3 | −13.8 | −11.9 | 0.0 | −11.4 | −14.4 |
| 3+ | 0.8 | 0.0 | 4.7 | 0.0 | −0.4 | 0.0 | 1.7 | −0.3 | 0.4 | 0.0 | 6.4 | −0.3 |

[1] Includes actuarially equivalent and basic alternative.

[2] $275 (2008) or $265 (2007) or $250 (2006).

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

With the exception of defined standard plans (which used only a 25 percent co-insurance tier), most enrollees were in plans that used both co-payment and co-insurance tiers. From 2007 to 2008, there was a continuation of the trend towards three rather than two co-payment tiers and towards one co-insurance tier, with particularly large changes taking place in actuarially equivalent plans. By 2008, more than three-quarters of MA-PD enrollees were in plans with three co-payment tiers, and more than three-quarters were in plans with one co-insurance tier. Co-insurance tiers typically require enrollees to pay a percentage of the total cost of expensive specialty drugs—typically 25 percent to 33 percent—instead of a low fixed-dollar co-payment per prescription. This can result in large OOP costs for enrollees taking expensive drugs for certain conditions, such as multiple sclerosis, rheumatoid arthritis, hemophilia, and some cancers.

Tables 4-13a and 4-13b present more detail on the drug-tiering design and cost-sharing amounts. They tabulate median (weighted by plan enrollment) co-payments and co-insurance percentages for the most common MA-PD drug-tiering designs (Table 4-13a) and show changes 2006–2008 (Table 4-13b). Co-payments are for a 30-day drug supply at in-network retail pharmacies. More than 90 percent of MA-PD enrollees were subject to one of the cost-sharing structures reported in Table 4-13a.

There was a continued shift from 2007 to 2008 to the most common cost-sharing structure of three co-payment and one co-insurance tiers. Sixty-two percent of all MA enrollees were subject to this structure in 2008 versus 55 percent in 2007 and 28 percent in 2006. There was also a shift 2007 to 2008 from two co-payment and no co-insurance tiers to two co-payment and one co-insurance tier.

Overall, median co-payments were generally slightly increasing or fairly stable between 2007 and 2008. Median co-insurance for injectable or specialty drugs in the most common cost-sharing structure fell from 33 percent to 30 percent, but in the second most common cost-sharing structure rose from 30 percent to 33 percent.

### 4.2.4 Initial Coverage Limit

Table 4-14a characterizes the ICL in MA-PDs, with percentage point changes from 2006–2008 shown in Table 4-14b. More than 91 percent of 2008 MA-PD enrollees were in plans with the standard $2,510 ICL. This continued the upward trend from 76 percent of enrollees in 2006 and the 86 percent in 2007 in plans with the standard ICL. In 2008, 3 percent of enrollees had a lower than standard, and 6 percent a higher than standard, ICL. The initial coverage may be lowered to keep the actuarial value of a plan equal to standard coverage while reducing other cost sharing, such as eliminating the deductible. A higher ICL is one way to enhance the standard Part D benefit, because it delays the drug-spending level at which an enrollee enters the coverage gap. HMOs were virtually the only plan type to raise the ICL. Virtually all enrollees with a higher than standard ICL resided in urban areas. No Northeastern MA-PD enrollees were in plans that raised their ICL above the standard amount in 2008, but more than 7 percent of Southern and Western enrollees were in such plans.

**Table 4-13a**
**Common cost-sharing structures in MA prescription drug plans, 2006–2008**
**(Median co-payments[1] or co-insurance, by drug tier)**

| Cost sharing tiers | 3 Co-payment/ 1 co-insurance | 3 Co-payment 2 co-insurance | 2 Co-payment/ 1 co-insurance | 0 Co-payment/ 1 co-insurance | 3 Co-payment/ 0 co-insurance | 2 Co-payment/ 2 co-insurance | 2 Co-payment/ 0 co-insurance |
|---|---|---|---|---|---|---|---|
| 2008 | | | | | | | |
| % Enrollment | 62.2% | 10.9% | 8.6% | 5.0% | 3.6% | 1.6% | 0.6% |
| Co-payment tiers (Typical drugs) | | | | | | | |
| 1 (Generics) | $4 | $7 | $10 | N/A | $6 | $5 | $0 |
| 2 (Preferred brand) | $30 | $30 | $45 | N/A | $30 | $25 | $44 |
| 3 (Non-preferred) | $60 | $61 | N/A | N/A | $50 | N/A | N/A |
| Co-insurance tiers (Typical drugs) | | | | | | | |
| 1 (Specialty) | 30% | 33% | 25% | 25% | N/A | 25% | N/A |
| 2 (Injectables) | N/A | 33% | N/A | N/A | N/A | 50% | N/A |
| 2007 | | | | | | | |
| % Enrollment | 54.9% | 10.1% | 3.1% | 6.0% | 5.8% | 3.3% | 8.4% |
| Co-payment tiers (Typical drugs) | | | | | | | |
| 1 (Generics) | $4 | $5 | $5 | N/A | $8 | $5 | $11 |
| 2 (Preferred brand) | $29 | $29 | $30 | N/A | $25 | $30 | $40 |
| 3 (Non-preferred) | $60 | $58 | N/A | N/A | $50 | N/A | N/A |
| Co-insurance tiers (Typical drugs) | | | | | | | |
| 1 (Speciality) | 33.0% | 30.0% | 25.0% | 25.0% | 0.0% | 33.0% | 0.0% |
| 2 (Injectables) | N/A | 30.0% | N/A | N/A | N/A | 50.0% | N/A |
| 2006 | | | | | | | |
| % Enrollment | 27.8% | 8.6% | 7.9% | 7.8% | 7.2% | 17.1% | 15.2% |
| Co-payment tiers (Typical drugs) | | | | | | | |
| 1 (Generics) | $5 | $5 | $20 | N/A | $5 | $9 | $10 |
| 2 (Preferred brand) | $28 | $27 | $40 | N/A | $20 | $27 | $30 |
| 3 (Non-preferred) | $58 | $50 | N/A | N/A | $50 | N/A | N/A |
| Co-insurance tiers (Typical drugs) | | | | | | | |
| 1 (Specialty) | 25% | 25% | 25% | 25% | N/A | 33% | N/A |
| 2 (Injectables) | N/A | 25% | N/A | N/A | N/A | 50% | N/A |

[1] For a 30-day supply from a retail pharmacy.

NOTES: Medians are weighted by plan enrollment. This cost sharing is before the ICL.

Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

## Table 4-13b
## Change in common cost-sharing structures in MA prescription drug plans, 2006–2008
## (Change in median co-payments[1] or co-insurance, by drug tier)

| Cost sharing tiers | 3 Co-payment/ 1 co-insurance (%) | 3 Co-payment 2 co-insurance (%) | 2 Co-payment/ 1 co-insurance (%) | 0 Co-payment/ 1 co-insurance (%) | 3 Co-payment/ 0 co-insurance (%) | 2 Co-payment/ 2 co-insurance (%) | 2 Co-payment/ 0 co-insurance (%) |
|---|---|---|---|---|---|---|---|
| Change (percentage points or dollars), 2007 to 2008 | | | | | | | |
| % Enrollment | 7.3 | 0.8 | 5.5 | −1.0 | −2.2 | −1.7 | −7.8 |
| Co-payment tiers (Typical drugs) | | | | | | | |
| 1 (Generics) | 0 | 2 | 5 | N/A | −2 | 0 | −11 |
| 2 (Preferred brand) | 1 | 1 | 15 | N/A | 5 | −5 | 4 |
| 3 (Non-preferred) | 0 | 3 | N/A | N/A | 0 | N/A | N/A |
| Co-insurance tiers (Typical drugs) | | | | | | | |
| 1 (Specialty) | −3.0 | 3.0 | 0.0 | 0.0 | N/A | −8.0 | N/A |
| 2 (Injectables) | N/A | 3.0 | N/A | N/A | N/A | 0.0 | N/A |
| Change (percentage points or dollars), 2006 to 2007 | | | | | | | |
| % Enrollment | 27.1 | 1.5 | −4.8 | −1.8 | −1.4 | −13.8 | −6.7 |
| Co-payment tiers (Typical drugs) | | | | | | | |
| 1 (Generics) | −1 | 0 | 15 | N/A | 3 | −4 | 1 |
| 2 (Preferred brand) | 1 | 2 | −10 | N/A | 5 | 3 | 10 |
| 3 (Non-preferred) | 2 | 8 | N/A | N/A | 0 | N/A | N/A |
| Co-insurance tiers (Typical drugs) | | | | | | | |
| 1 (Specialty) | 8.0 | 5.0 | 0.0 | 0.0 | N/A | 0.0 | N/A |
| 2 (Injectables) | N/A | 5.0 | N/A | N/A | N/A | 0.0 | N/A |
| Change (percentage points or dollars), 2006 to 2008 | | | | | | | |
| % Enrollment | 34.4 | 2.3 | 0.7 | −2.8 | −3.6 | −15.4 | −14.5 |
| Co-payment tiers (Typical drugs) | | | | | | | |
| 1 (Generics) | −1 | 2 | −10 | N/A | 1 | −4 | −10 |
| 2 (Preferred brand) | 2 | 3 | 5 | N/A | 10 | −2 | 14 |
| 3 (Non-preferred) | 2 | 11 | N/A | N/A | 0 | N/A | N/A |
| Co-insurance tiers (Typical drugs) | | | | | | | |
| 1 (Specialty) | N/A | 8.0 | N/A | N/A | N/A | −8.0 | N/A |
| 2 (Injectables) | N/A | 8.0 | N/A | N/A | N/A | 0.0 | N/A |

[1] For a 30-day supply from a retail pharmacy.

NOTES: Medians are weighted by plan enrollment. This cost sharing is before the ICL.

Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-14a**
**ICL in MA prescription drug plans, by plan and geographic characteristics, 2006–2008**
**(Percentage of enrollees)**

| Plan/geographic characteristics | 2008 <$2,510 (%) | 2008 $2,510 (%) | 2008 >$2,510 (%) | 2007 <$2,400 (%) | 2007 $2,400 (%) | 2007 >$2,400 (%) | 2006 <$2,250 (%) | 2006 $2,250 (%) | 2006 >$2,250 (%) |
|---|---|---|---|---|---|---|---|---|---|
| Total, open-enrollment plans | 3.2 | 91.3 | 5.5 | 8.0 | 86.0 | 6.1 | 15.0 | 75.7 | 9.4 |
| Benefit type | | | | | | | | | |
| Defined standard | 0.0 | 100.0 | 0.0 | 0.0 | 100.0 | 0.0 | 0.0 | 100.0 | 0.0 |
| Actuarially equivalent | 4.0 | 96.0 | 0.0 | 10.0 | 90.1 | 0.0 | 15.7 | 84.0 | 0.3 |
| Enhanced | 3.3 | 90.3 | 6.4 | 8.1 | 83.7 | 8.2 | 16.2 | 70.5 | 13.3 |
| Plan type | | | | | | | | | |
| HMO[1] | 3.6 | 89.0 | 7.4 | 8.1 | 84.0 | 7.9 | 16.5 | 72.6 | 10.9 |
| Local PPO | 6.6 | 93.3 | 0.03 | 11.5 | 88.5 | 0.0 | 12.3 | 83.8 | 3.9 |
| Regional PPO | 1.7 | 98.3 | 0.0 | 1.8 | 98.2 | 0.0 | 1.8 | 98.2 | 0.0 |
| PFFS | 0.1 | 99.9 | 0.0 | 7.2 | 92.8 | 0.0 | 5.4 | 94.6 | 0.0 |
| Urbanicity | | | | | | | | | |
| Urban | 3.4 | 90.5 | 6.1 | 8.2 | 85.2 | 6.6 | 15.5 | 74.5 | 10.0 |
| Rural | 1.7 | 98.3 | 0.01 | 5.6 | 94.3 | 0.1 | 8.1 | 91.6 | 0.3 |
| Region | | | | | | | | | |
| Northeast | 9.8 | 90.2 | 0.0 | 15.8 | 84.2 | 0.0 | 18.4 | 80.2 | 1.4 |
| Midwest | 2.5 | 95.3 | 2.2 | 10.5 | 87.3 | 2.2 | 11.1 | 87.9 | 1.0 |
| South | 1.2 | 90.1 | 8.7 | 1.4 | 88.9 | 9.8 | 13.2 | 75.4 | 11.4 |
| West | 1.3 | 91.3 | 7.5 | 8.0 | 83.6 | 8.4 | 16.0 | 68.0 | 16.1 |

[1] HMO includes HMO POS and PSO plans.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-14b**
**Change in ICL in MA prescription drug plans, by plan and geographic characteristics, 2006–2008**
**(Change in percentage points of enrollees with ICL less than, equal to, or greater than the defined standard benefit ICL)**

| Plan/geographic characteristics | 2007 to 2008 <ICL[1] (%) | 2007 to 2008 ICL[1] (%) | 2007 to 2008 >ICL[1] (%) | 2006 to 2007 <ICL[1] (%) | 2006 to 2007 ICL[1] (%) | 2006 to 2007 >ICL[1] (%) | 2006 to 2008 <ICL[1] (%) | 2006 to 2008 ICL[1] (%) | 2006 to 2008 >ICL[1] (%) |
|---|---|---|---|---|---|---|---|---|---|
| Total, open-enrollment plans | −4.8 | 5.4 | −0.6 | −7.0 | 10.3 | −3.3 | −11.8 | 15.7 | −3.9 |
| Benefit type | | | | | | | | | |
| Defined standard | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Actuarially equivalent | −5.9 | 5.9 | 0.0 | −5.8 | 6.1 | −0.3 | −11.7 | 12.0 | −0.3 |
| Enhanced | −4.8 | 6.7 | −1.9 | −8.1 | 13.2 | −5.1 | −12.9 | 19.8 | −7.0 |
| Plan type | | | | | | | | | |
| HMO[2] | −4.6 | 5.0 | −0.4 | −8.3 | 11.4 | −3.1 | −12.9 | 16.4 | −3.5 |
| Local PPO | −4.9 | 4.9 | 0.0 | −0.7 | 4.7 | −3.9 | −5.7 | 9.5 | −3.9 |
| Regional PPO | −0.1 | 0.1 | 0.0 | −3.6 | 3.6 | 0.0 | −0.1 | 0.1 | 0.0 |
| PFFS | −7.0 | 7.0 | 0.0 | 5.4 | −5.4 | 0.0 | −5.3 | 5.3 | 0.0 |
| Urbanicity | | | | | | | | | |
| Urban | −4.8 | 5.4 | −0.5 | −7.3 | 10.7 | −3.4 | −12.1 | 16.0 | −4.0 |
| Rural | −4.0 | 4.0 | −0.1 | −2.5 | 2.7 | −0.3 | −6.4 | 6.7 | −0.3 |
| Region | | | | | | | | | |
| Northeast | −6.1 | 6.1 | 0.0 | −2.6 | 3.9 | −1.4 | −8.6 | 10.0 | −1.4 |
| Midwest | −8.0 | 8.1 | −0.1 | −0.6 | −0.6 | 1.2 | −8.6 | 7.5 | 1.1 |
| South | −0.2 | 1.2 | −1.1 | −11.9 | 13.5 | −1.6 | −12.0 | 14.7 | −2.7 |
| West | −6.8 | 7.7 | −0.9 | −8.0 | 15.7 | −7.7 | −14.7 | 23.3 | −8.6 |

[1] $2,510 in 2008, $2,400 in 2007, and $2,250 in 2006.

[2] HMO includes HMO POS and PSO plans.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

### 4.2.5 Gap Coverage

Medicare Part D plans, as one form of enhancement to the standard Part D benefit, may offer coverage in the coverage gap. Table 4-15a shows that 63 percent of MA-PD enrollees were in plans with some form of gap coverage in 2008, which is up from 34 percent in 2007.[21] Gap coverage was predominantly for generic drugs only, but 23 percent of 2008 MA-PD enrollees had "generics and brand" gap coverage, and 1.8 percent had coverage for "all formulary drugs." The percentage of MA-PD enrollees with some brand coverage in the gap nearly tripled from 2007 to 2008—from 9 percent to 25 percent—if one includes the reporting category "all formulary drugs" as brand gap coverage. "All formulary drugs" presumably typically includes some brand drugs.

Gap coverage was offered only in enhanced alternative benefit plans. In 2008, approximately 60 percent of HMO and PPO enrollees had gap coverage. Approximately 85 percent of PFFS MA-PD enrollees had gap coverage, which is a huge increase from 2007 in which only 8 percent of PFFS MA-PD enrollees had gap coverage. Approximately 70 percent of PFFS enrollees had some brand coverage in the gap in 2008, compared to approximately 15 percent of HMO enrollees (again including "all formulary drugs" as some brand coverage). The percentage of enrollees with some gap coverage rose substantially from 2007 to 2008 for all plan types.

In 2008, a higher percentage of rural than urban MA-PD enrollees had gap coverage, and rural enrollees were more than twice as likely to have some brand coverage. By region, in 2008, Northeastern MA-PD enrollees were least likely to have gap coverage (approximately half did not have it), and Southern enrollees most likely to have gap coverage (nearly three-quarters had it). Brand gap coverage was rare in the Northeast and the West, but approximately one-third of Midwestern enrollees had it, and 44 percent of Southern enrollees had it. From 2007 to 2008, there was very strong growth of gap coverage in all regions except the Northeast, and there was some brand gap coverage in the South and Midwest. The Northeast had the highest percentage of gap coverage of any region in 2007 and the lowest in 2008.

Table 4-15c shows detailed gap coverage categories for 2008 only. Most MA-PD generics coverage (26 of 39 percentage points) was for "all generics." But most MA-PD "generics and brands" coverage (21 of 23 percentage points) was for "some generics and some brands" or "all preferred generics and some other generics and some brands." In short, although "generics only" coverage was typically for "all" generics, generics and brands coverage typically covered only "some" brands and only "some" generics or "preferred" generics. This means that although gap coverage, including some brand gap coverage, increased substantially for MA-PD enrollees between 2007 and 2008, in 2008 many MA-PD enrollees still had limited brand coverage in the gap. HMO gap coverage was particularly likely to be "all" or "preferred" generics. PFFS gap coverage was mostly "some generics and some brands."

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[21] Table 4-15 excludes SNPs. Beneficiaries with the Part D low-income subsidy benefit may have most of their cost sharing eliminated and thus, effectively, do not face a coverage gap, even if their plan has one.

## Table 4-15a
## Gap coverage in open-access (non-SNP) MA prescription drug plans, by plan and geographic characteristics, 2006–2008
## (Percentage of enrollees)

| Benefit type/plan type/urbanicity/region | 2008 None (%) | 2008 All formulary drugs (%) | 2008 Generics only (%) | 2008 Generics and brand (%) | 2007 None (%) | 2007 All formulary drugs (%) | 2007 Generics only (%) | 2007 Generics and brand (%) | 2006 None (%) | 2006 All formulary drugs (%) | 2006 Generics only (%) | 2006 Generics and brand (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total, open-enrollment plans | 36.7 | 1.8 | 38.6 | 23.0 | 66.2 | 3.3 | 24.8 | 5.7 | 72.3 | N/A | 22.4 | 5.3 |
| Benefit type | | | | | | | | | | | | |
| Defined standard | 100.0 | 0.0 | 0.0 | 0.0 | 100.0 | 0.0 | 0.0 | 0.0 | 100.0 | N/A | 0.0 | 0.0 |
| Actuarially equivalent | 100.0 | 0.0 | 0.0 | 0.0 | 100.0 | 0.0 | 0.0 | 0.0 | 100.0 | N/A | 0.0 | 0.0 |
| Enhanced | 32.0 | 1.9 | 41.4 | 24.7 | 57.6 | 4.1 | 31.1 | 7.1 | 62.5 | N/A | 30.4 | 7.2 |
| Plan type | | | | | | | | | | | | |
| HMO[1] | 40.4 | 2.3 | 44.5 | 12.8 | 60.6 | 4.2 | 28.2 | 7.0 | 68.2 | N/A | 25.5 | 6.3 |
| Local PPO | 44.8 | 1.1 | 37.4 | 16.6 | 65.6 | 0.8 | 31.9 | 1.7 | 72.6 | N/A | 25.0 | 2.4 |
| Regional PPO | 39.5 | 0.0 | 27.2 | 33.3 | 74.4 | 1.5 | 24.1 | 0.0 | 96.2 | N/A | 3.8 | 0.0 |
| PFFS | 15.4 | 0.0 | 15.1 | 69.5 | 92.1 | 0.0 | 6.3 | 1.6 | 100.0 | N/A | 0.0 | 0.0 |
| Urbanicity | | | | | | | | | | | | |
| Urban | 37.4 | 1.8 | 40.2 | 20.5 | 64.6 | 3.4 | 25.8 | 6.2 | 70.9 | N/A | 23.6 | 5.5 |
| Rural | 29.7 | 1.0 | 24.0 | 45.4% | 82.7 | 2.0 | 14.8 | 0.5 | 90.6 | N/A | 6.5 | 2.9 |
| Region | | | | | | | | | | | | |
| Northeast | 50.6 | 0.0 | 45.7 | 3.7 | 57.8 | 0.0 | 40.0 | 2.2 | 79.7 | N/A | 20.3 | 0.0 |
| Midwest | 31.7 | 0.5 | 35.7 | 32.1 | 74.5 | 0.6 | 24.5 | 0.5 | 91.0 | N/A | 8.1 | 0.9 |
| South | 25.9 | 0.1 | 29.9 | 44.1 | 60.9 | 4.9 | 24.4 | 9.9 | 64.9 | N/A | 27.8 | 7.3 |
| West | 41.5 | 5.4 | 44.6 | 8.5 | 73.1 | 5.3 | 15.4 | 6.2 | 66.6 | N/A | 24.8 | 8.6 |

[1] HMO includes HMO POS and PSO plans.

NOTES: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Excludes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and Landscape file data.

## Table 4-15b
## Change in gap coverage in open-access (non-SNP) MA prescription drug plans, by plan and geographic characteristics, 2006–2008 (Change in percentage points of enrollees)

| Benefit type/plan type/urbanicity/region | 2007 to 2008, None (%) | 2007 to 2008, All formulary drugs (%) | 2007 to 2008, Generics only (%) | 2007 to 2008, Generics and brand (%) | 2006 to 2007, None (%) | 2006 to 2007, All formulary drugs (%) | 2006 to 2007, Generics only (%) | 2006 to 2007, Generics and brand (%) | 2006 to 2008, None (%) | 2006 to 2008, All formulary drugs (%) | 2006 to 2008, Generics only (%) | 2006 to 2008, Generics and brand (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total, open-enrollment plans | −29.5 | −1.6 | 13.7 | 17.3 | −6.1 | N/A | 2.4 | 0.4 | −35.6 | N/A | 16.1 | 17.7 |
| Benefit type | | | | | | | | | | | | |
| Defined standard | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | N/A | 0.0 | 0.0 | 0.0 | N/A | 0.0 | 0.0 |
| Actuarially equivalent | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | N/A | 0.0 | 0.0 | 0.0 | N/A | 0.0 | 0.0 |
| Enhanced | −25.7 | −2.3 | 10.3 | 17.6 | −4.8 | N/A | 0.8 | −0.1 | −30.5 | N/A | 11.1 | 17.5 |
| Plan type | | | | | | | | | | | | |
| HMO[1] | −20.2 | −1.9 | 16.3 | 5.8 | −7.6 | N/A | 2.6 | 0.7 | −27.7 | N/A | 19.0 | 6.5 |
| Local PPO | −20.8 | 0.4 | 5.5 | 14.9 | −7.0 | N/A | 7.0 | −0.7 | −27.8 | N/A | 12.4 | 14.2 |
| Regional PPO | −34.9 | −1.5 | 3.1 | 33.3 | −21.8 | N/A | 20.3 | 0.0 | −56.7 | N/A | 23.4 | 33.3 |
| PFFS | −76.7 | 0.0 | 8.8 | 67.9 | −7.9 | N/A | 6.3 | 1.6 | −84.6 | N/A | 15.1 | 69.5 |
| Urbanicity | | | | | | | | | | | | |
| Urban | −27.2 | −1.6 | 14.4 | 14.4 | −6.3 | N/A | 2.2 | 0.7 | −33.5 | N/A | 16.6 | 15.0 |
| Rural | −53.0 | −1.1 | 9.2 | 44.8 | −7.9 | N/A | 8.2 | −2.3 | −60.9 | N/A | 17.4 | 42.5 |
| Region | | | | | | | | | | | | |
| Northeast | −7.1 | 0.0 | 5.7 | 1.5 | −21.9 | N/A | 19.7 | 2.2 | −29.0 | N/A | 25.3 | 3.7 |
| Midwest | −42.8 | 0.0 | 11.2 | 31.6 | −16.5 | N/A | 16.4 | −0.4 | −59.3 | N/A | 27.6 | 31.2 |
| South | −35.0 | −4.7 | 5.5 | 34.2 | −4.1 | N/A | −3.4 | 2.6 | −39.1 | N/A | 2.1 | 36.8 |
| West | −31.6 | 0.1 | 29.2 | 2.3 | 6.5 | N/A | −9.4 | −2.4 | −25.1 | N/A | 19.8 | 0.0 |

[1] HMO includes HMO POS and PSO plans.

NOTES: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Excludes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and Landscape file data.

## Table 4-15c
## Detailed gap coverage categories in open-access (non-SNP) MA prescription drug plans, by plan and geographic characteristics, 2008 (Percentage of enrollees)

| Benefit type/plan type/urbanicity/region | Total (%) | None (%) | All drugs on your formulary (%) | Total (%) | All generics (%) | All preferred generics (%) | Some generics (%) | Total (%) | All preferred generics and some other generics and some brands (%) | Some generics and some brands (%) | Other "generics and brands" categories[2] (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total, open-enrollment plans | 100.0 | 36.7 | 1.8 | 38.6 | 26.0 | 8.0 | 4.5 | 23.0 | 6.8 | 14.3 | 1.9 |
| Benefit type | | | | | | | | | | | |
| Defined standard | 100.0 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Actuarially equivalent | 100.0 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Enhanced | 100.0 | 32.0 | 1.9 | 41.4 | 28.0 | 8.6 | 4.9 | 24.7 | 7.3 | 15.4 | 2.0 |
| Plan type | | | | | | | | | | | |
| HMO[1] | 100.0 | 40.4 | 2.3 | 44.5 | 31.3 | 10.1 | 3.1 | 12.8 | 8.4 | 1.8 | 2.6 |
| Local PPO | 100.0 | 44.8 | 1.1 | 37.4 | 24.7 | 8.7 | 4.0 | 16.6 | 9.4 | 6.9 | 0.3 |
| Regional PPO | 100.0 | 39.5 | 0.0 | 27.2 | 0.9 | 0.0 | 26.3 | 33.3 | 0.0 | 33.3 | 0.0 |
| PFFS | 100.0 | 15.4 | 0.0 | 15.1 | 8.5 | 0.1 | 6.5 | 69.5 | 0.0 | 69.5 | 0.0 |
| Urbanicity | | | | | | | | | | | |
| Urban | 100.0 | 37.4 | 1.8 | 40.2 | 27.1 | 8.7 | 4.4 | 20.5 | 7.4 | 11.0 | 2.1 |
| Rural | 100.0 | 29.7 | 1.0 | 24.0 | 16.1 | 1.9 | 6.0 | 45.4 | 1.4 | 43.5 | 0.5 |
| Region | | | | | | | | | | | |
| Northeast | 100.0 | 50.6 | 0.0 | 45.7 | 30.4 | 13.9 | 1.4 | 3.7 | 0.0 | 3.3 | 0.4 |
| Midwest | 100.0 | 31.7 | 0.5 | 35.7 | 17.7 | 4.7 | 13.3 | 32.1 | 1.3 | 30.8 | 0.0 |
| South | 100.0 | 25.9 | 0.1 | 29.9 | 23.0 | 5.2 | 1.7 | 44.1 | 20.2 | 20.3 | 3.5 |
| West | 100.0 | 41.5 | 5.4 | 44.6 | 31.0 | 9.0 | 4.7 | 8.5 | 0.3 | 5.9 | 2.3 |

[1] HMO includes HMO POS and PSO plans.

[2] Other "generics and brands" categories include the following:
- All Generics and All Brands
- All Generics and All Preferred Brands
- All Generics and Some Brands
- All Preferred Generics and All Preferred Brands
- All Preferred Generics and Some Brands.

NOTES: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Excludes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008 and Landscape file data.

## 4.3 Other Benefits and Cost Sharing

This section changes from a discussion of MA plans' Part D drug benefits to consideration of other benefit and cost-sharing policies of MA plans in 2008 and changes during 2006–2008. Section 4.3.1 discusses supplemental benefits offered by MA plans, Section 4.3.2 considers cost-sharing policies, and Section 4.3.3 analyzes OOP cost maximums.

### 4.3.1 Supplemental Benefits

MA plans can supplement the standard Medicare FFS Parts A and B benefit package by including additional benefits in their plans. Table 4-16a shows the percentage of MA enrollees who enjoyed selected mandatory supplemental benefits by plan type 2006–2008, with changes in Table 4-16b. "Supplemental" means that the benefits supplement the standard Medicare FFS Part A and B benefits. "Mandatory" means that the benefits were included as part of a plan's basic benefit package.[22]

The most common of the supplemental benefits considered is vision coverage (eye exams and glasses), which 84 percent of MA enrollees had in 2008. Approximately two-thirds of MA enrollees had coverage for hearing exams, 39 percent had dental coverage, approximately one-quarter had coverage for podiatry, and 5 percent had coverage for chiropractic treatment. The percentages of MA enrollees with these benefits in 2008 rose slightly from 2007, with the exception of a slight decline in the proportion of enrollees with chiropractic and podiatrist coverage. Among plan types, HMO and PPO enrollees were most likely to have vision coverage, PFFS enrollees were most likely to have hearing exam coverage, PPO enrollees were most likely to have dental and podiatry coverage, and local PPO enrollees were mostly likely to have chiropractic coverage. MSA plans do not offer mandatory supplemental benefits, but MSA enrollees could use their MSAs to pay for the costs associated with such services on a tax-free basis (if the services were "qualified medical expenses" under Internal Revenue Service [IRS] rules). With regard to trends in supplemental benefits 2006 to 2008, vision coverage grew strongly in non-HMO plans, and dental coverage grew in local PPOs and PFFS plans.

### 4.3.2 Cost Sharing

Table 4-17a shows the percentage of MA enrollees who faced cost sharing of the indicated amounts for selected services in 2006–2008, by plan type, with changes in Table 4-17b.[23] In 2008, as in 2007 and 2006, most MA enrollees faced co-payments of $5 to $15 for primary care physician visits. However, an increasing portion of MA enrollees were paying co-insurance and fewer co-payments for primary care visits. The percentage of enrollees with no ($0) co-payment rose from 10 to 19 percent between 2007 and 2008 and the percentage with co-insurance rose from 4 to 11 percent. The greater proportion with co-insurance was driven by the increase in PFFS plans, and the higher proportion with no co-payment resulted from changes among HMOs and local PPOs.

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[22] As opposed to "optional supplemental" benefits offered as riders with an additional premium that a plan enrollee may accept or decline.

[23] MSA plans are excluded from Tables 4-17a and 4-17b. MSA plan enrollees face 100 percent cost sharing for most services below the plan deductible (MSA demonstration plans may fully or partly cover Medicare-eligible preventive services below the deductible). MSA demonstration plans may have co-insurance or co-payments between the plan deductible and OOP limit.

**Table 4-16a**
**Selected mandatory supplemental benefits in MA plans, 2006–2008**
**(Percentage of enrollees with benefit)**

| Benefit | Total (%) | HMO[6] (%) | Local PPO (%) | Regional PPO (%) | MSA[7] (%) | PFFS (%) |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Vision[1] | 84.3 | 92.8 | 90.8 | 96.5 | 0.0 | 53.6 |
| Hearing exam[2] | 68.6 | 65.1 | 44.5 | 43.7 | 0.0 | 91.8 |
| Dental[3] | 39.2 | 40.5 | 58.3 | 64.6 | 0.0 | 24.5 |
| Podiatrist[4] | 27.0 | 32.4 | 34.1 | 44.1 | 0.0 | 4.8 |
| Chiropractic[5] | 4.8 | 5.8 | 10.9 | 0.2 | 0.0 | 0.2 |
| 2007 | | | | | | |
| Vision[1] | 79.2 | 88.4 | 84.3 | 69.6 | 0.0 | 47.4 |
| Hearing exam[2] | 65.5 | 59.9 | 57.1 | 52.5 | 0.0 | 88.8 |
| Dental[3] | 31.5 | 32.4 | 44.1 | 43.1 | 0.0 | 23.9 |
| Podiatrist[4] | 27.0 | 32.7 | 44.2 | 44.0 | 0.0 | 1.0 |
| Chiropractic[5] | 5.2 | 6.4 | 12.9 | 0.0 | 0.0 | 0.0 |
| 2006 | | | | | | |
| Vision[1] | 83.3 | 94.1 | 77.1 | 59.6 | N/A | 20.3 |
| Hearing exam[2] | 64.4 | 63.0 | 51.4 | 59.6 | N/A | 78.4 |
| Dental[3] | 32.0 | 35.1 | 39.2 | 66.5 | N/A | 6.3 |
| Podiatrist[4] | 28.1 | 31.3 | 43.6 | 36.9 | N/A | 1.9 |
| Chiropractic[5] | 6.1 | 6.7 | 13.8 | 0.0 | N/A | 0.0 |

[1] Includes eye exams and glasses/contact lenses.

[2] Includes routine hearing tests.

[3] Includes prophylaxis (cleaning).

[4] Includes routine foot care.

[5] Includes routine care.

[6] HMO includes HMO POS and PSO plans.

[7] Includes MSA demonstration contracts.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico, and the U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-16b**
**Change in selected mandatory supplemental benefits in MA plans, 2006–2008**
**(Change in percentage points of enrollees with benefit)**

| Benefit | Total (%) | HMO[6] (%) | Local PPO (%) | Regional PPO (%) | MSA[7] (%) | PFFS (%) |
|---|---|---|---|---|---|---|
| 2007 to 2008 | | | | | | |
| Vision[1] | 5.1 | 4.4 | 6.5 | 27.0 | N/A | 6.2 |
| Hearing exam[2] | 3.0 | 5.1 | −12.6 | −8.8 | N/A | 3.1 |
| Dental[3] | 7.6 | 8.0 | 14.2 | 21.5 | N/A | 0.5 |
| Podiatrist[4] | −0.1 | −0.3 | −10.2 | 0.1 | N/A | 3.7 |
| Chiropractic[5] | −0.4 | −0.5 | −2.0 | 0.2 | N/A | 0.2 |
| 2006 to 2007 | | | | | | |
| Vision[1] | −4.0 | −5.7 | 7.2 | 9.9 | N/A | 27.2 |
| Hearing exam[2] | 1.2 | −3.0 | 5.7 | −7.1 | N/A | 10.4 |
| Dental[3] | −0.5 | −2.6 | 4.9 | −23.4 | N/A | 17.6 |
| Podiatrist[4] | −1.1 | 1.4 | 0.7 | 7.2 | N/A | −0.9 |
| Chiropractic[5] | −0.9 | −0.4 | −0.8 | 0.0 | N/A | 0.0 |
| 2006 to 2008 | | | | | | |
| Vision[1] | 1.1 | −1.3 | 13.6 | 36.9 | N/A | 33.4 |
| Hearing exam[2] | 4.2 | 2.1 | −6.9 | −16.0 | N/A | 13.4 |
| Dental[3] | 7.2 | 5.4 | 19.1 | −2.0 | N/A | 18.2 |
| Podiatrist[4] | −1.2 | 1.1 | −9.5 | 7.3 | N/A | 2.8 |
| Chiropractic[5] | −1.3 | −0.9 | −2.8 | 0.2 | N/A | 0.2 |

[1] Includes eye exams and glasses/contact lenses.

[2] Includes routine hearing tests.

[3] Includes prophylaxis (cleaning).

[4] Includes routine foot care.

[5] Includes routine care.

[6] HMO includes HMO POS and PSO plans.

[7] Includes MSA demonstration contracts.

NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico, and the U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System from July 2006 through July 2008.

# Table 4-17a
## Cost sharing for selected services in MA plans, by plan type[1], 2006–2008 (Percentage of enrollees)

| Cost sharing | 2008 Total (%) | 2008 HMO (%) | 2008 Local PPO (%) | 2008 Regional PPO (%) | 2008 PFFS (%) | 2007 Total (%) | 2007 HMO (%) | 2007 Local PPO (%) | 2007 Regional PPO (%) | 2007 PFFS (%) | 2006 Total (%) | 2006 HMO (%) | 2006 Local PPO (%) | 2006 Regional PPO (%) | 2006 PFFS (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Primary care physician visit co-payment | | | | | | | | | | | | | | | |
| Total[2] | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| $0 | 19.2 | 25.7 | 20.1 | 2.0 | 3.4 | 9.7 | 13.7 | 0.3 | 0.0 | 0.3 | 10.3 | 12.1 | 4.1 | 0.0 | 3.6 |
| $0.01–$5 | 13.6 | 16.4 | 30.2 | 0.6 | 2.2 | 17.3 | 16.6 | 26.4 | 19.4 | 17.4 | 18.0 | 19.7 | 20.7 | 1.8 | 9.6 |
| $5.01–$10 | 33.6 | 32.9 | 25.7 | 93.9 | 29.0 | 34.6 | 35.6 | 36.3 | 78.9 | 26.3 | 38.6 | 39.5 | 41.1 | 96.2 | 27.3 |
| $10.01–$15 | 27.2 | 17.5 | 17.1 | 2.3 | 61.9 | 29.0 | 22.2 | 25.0 | 0.2 | 54.8 | 25.1 | 19.8 | 21.9 | 1.6 | 58.0 |
| $15.01–$25 | 3.8 | 3.6 | 6.5 | 1.2 | 3.6 | 4.3 | 5.0 | 11.4 | 1.6 | 1.1 | 7.8 | 8.8 | 12.2 | 0.4 | 1.6 |
| More than $25 | 2.6 | 3.9 | 0.4 | 0.0 | 0.1 | 5.0 | 7.0 | 0.7 | 0.0 | 0.1 | 0.2 | 0.2 | 0.0 | 0.0 | 0.0 |
| Co-insurance | 10.8 | 4.2 | 1.7 | 9.7 | 34.8 | 3.5 | 3.7 | 0.2 | 0.8 | 3.6 | 3.5 | 4.2 | 0.2 | 0.0 | 0.2 |
| Specialist physician visit co-payment | | | | | | | | | | | | | | | |
| Total[2] | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| $0 | 5.9 | 7.1 | 3.5 | 6.6 | 3.0 | 2.9 | 4.0 | 0.0 | 0.0 | 0.3 | 3.4 | 3.5 | 1.5 | 0.0 | 3.6 |
| $0.01–$5 | 3.6 | 3.2 | 18.3 | 0.0 | 0.4 | 2.6 | 2.5 | 14.7 | 0.0 | 0.3 | 2.9 | 2.9 | 12.5 | 0.9 | 0.0 |
| $5.01–$10 | 13.4 | 16.1 | 8.7 | 23.4 | 5.4 | 14.8 | 15.2 | 16.2 | 28.6 | 11.4 | 17.4 | 18.6 | 12.3 | 21.7 | 11.4 |
| $10.01–$15 | 11.9 | 11.9 | 15.7 | 0.1 | 12.4 | 12.4 | 11.7 | 23.8 | 0.0 | 13.2 | 12.2 | 12.4 | 19.4 | 0.8 | 9.6 |
| $15.01–$25 | 29.5 | 33.1 | 32.3 | 36.0 | 17.2 | 31.9 | 38.0 | 22.7 | 44.4 | 12.5 | 39.4 | 45.2 | 27.5 | 36.1 | 11.0 |
| $25.01–$35 | 34.8 | 27.5 | 18.0 | 34.0 | 61.5 | 33.6 | 26.4 | 17.3 | 26.9 | 62.2 | 23.9 | 16.2 | 26.9 | 40.4 | 64.5 |
| $35.01–$50 | 1.0 | 1.0 | 3.5 | 0.0 | 0.1 | 1.9 | 2.2 | 5.4 | 0.0 | 0.1 | 0.9 | 1.1 | 0.1 | 0.0 | 0.0 |
| Co-insurance | 5.6 | 6.4 | 1.7 | 9.7 | 3.6 | 4.6 | 5.4 | 0.2 | 0.8 | 3.6 | 4.2 | 5.2 | 0.2 | 0.0 | 0.2 |
| Emergency room visit co-payment | | | | | | | | | | | | | | | |
| Total[2] | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| $0 | 2.7 | 2.7 | 5.7 | 4.8 | 0.7 | 0.9 | 1.1 | 0.1 | 0.0 | 0.0 | 1.2 | 1.4 | 0.1 | 0.0 | 0.0 |
| $0.01–$20 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| $20.01–$40 | 4.4 | 1.4 | 0.2 | 0.0 | 21.3 | 3.8 | 0.9 | 0.0 | 0.0 | 22.0 | 5.0 | 4.7 | 11.8 | 3.9 | 3.7 |
| $40.01–$50 | 92.9 | 95.9 | 94.1 | 95.2 | 78.0 | 95.2 | 97.8 | 99.9 | 100.0 | 77.9 | 93.8 | 93.9 | 88.2 | 96.1 | 96.3 |
| Any cost sharing (either co-payment or co-insurance)[3] | | | | | | | | | | | | | | | |
| Acute hospital admission | 89.6 | 88 | 84 | 100 | 95 | 88.1 | 86.0 | 83.8 | 99.3 | 94.9 | 86.4 | 84.5 | 85.9 | 99.0 | 97.5 |
| Hospital outpatient | 87.7 | 87 | 65 | 95 | 98 | 87.5 | 86.0 | 66.8 | 95.7 | 97.1 | 86.6 | 85.2 | 70.4 | 97.0 | 100.0 |
| X-ray services | 86.0 | 84 | 63 | 100 | 98 | 78.9 | 74.7 | 58.9 | 79.3 | 98.6 | 74.6 | 70.6 | 66.2 | 97.0 | 100.0 |
| Laboratory services | 71 | 66 | 48 | 86 | 94 | 78.3 | 74.3 | 57.2 | 96.2 | 95.5 | 76.9 | 74.2 | 62.3 | 97.0 | 96.8 |

[1] Excludes MSA plans.
[2] Sums to 100.0% across co-payment categories. Some plans also have co-insurance for certain services.
[3] Does not include any applicable deductibles.
NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.
SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

# Table 4-17b
## Change in cost sharing for selected services in MA plans, by plan type[1], 2006–2008
## (Change in percentage points of enrollees)

| Cost sharing | 2007 to 2008 Total (%) | 2007 to 2008 HMO (%) | 2007 to 2008 Local PPO (%) | 2007 to 2008 Regional PPO (%) | 2007 to 2008 PFFS (%) | 2006 to 2007 Total (%) | 2006 to 2007 HMO (%) | 2006 to 2007 Local PPO (%) | 2006 to 2007 Regional PPO (%) | 2006 to 2007 PFFS (%) | 2006 to 2008 Total (%) | 2006 to 2008 HMO (%) | 2006 to 2008 Local PPO (%) | 2006 to 2008 Regional PPO (%) | 2006 to 2008 PFFS (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Primary care physician visit co-payment | | | | | | | | | | | | | | | |
| Total[2] | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| $0 | 9.5 | 12.0 | 19.8 | 2.0 | 3.0 | −0.6 | 1.6 | −3.8 | 0.0 | −3.3 | 9.0 | 13.6 | 16.0 | 2.0 | −0 3 |
| $0.01–$5 | −3.8 | −0.3 | 3.8 | −18.7 | −15.2 | −0.6 | −3.0 | 5.6 | 17.6 | 7.8 | −4.4 | −3.3 | 9.4 | -−1.1 | −7.4 |
| $5.01–$10 | −1.0 | −2.7 | −10.6 | 15.0 | 2.7 | −4.0 | −3.9 | −4.8 | −17.4 | −1.0 | −5.0 | −6.5 | −15.4 | −2.3 | 1.7 |
| $10.01–$15 | −1.8 | −4.7 | −7 9 | 2.0 | 7.0 | 3 9 | 2.4 | 3.1 | −1.4 | −3.1 | 2.1 | −2.3 | −4.8 | 0.6 | 3 9 |
| $15.01–$25 | −0.6 | −1.3 | −4 9 | −0.3 | 2.5 | −3 5 | −3.9 | −0.8 | 1.2 | −0.5 | −4.0 | −5.2 | −5.7 | 0.8 | 2.0 |
| More than $25 | −2.4 | −3.1 | −0 2 | 0.0 | −0.1 | 4.8 | 6.8 | 0.7 | 0.0 | 0.1 | 2.4 | 3.7 | 0.4 | 0.0 | 0 1 |
| Co-insurance | 7.4 | 0.5 | 1 5 | 8.9 | 31.2 | 0.0 | −0.5 | 0.0 | 0.8 | 3.4 | 7.4 | 0.0 | 1.5 | 9.7 | 34.6 |
| Specialist physician visit co-payment | | | | | | | | | | | | | | | |
| Total[2] | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| $0 | 3.0 | 3.2 | 3 5 | 6.6 | 2.7 | −0 5 | 0.4 | −1.5 | 0.0 | −3.3 | 2.5 | 3.6 | 2.0 | 6.6 | −0.6 |
| $0.01–$5 | 1.0 | 0.7 | 3.7 | 0.0 | 0.1 | −0 3 | −0.4 | 2.2 | −0.9 | 0.3 | 0.7 | 0.4 | 5.8 | −0.9 | 0.4 |
| $5.01–$10 | −1.4 | 0.9 | −7 5 | −5.3 | −6.0 | −2.6 | −3.4 | 4.0 | 7.0 | 0.0 | −4.0 | −2.5 | −3.5 | 1.7 | −5 9 |
| $10.01–$15 | −0.5 | 0.2 | −8 1 | 0.1 | −0.8 | 0 2 | −0.7 | 4.4 | -0.8 | 3.7 | −0.3 | −0.5 | −3.7 | −0.7 | 2 9 |
| $15.01–$25 | −2.4 | −4.9 | 9.6 | −8.5 | 4.7 | −7 5 | −7.2 | −4.7 | 8.3 | 1.6 | −9.9 | −12.1 | 4.9 | −0.2 | 6 2 |
| $25.01–$35 | 1.2 | 1.1 | 0.8 | 7.0 | −0.7 | 9.8 | 10.2 | −9.6 | −13.5 | −2.3 | 10.9 | 11.3 | −8.9 | −6.5 | −3.0 |
| $35.01–$50 | −0.9 | −1.2 | −1 9 | 0.0 | 0.0 | 1.0 | 1.1 | 5.3 | 0.0 | 0.1 | 0.1 | −0.1 | 3.4 | 0.0 | 0 1 |
| Co-insurance | 1.0 | 1.1 | 1 5 | 8.9 | 0.0 | 0.4 | 0.2 | 0.0 | 0.8 | 3.4 | 1.4 | 1.2 | 1.5 | 9.7 | 3 5 |
| Emergency room visit co-payment | | | | | | | | | | | | | | | |
| Total[2] | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| $0 | 1.9 | 1.6 | 5.6 | 4.8 | 0.7 | −0 3 | −0.3 | 0.0 | 0.0 | 0.0 | 1.5 | 1.3 | 5.7 | 4.8 | 0.7 |
| $0.01–$20 | −0.1 | −0.1 | 0.0 | 0.0 | 0.0 | 0 1 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| $20.01–$40 | 0.6 | 0.5 | 0 2 | 0.0 | −0.8 | −1 2 | −3.8 | −11.8 | −3.9 | 18.3 | −0.6 | −3.3 | −11.6 | −3.9 | 17.6 |
| $40.01–$50 | −2.4 | −1.9 | −5.8 | −4.8 | 0.1 | 1.4 | 3.9 | 11.7 | 3.9 | −18.4 | −0.9 | 2.0 | 5.9 | −0.9 | −18 3 |
| Any cost sharing (either co-payment or co-insurance)[3] | | | | | | | | | | | | | | | |
| Acute hospital admission | 1.6 | 2.0 | −0 1 | 0.7 | −0.1 | 1.6 | 1.6 | −2.1 | 0.4 | −2.6 | 3.2 | 3.6 | −2.2 | 1.1 | −2.7 |
| Hospital outpatient | 0.2 | 0.5 | −2 2 | −0.5 | 0.9 | 0 9 | 0.8 | −3.6 | −1.3 | −2.9 | 1.1 | 1.3 | −5.9 | −1.8 | −2.0 |
| X-ray services | 7.0 | 9.1 | 4 1 | 20.6 | −0.6 | 4 3 | 4.1 | −7.3 | −17.7 | −1.4 | 11.4 | 13.2 | −3.2 | 2.9 | −2 1 |
| Laboratory services | −7.1 | −8.5 | −9 5 | −10.3 | −1.8 | 1.4 | 0.1 | −5.1 | −0.9 | −1.4 | −5.6 | −8.4 | −14.6 | −11.2 | −3 2 |

[1] Excludes MSA plans.
[2] Sums to 0.0% across co-payment categories. Some plans also have co-insurance for certain services.
[3] Does not include any applicable deductibles.
NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.
SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

Co-payments for specialist physician visits were higher. The most common amounts in 2008 were in the $25.01 to $35 and $15.01 to $25 ranges. Changes from 2007 were small. Typically, emergency department co-payments were approximately $50. Nearly 90 percent of MA enrollees faced co-payments or co-insurance for hospital services, either acute inpatient admissions or outpatient care. High proportions were also charged co-payments or co-insurance for X-ray and clinical laboratory services, with the proportion being charged for X-rays rising and the proportion for laboratory services declining from 2007.

Cost sharing tended to be higher in PFFS plans than in other MA plan types, except for emergency room visits. For example, the largest percentage of PFFS enrollees paid primary care visit co-payments of $10.01 to $15 rather than $5.01 to $10. Almost all PFFS enrollees paid cost sharing for acute hospital admissions and for hospital outpatient, X-ray, and laboratory services.

### 4.3.3 Out-of-Pocket Cost Maximums

OOP cost-sharing maximums offer MA enrollees protection against high medical expenses, especially beneficiaries who are in poorer health status and use more health services. This "stop loss" coverage, which is not available in the traditional FFS Medicare program without supplemental insurance coverage, sets an upper limit on the amount an enrollee will have to pay for covered Part C benefits in a year.[24] Tables 4-18a and 4-19a provide analysis of MA plans' and enrollees' OOP cost maximums during 2006–2008 (with changes in Tables 4-18b and 4-19b). Nearly half (46 percent) of MA enrollees had an OOP maximum in 2008, approximately the same as in 2007 (Table 4-18a). The most common OOP maximum in 2008 was in the $3,001 to $4,000 range, which is a range that became considerably more common at the expense of both lower and higher OOP maximums from 2006 to 2008 (Table 4-18b). Most 2008 maximums ranged from $2,001 to $5,000. The median OOP maximum was $3,200 in 2008, up from $3,100 in 2007 and $3,000 in 2006 (Table 4-19a).

OOP maximums were least common in HMOs—only 35 percent of HMO enrollees had one in 2008 (Table 4-19a). All regional PPO and MSA enrollees and nearly two-thirds of PFFS and local PPO enrollees had an OOP maximum[25]. The proportion of local PPO enrollees with an OOP maximum grew 10 percentage points from 2007 to 2008, but the proportion of PFFS enrollees with a maximum fell 12 percentage points to 66 percent, down from 80 percent in 2006 (Tables 4-19a and 4-19b). Of enrollees with an OOP maximum, local PPO enrollees had the lowest (in-network) 2008 median OOP maximum of $2,400 (but up from $1,000 from 2007).

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[24] MA plans' OOP maximums do not pertain to enrollee OOP costs for Part D-covered drugs. Part D OOP costs are governed by a separate set of MMA-mandated rules revolving around the "true OOP cost" concept. MA plans' OOP maximums also do not apply to non-covered benefits, such as long-term care, and to network-based plans, which are for services received in network.

[25] Non-demonstration MSA plans pay all Medicare-covered expenses of their enrollees above the plan's deductible. Hence, the deductible is the plan's OOP maximum. Demonstration MSA plans may have separate deductibles and OOP maximums, with cost sharing for expenses between the deductible and the OOP maximum.

**Table 4-18a**
**OOP maximums in MA plans, 2006–2008 (Percentage of enrollees)**

| OOP maximum characteristic | 2008 (%) | 2007 (%) | 2006 (%) |
|---|---|---|---|
| Has OOP maximum | 46.2 | 45.1 | 41.4 |
| OOP maximum applies to[1] | | | |
| All covered services | N/A | 20.5 | 14.8 |
| Some covered services excluded | N/A | 23.9 | 26.6 |
| Inpatient hospital acute included | N/A | 23.5 | 25.1 |
| Inpatient hospital acute excluded | N/A | 0.4 | 1.5 |
| OOP maximum amount | | | |
| $1–$1,000 | 2.9 | 4.0 | 2.7 |
| $1,001–$2,000 | 4.0 | 2.9 | 7.7 |
| $2,001–$3,000 | 13.3 | 12.6 | 15.7 |
| $3,001–$4,000 | 16.0 | 13.4 | 5.0 |
| $4,001–$5,000 | 8.4 | 11.3 | 10.4 |
| $5,001+ | 0.2 | 0.2 | 0.1 |

[1] The variables reporting this information in the 2006 and 2007 Health Plan Management System (HPMS) files were not present in the 2008 HPMS file.

NOTES: In-network OOP maximum. Deductible of MSA non-demonstration plans is considered to be their OOP maximum. All 2007 and 2008 regional PPO enrollees are imputed to have an OOP maximum; some regional PPO plans did not report an OOP maximum in the 2007 and 2008 HPMS data. Regional PPO enrollees in plans not reporting an OOP maximum are excluded from the 2007 and 2008 distribution of enrollees by covered services and by maximum amount.

Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-18b**
**Change in OOP maximums in MA plans, 2006–2008**
**(Change in percentage points of enrollees)**

| OOP maximum characteristic | 2007 to 2008 (%) | 2006 to 2007 (%) | 2006 to 2008 (%) |
|---|---|---|---|
| Has OOP maximum | 1.1 | 3.7 | 4.8 |
| OOP maximum applies to[1] | | | |
| All covered services | N/A | 5.7 | N/A |
| Some covered services excluded | N/A | −2.7 | N/A |
| Inpatient hospital acute included | N/A | −1.6 | N/A |
| Inpatient hospital acute excluded | N/A | −1.1 | N/A |
| OOP maximum amount | | | |
| $1–$1,000 | −1.1 | 1.4 | 0.3 |
| $1,001–$2,000 | 1.1 | −4.8 | −3.7 |
| $2,001–$3,000 | 0.6 | −3.0 | −2.4 |
| $3,001–$4,000 | 2.6 | 8.4 | 11.0 |
| $4,001–$5,000 | −2.9 | 0.9 | −2.0 |
| $5,001+ | −0.1 | 0.1 | 0.1 |

[1] The variables reporting this information in the 2006 and 2007 HPMS files were not present in the 2008 HPMS file.

NOTES: In-network OOP maximum. Deductible of MSA non-demonstration plans is considered to be their OOP maximum. All 2007 and 2008 regional PPO enrollees are imputed to have an OOP maximum; some regional PPO plans did not report an OOP maximum in the 2007 and 2008 HPMS data. Regional PPO enrollees in plans not reporting an OOP maximum are excluded from the 2007 and 2008 distribution of enrollees by covered services and by maximum amount.

Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System data from July 2006 through July 2008.

**Table 4-19a**
**OOP maximums in MA plans by plan type, urbanicity, and region, 2006–2008**

| Plan type/ urbanicity/region | % Enrollees with OOP maximum, 2008 | Median[1] OOP maximum, 2008 ($) | % Enrollees with OOP maximum, 2007 | Median[1] OOP maximum, 2007 ($) | % Enrollees with OOP maximum, 2006 | Median[1] OOP maximum, 2006 ($) |
|---|---|---|---|---|---|---|
| Total | 46.2 | 3,200 | 45.1 | 3,100 | 41.4 | 3,000 |
| Plan type | | | | | | |
| HMO[2] | 35.3 | 3,100 | 32.8 | 3,100 | 33.1 | 3,000 |
| Local PPO | 62.4 | 2,400 | 52.7 | 1,000 | 54.1 | 1,500 |
| Regional PPO[3] | 100.0 | 3,000 | 100.0 | 3,000 | 100.0 | 3,000 |
| MSA[4] | 100.0 | 3,000 | 100.0 | 2,500 | N/A | N/A |
| PFFS | 65.7 | 4,000 | 77.2 | 5,000 | 80.1 | 5,000 |
| Urbanicity | | | | | | |
| Urban | 43.9 | 3,200 | 42.5 | 3,100 | 39.6 | 3,000 |
| Rural | 62.5 | 3,250 | 65.3 | 3,200 | 60.9 | 5,000 |
| Region | | | | | | |
| Northeast | 25.3 | 3,000 | 20.3 | 3,000 | 13.0 | 2,960 |
| Midwest | 61.3 | 3,000 | 65.4 | 3,100 | 68.6 | 3,500 |
| South | 54.0 | 3,200 | 52.1 | 3,100 | 46.2 | 3,000 |
| West | 43.8 | 3,500 | 44.8 | 4,000 | 44.8 | 3,000 |

[1] Enrollment-weighted plan median. In-network OOP maximum.
[2] HMO includes HMO POS and PSO plans.
[3] All regional PPO enrollees are imputed to have 2007/2008 OOP maximum; some regional PPO did not report an OOP maximum in the 2007/2008 HPMS data. Regional PPO enrollees in plans not reporting a maximum are excluded from calculation of median 2007/2008 OOP maximums.
[4] Includes MSA demonstration contracts. Deductible of MSA non-demonstration plans is considered to be their OOP maximum.
NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.
SOURCE: RTI analysis of CMS Health Plan Management System and Management Information Integrated Repository data from July 2006 through July 2008.

**Table 4-19b**
**Change in OOP maximums in MA plans by plan type, urbanicity, and region, 2006–2008**

| Plan type/ urbanicity/region | 2007 to 2008 With OOP maximum[1] (%) | 2007 to 2008 Median[2] ($) | 2006 to 2007 With OOP maximum[1] (%) | 2006 to 2007 Median[2] ($) | 2006 to 2008 With OOP maximum[1] (%) | 2006 to 2008 Median[2] ($) |
|---|---|---|---|---|---|---|
| Total | 1.1 | $100 | 3.7 | $100 | 4.8 | 200 |
| Plan type | | | | | | |
| HMO[3] | 2.5 | 0 | −0.3 | 100 | 2.2 | 100 |
| Local PPO | 9.7 | 1,400 | −1.4 | −500 | 8.3 | 900 |
| Regional PPO[4] | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 |
| MSA[5] | 0.0 | 500 | N/A | N/A | N/A | N/A |
| PFFS | −11.5 | −1,000 | −2.8 | 0 | −14.4 | −1,000 |
| Urbanicity | | | | | | |
| Urban | 1.4 | 100 | 3.0 | 100 | 4.4 | 200 |
| Rural | −2.8 | 50 | 4.4 | −1,800 | 1.5 | −1,750 |
| Region | | | | | | |
| Northeast | 5.0 | 0 | 7.3 | 40 | 12.3 | 40 |
| Midwest | −4.2 | −100 | −3.2 | −400 | −7.4 | −500 |
| South | 1.9 | 100 | 5.9 | 100 | 7.8 | 200 |
| West | −1.1 | −500 | 0.0 | 1,000 | −1.0 | 500 |

[1] Change in percentage points of enrollees.
[2] Enrollment-weighted plan median. In-network OOP maximum. Change in dollars.
[3] HMO includes HMO POS and PSO plans.
[4] All regional PPO enrollees are imputed to have 2007/2008 OOP maximum; some regional PPO did not report an OOP maximum in the 2007/2008 HPMS data. Regional PPO enrollees in plans not reporting a maximum are excluded from calculation of median 2007/2008 OOP maximums.
[5] Includes MSA demonstration contracts. Deductible of MSA non-demonstration plans is considered to be their OOP maximum.
NOTE: Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Includes SNPs.

SOURCE: RTI analysis of CMS Health Plan Management System and data from July 2006 through July 2008 and data from the Management Information Integrated Repository.

HMO, regional PPO, and MSA enrollees had median OOP maximums of $3,000 or $3,100. PFFS plan enrollees had the highest median OOP maximum of $4,000, which was down from $5,000 in 2007.

Urban enrollees were less likely to have OOP cost maximums than rural enrollees, but the median urban and rural maximums were nearly the same. Urban-rural differences in percentage of enrollees with maximums and median maximums narrowed from 2006 to 2008. Regionally, more than half of Midwestern and Southern MA enrollees were protected by an OOP maximum, but only one-quarter of Northeastern enrollees were. Median maximums ranged from $3,000 to $3,500 across regions.

## 4.4 Out-of-Pocket Costs

The "bottom line" of premiums, benefits, and cost sharing is expenses that enrollees in MA plans must pay out of their own pockets for healthcare. This section analyzes simulated 2007 and 2008 OOP costs, total and by major component, for MA enrollees by health status, plan type, urbanicity, and region. Data presented in this section are limited to MA plans that offer both Part C and Part D benefits and assume beneficiary enrollment in both Parts C and D (so that OOP costs are compared for a consistent benefit package). Data on MSA plans and on dual-eligible SNPs were not available; they are excluded from this section. Simulated OOP costs exclude the costs of long-term care services and of non-Medicare-covered hearing, vision, preventive screening, chiropractic, routine physical exam, and podiatry services. Where out of network benefits are offered, OOP costs represent in-network cost sharing. OOP cost data were not available for 2006; hence, this section presents an analysis of OOP costs in 2007 and 2008. Because this section relies on a different sample of plans and different data source, results presented in this section (e.g., for premiums) may differ slightly from those presented in earlier sections of this report.

### 4.4.1 By Plan Type

Table 4-20a shows simulated 2007 and 2008 OOP costs, total and by major component, for MA enrollees by plan type and health status, with percentage changes in Table 4-20b in dollars. Across all MA enrollees, 2008 OOP costs were simulated to be $298.50 per month, or $3,582 per year. Thirty-two percent of total 2008 OOP cost was the Medicare Part B premium ($95.40 on average after plan Part B premium reductions). Another 11 percent, or $34 per month, comprised the plan Part C and Part D premiums, for a total of 43 percent accounted for by insurance premiums. Approximately 30 percent more of the total—$88 per month or $1,059 per year—represented outpatient drug expenses, even with prescription drug coverage through Medicare Parts D and B. The remaining 27 percent of OOP costs, or $81 per month, were payments for inpatient (8 percent of the total), dental (8 percent), and all other services (11 percent).

The primary purpose of health insurance is to insure enrollees against the high expenditures for medical services associated with poor health. To investigate how well MA plans do this, we compare in Table 4-20a the simulated OOP costs for enrollees in excellent versus poor health. If enrollees were fully insured against poor health, OOP costs would be the same for enrollees regardless of health. But insurance benefit designs typically require enrollees to share in the costs of poorer health to discourage overuse of medical services and to keep premiums down.

## Table 4-20a
## Simulated monthly OOP costs, by plan type, 2007–2008 (For plans offering Parts C and D)

| Plan type | 2008 Health status, Any ($) | 2008 Health status, Excellent ($) | 2008 Health status, Poor ($) | 2007 Health status, Any ($) | 2007 Health status, Excellent ($) | 2007 Health status, Poor ($) |
|---|---|---|---|---|---|---|
| All[1, 4] | | | | | | |
| Total | 298.50 | 234.76 | 416.06 | 303.33 | 237.32 | 425.91 |
| Part B premium | 95.41 | 95.41 | 95.41 | 91.46 | 91.46 | 91.46 |
| Part C premium | 22.10 | 22.10 | 22.10 | 22.57 | 22.57 | 22.57 |
| Part D premium | 11.67 | 11.67 | 11.67 | 10.61 | 10.61 | 10.61 |
| Outpatient Rx | 88.30 | 46.83 | 144.65 | 95.21 | 51.56 | 159.95 |
| Inpatient | 23.20 | 8.11 | 70.32 | 25.12 | 7.83 | 64.37 |
| Dental | 24.55 | 31.68 | 15.65 | 25.31 | 33.30 | 19.35 |
| All other | 33.28 | 18.97 | 56.27 | 33.04 | 19.98 | 57.59 |
| HMO[2, 3] | | | | | | |
| Total | 298.00 | 232.33 | 417.62 | 304.45 | 237.94 | 427.24 |
| Part B premium | 95.10 | 95.10 | 95.10 | 91.96 | 91.96 | 91.96 |
| Part C premium | 21.94 | 21.94 | 21.94 | 23.92 | 23.92 | 23.92 |
| Part D premium | 9.72 | 9.72 | 9.72 | 9.33 | 9.33 | 9.33 |
| Outpatient Rx | 94.45 | 49.58 | 155.32 | 8.74 | 53.44 | 165.87 |
| Inpatient | 22.67 | 7.98 | 68.55 | 24.51 | 7.66 | 62.79 |
| Dental | 23.97 | 30.94 | 15.31 | 4.97 | 32.84 | 19.12 |
| All other | 30.14 | 17.06 | 51.66 | 31.02 | 18.78 | 54.26 |
| Local PPO[2] | | | | | | |
| Total | 313.86 | 260.88 | 416.06 | 337.87 | 276.36 | 454.18 |
| Part B premium | 96.30 | 96.30 | 96.30 | 92.59 | 92.59 | 92.59 |
| Part C premium | 44.94 | 44.94 | 44.94 | 50.50 | 50.50 | 50.50 |
| Part D premium | 25.54 | 25.54 | 25.54 | 26.08 | 26.08 | 26.08 |
| Outpatient Rx | 77.98 | 42.35 | 127.19 | 90.01 | 48.91 | 151.14 |
| Inpatient | 18.51 | 6.28 | 59.75 | 22.77 | 7.04 | 58.98 |
| Dental | 23.47 | 30.18 | 15.17 | 25.04 | 32.86 | 19.33 |
| All other | 27.11 | 15.29 | 47.17 | 30.89 | 18.38 | 55.55 |
| Regional PPO[2] | | | | | | |
| Total | 312.12 | 240.52 | 451.44 | 317.02 | 242.44 | 460.10 |
| Part B premium | 96.40 | 96.40 | 96.40 | 93.50 | 93.50 | 93.50 |
| Part C premium | 24.50 | 24.50 | 24.50 | 22.50 | 22.50 | 22.50 |
| Part D premium | 12.05 | 12.05 | 12.05 | 13.65 | 13.65 | 13.65 |
| Outpatient Rx | 83.98 | 45.00 | 136.96 | 91.93 | 49.78 | 154.34 |
| Inpatient | 35.24 | 12.95 | 100.95 | 35.95 | 12.22 | 90.53 |
| Dental | 22.56 | 29.18 | 14.60 | 22.79 | 29.78 | 18.03 |
| All other | 37.40 | 20.45 | 65.99 | 36.70 | 21.01 | 67.54 |

(continued)

## Table 4-20a (continued)
## Simulated monthly OOP costs, by plan type, 2007–2008 (For plans offering Parts C and D)

| Plan type | 2008 Health status, Any ($) | 2008 Health status, Excellent ($) | 2008 Health status, Poor ($) | 2007 Health status, Any ($) | 2007 Health status, Excellent ($) | 2007 Health status, Poor ($) |
|---|---|---|---|---|---|---|
| PFFS[2] | | | | | | |
| Total | 296.28 | 237.96 | 408.72 | 296.73 | 229.83 | 423.05 |
| Part B premium | 95.79 | 95.79 | 95.79 | 87.57 | 87.57 | 87.57 |
| Part C premium | 16.54 | 16.54 | 16.54 | 13.41 | 13.41 | 13.41 |
| Part D premium | 15.21 | 15.21 | 15.21 | 10.56 | 10.56 | 10.56 |
| Outpatient Rx | 63.24 | 35.24 | 102.06 | 80.89 | 43.76 | 136.39 |
| Inpatient | 25.47 | 8.70 | 77.13 | 28.53 | $8.87 | 72.70 |
| Dental | 28.06 | 36.24 | 17.59 | 27.55 | 36.32 | 20.77 |
| All other | 51.97 | 30.23 | 84.41 | 48.23 | 29.34 | 81.65 |
| SNP[4] | | | | | | |
| Total | 282.16 | 216.72 | 397.05 | 265.90 | 208.88 | 371.34 |
| Part B premium | 96.35 | 96.35 | 96.35 | 93.47 | 93.47 | 93.47 |
| Part C premium | 7.62 | 7.62 | 7.62 | 2.39 | 2.39 | 2.39 |
| Part D premium | 6.52 | 6.52 | 6.52 | 11.64 | 11.64 | 11.64 |
| Outpatient Rx | 101.16 | 53.38 | 163.75 | 94.06 | 51.31 | 156.82 |
| Inpatient | 22.40 | 7.67 | 68.85 | 21.03 | 5.93 | 55.40 |
| Dental | 24.14 | 31.12 | 15.50 | 25.20 | 33.18 | 19.26 |
| All other | 23.96 | 14.06 | 38.46 | 18.11 | 10.97 | 32.36 |

[1] Excludes MSA plans.

[2] Excludes SNPs.

[3] HMO includes HMO POS and PSO plans.

[4] Includes chronic-condition/institutional SNPs only, excludes dual-eligible SNPs.

NOTES: Includes only plans offering both Parts C and D. Excludes MSA plans and dual-eligible SNPs. Excludes long-term care costs.

Weighted by contract/plan/county enrollment. Excludes employer-only and Part B only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS 2007/2008 OOP cost data and July 2007/2008 data from the Management Information Integrated Repository.

**Table 4-20b**
**Change in simulated monthly OOP costs, by plan type, 2007–2008**
**(For plans offering Parts C and D)**

| Plan type | 2007 to 2008 Health status, Any ($) | 2007 to 2008 Health status, Excellent ($) | 2007 to 2008 Health status, Poor ($) |
|---|---|---|---|
| All[1, 4] | | | |
| Total | −4.83 | −2.56 | −9.85 |
| Part B premium | 3.95 | 3.95 | 3.95 |
| Part C premium | −0.47 | −0.47 | −0.47 |
| Part D premium | 1.06 | 1.06 | 1.06 |
| Outpatient Rx | −6.91 | −4.73 | −15.30 |
| Inpatient | −1.92 | 0.28 | 5.95 |
| Dental | −0.76 | −1.62 | −3.70 |
| All other | 0.24 | −1.01 | −1.32 |
| HMO[2, 3] | | | |
| Total | −6.45 | −5.61 | −9.62 |
| Part B premium | 3.14 | 3.14 | 3.14 |
| Part C premium | −1.98 | −1.98 | −1.98 |
| Part D premium | 0.39 | 0.39 | 0.39 |
| Outpatient Rx | −4.29 | −3.86 | −10.55 |
| Inpatient | −1.84 | 0.32 | 5.76 |
| Dental | −1.00 | −1.90 | −3.81 |
| All other | −0.88 | −1.72 | −2.60 |
| Local PPO[2] | | | |
| Total | −24.01 | −15.48 | −38.12 |
| Part B premium | 3.71 | 3.71 | 3.71 |
| Part C premium | −5.56 | −5.56 | −5.56 |
| Part D premium | −0.54 | −0.54 | −0.54 |
| Outpatient Rx | −12.03 | −6.56 | −23.95 |
| Inpatient | −4.26 | −0.76 | 0.77 |
| Dental | −1.57 | −2.68 | −4.16 |
| All other | −3.78 | −3.09 | −8.38 |
| Regional PPO[2] | | | |
| Total | −4.90 | −1.92 | −8.66 |
| Part B premium | 2.90 | 2.90 | 2.90 |
| Part C premium | 2.00 | 2.00 | 2.00 |
| Part D premium | −1.60 | −1.60 | −1.60 |
| Outpatient Rx | −7.95 | −4.78 | −17.38 |
| Inpatient | −0.71 | 0.73 | 10.42 |
| Dental | −0.23 | −0.60 | −3.43 |
| All other | 0.70 | −0.56 | −1.55 |

(continued)

**Table 4-20b (continued)**
**Change in simulated monthly OOP costs, by plan type, 2007–2008**
**(For plans offering Parts C and D)**

| Plan type | 2007 to 2008 Health status, Any ($) | 2007 to 2008 Health status, Excellent ($) | 2007 to 2008 Health status, Poor ($) |
|---|---|---|---|
| PFFS[2] | | | |
| Total | −0.45 | 8.13 | −14.33 |
| Part B premium | 8.22 | 8.22 | 8.22 |
| Part C premium | 3.13 | 3.13 | 3.13 |
| Part D premium | 4.65 | 4.65 | 4.65 |
| Outpatient Rx | −17.65 | −8.52 | −34.33 |
| Inpatient | −3.06 | −0.17 | 4.43 |
| Dental | 0.51 | −0.08 | −3.18 |
| All other | 3.74 | 0.89 | 2.76 |
| SNP[4] | | | |
| Total | 16.26 | 7.84 | 25.71 |
| Part B premium | 2.88 | 2.88 | 2.88 |
| Part C premium | 5.23 | 5.23 | 5.23 |
| Part D premium | −5.12 | −5.12 | −5.12 |
| Outpatient Rx | 7.10 | 2.07 | 6.93 |
| Inpatient | 1.37 | 1.74 | 13.45 |
| Dental | −1.06 | −2.06 | −3.76 |
| All other | 5.85 | 3.09 | 6.10 |

[1] Excludes MSA plans.

[2] Excludes SNPs.

[3] HMO includes HMO POS and PSO plans.

[4] Includes chronic-condition/institutional SNPs only, excludes dual-eligible SNPs.

NOTES: Includes only plans offering both Parts C and D. Excludes MSA plans and dual-eligible SNPs. Excludes long-term care costs.

Weighted by contract/plan/county enrollment. Excludes employer-only and Part B only plans. Excludes Puerto Rico and U.S., territories

SOURCE: RTI analysis of CMS 2007/2008 OOP cost data and July 2007/2008 data from the Management Information Integrated Repository.

Table 4-20a shows that simulated OOP costs are 77 percent greater, $416 versus $235 per month, for beneficiaries in poor health compared to those in excellent health. Premiums are the same for all enrollees—MA plans are not allowed to underwrite premiums based on health status. The largest contributor to higher OOP costs with poor health is increased outpatient

prescription drug expenses, accounting for approximately half (54 percent) of the total increase. MA plans' Part D benefits, and the Medicare Part D benefit in general, contain substantial beneficiary cost sharing for higher drug costs, in the form of deductibles, co-payments or co-insurance, and the coverage gap. The remaining half (46 percent) of increased OOP costs with poorer health are higher expenses for inpatient and other medical services.

Among plan types, simulated total OOP costs for an enrollee of average health status are above average for PPOs (both local and regional), approximately average for HMOs and PFFS plans, and below average for chronic-condition/institutional SNPs.[26] The differences among the open-access plan types are not dramatic. For example, local PPOs' average OOP costs are only $15 per month, or $184 per year, above average. Differences in Part C and Part D premiums contribute to variations in plan type OOP costs. Local PPOs have the highest average premiums and SNPs the lowest. HMOs have relatively high outpatient drug OOP costs, but whereas lower premiums than local PPOs, and lower cost sharing for medical services than PFFS plans. For enrollees in excellent health, HMOs offer slightly lower-than-average OOP costs, whereas PPOs (both local and regional) are expensive. For enrollees with a poor health status, regional PPOs are particularly expensive, largely because of high inpatient cost sharing, while PFFS plans are less expensive than average because of low outpatient drug costs.

Total average monthly OOP costs for all plan types, any health status, fell by $5, or 2 percent, from 2007 to 2008 (Table 4-20b).[27] Greater generosity of outpatient prescription drug coverage more than offset a rise in the Medicare Part B premium. Local PPO OOP costs fell the most between 2007 and 2008, by $24 per month, or 7 percent. PFFS average OOP costs were almost flat between the 2 years, and chronic/institutional SNP average OOP costs rose.

### 4.4.2 By Urbanicity and Region

As shown in Table 4-21a, simulated average total monthly MA enrollee OOP costs were slightly higher in rural than urban areas (3 percent greater in rural areas for any health status in 2008). Rural residents paid higher premiums, but had lower outpatient prescription drug costs. Both urban and rural average total OOP costs declined slightly from 2007 to 2008 (Table 4-21b).

Differences are larger across regions, as shown in Table 4-22a. Average 2008 total monthly OOP costs were $51 higher in the Northeast than in the South, or $609 per year. The Northeast/South difference is mostly due to higher plan Part C and Part D premiums in the Northeast. Average OOP costs in the West are almost as high as in the Northeast. Western premiums are lower, but drug, inpatient, and dental cost sharing is greater than in the Northeast. Midwestern MA enrollee simulated costs are lower than in the Northeast or West, but higher than in the South. Western MA enrollees in poor health face the highest simulated OOP costs, followed by Northeastern enrollees. Western costs are high particularly because of high simulated OOP drug costs, indicating a less generous average Part D benefit in the West.

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[26] SNPs for dual eligibles are not included in the CMS OOP cost data, presumably because dual eligibles typically have most of their OOP costs paid by Medicaid wrap-around coverage.

[27] In Table 4-20b, for all plan types, average inpatient OOP costs fell from 2007 to 2008 for any health status, but rose for excellent and poor health statuses. This apparent anomaly is explained by the fact that OOP costs fell substantially for "fair" health status and slightly for "very good" health status, which are not shown in the table.

Between 2007 and 2008, average total OOP costs fell most in the Midwest and the Northeast, least in the West (Table 4-22b).

**Table 4-21a**
**Simulated monthly OOP costs, by urbanicity, 2007–2008**
**(For plans offering Parts C and D)**

| Urbanicity | 2008 Health status, Any ($) | 2008 Health status, Excellent ($) | 2008 Health status, Poor ($) | 2007 Health status, Any ($) | 2007 Health status, Excellent ($) | 2007 Health status, Poor ($) |
|---|---|---|---|---|---|---|
| Urban | | | | | | |
| Total | 297.43 | 233.36 | 415.40 | 302.58 | 236.48 | 425.18 |
| Part B premium | 95.31 | 95.31 | 95.31 | 91.33 | 91.33 | 91.33 |
| Part C premium | 21.69 | 21.69 | 21.69 | 22.51 | 22.51 | 22.51 |
| Part D premium | 11.18 | 11.18 | 11.18 | 10.30 | 10.30 | 10.30 |
| Outpatient Rx | 89.53 | 47.37 | 146.80 | 95.83 | 51.90 | 160.97 |
| Inpatient | 23.22 | 8.14 | 70.26 | 25.15 | 7.85 | 64.39 |
| Dental | 24.30 | 31.36 | 15.51 | 25.12 | 33.04 | 19.23 |
| All other | 32.19 | 18.31 | 54.64 | 32.34 | 19.55 | 56.45 |
| Rural | | | | | | |
| Total | 307.86 | 247.09 | 421.76 | 311.33 | 246.24 | 433.67 |
| Part B premium | 96.25 | 96.25 | 96.25 | 92.85 | 92.85 | 92.85 |
| Part C premium | 25.70 | 25.70 | 25.70 | 23.22 | 23.22 | 23.22 |
| Part D premium | 16.01 | 16.01 | 16.01 | 13.91 | 13.91 | 13.91 |
| Outpatient Rx | 77.29 | 41.95 | 125.37 | 88.62 | 47.97 | 149.08 |
| Inpatient | 22.97 | 7.88 | 70.81 | 24.82 | 7.64 | 64.20 |
| Dental | 26.70 | 34.47 | 16.86 | 27.37 | 36.09 | 20.65 |
| All other | 42.93 | 24.82 | 70.75 | 40.54 | 24.57 | 69.77 |

NOTES: Includes only plans offering both Parts C and D. Excludes MSA plans and dual-eligible SNPs. Excludes long-term care costs. Weighted by contract/plan/county enrollment. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS 2007/2008 OOP cost data and July 2007/2008 data from the Management Information Integrated Repository.

**Table 4-21b**
**Change in simulated monthly OOP costs, by urbanicity, 2007–2008**
**(For plans offering Parts C and D)**

| Urbanicity | 2007 to 2008 Health status, Any ($) | 2007 to 2008 Health status, Excellent ($) | 2007 to 2008 Health status, Poor ($) |
|---|---|---|---|
| Urban | | | |
| Total | −5.15 | −3.12 | −9.78 |
| Part B premium | 3.98 | 3.98 | 3.98 |
| Part C premium | −0.82 | −0.82 | −0.82 |
| Part D premium | 0.88 | 0.88 | 0.88 |
| Outpatient Rx | −6.30 | −4.53 | −14.17 |
| Inpatient | −1.93 | 0.29 | 5.87 |
| Dental | −0.82 | −1.68 | −3.72 |
| All other | −0.15 | −1.24 | −1.81 |
| Rural | | | |
| Total | −3.47 | 0.85 | −11.91 |
| Part B premium | 3.40 | 3.40 | 3.40 |
| Part C premium | 2.48 | 2.48 | 2.48 |
| Part D premium | 2.10 | 2.10 | 2.10 |
| Outpatient Rx | −11.33 | −6.02 | −23.71 |
| Inpatient | −1.85 | 0.24 | 6.61 |
| Dental | −0.67 | −1.62 | −3.79 |
| All other | 2.39 | 0.25 | 0.98 |

NOTES: Includes only plans offering both Parts C and D. Excludes MSA plans and dual-eligible SNPs. Excludes long-term care costs. Weighted by contract/plan/county enrollment. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS 2007/2008 OOP cost data and July 2007/2008 data from the Management Information Integrated Repository.

**Table 4-22a**
**Simulated monthly OOP costs, by census region, 2007–2008**
**(For plans offering Parts C and D)**

| Census region | 2008 Health status, Any ($) | 2008 Health status, Excellent ($) | 2008 Health status, Poor ($) | 2007 Health status, Any ($) | 2007 Health status, Excellent ($) | 2007 Health status, Poor ($) |
|---|---|---|---|---|---|---|
| Northeast | | | | | | |
| Total | 318.44 | 258.98 | 425.50 | 325.13 | 263.66 | 437.94 |
| Part B premium | 96.38 | 96.38 | 96.38 | 93.48 | 93.48 | 93.48 |
| Part C premium | 38.71 | 38.71 | 38.71 | 42.90 | 42.90 | 42.90 |
| Part D premium | 22.59 | 22.59 | 22.59 | 20.57 | 20.57 | 20.57 |
| Outpatient Rx | 89.48 | 47.71 | 145.62 | 94.52 | 51.36 | 158.57 |
| Inpatient | 16.38 | 5.59 | 53.36 | 19.07 | 5.76 | 49.99 |
| Dental | 23.26 | 29.97 | 15.02 | 23.08 | 30.21 | 18.13 |
| All other | 31.64 | 18.04 | 53.82 | 31.52 | 19.38 | 54.31 |
| Midwest | | | | | | |
| Total | 303.39 | 241.88 | 417.51 | 312.49 | 244.62 | 440.92 |
| Part B premium | 96.39 | 96.39 | 96.39 | 93.50 | 93.50 | 93.50 |
| Part C premium | 22.67 | 22.67 | 22.67 | 19.64 | 19.64 | 19.64 |
| Part D premium | 13.20 | 13.20 | 13.20 | 13.70 | 13.70 | 13.70 |
| Outpatient Rx | 80.56 | 43.24 | 131.46 | 89.26 | 48.29 | 150.29 |
| Inpatient | 23.68 | 8.27 | 71.42 | 29.16 | 9.21 | 74.26 |
| Dental | 26.96 | 34.82 | 16.99 | 27.57 | 36.36 | 20.76 |
| All other | 39.95 | 23.29 | 65.39 | 39.65 | 23.92 | 68.76 |
| South | | | | | | |
| Total | 267.66 | 206.46 | 382.41 | 270.89 | 207.13 | 390.40 |
| Part B premium | 93.66 | 93.66 | 93.66 | 87.96 | 87.96 | 87.96 |
| Part C premium | 8.32 | 8.32 | 8.32 | 6.90 | 6.90 | 6.90 |
| Part D premium | 7.25 | 7.25 | 7.25 | 6.17 | 6.17 | 6.17 |
| Outpatient Rx | 78.74 | 41.87 | 127.79 | 89.19 | 48.20 | 150.07 |
| Inpatient | 25.30 | 8.80 | 75.96 | 25.43 | 7.72 | 65.86 |
| Dental | 21.61 | 27.92 | 13.99 | 23.96 | 31.47 | 18.49 |
| All other | 32.79 | 18.63 | 55.43 | 31.29 | 18.72 | 54.96 |
| West | | | | | | |
| Total | 316.33 | 245.74 | 445.89 | 318.66 | 248.31 | 447.79 |
| Part B premium | 96.14 | 96.14 | 96.14 | 92.80 | 92.80 | 92.80 |
| Part C premium | 25.84 | 25.84 | 25.84 | 27.34 | 27.34 | 27.34 |
| Part D premium | 8.39 | 8.39 | 8.39 | 7.36 | 7.36 | 7.36 |
| Outpatient Rx | 102.29 | 53.67 | 169.78 | 104.84 | 56.80 | 175.86 |
| Inpatient | 25.17 | 8.94 | 74.81 | 26.69 | 8.59 | 67.15 |
| Dental | 27.28 | 35.20 | 17.14 | 27.04 | 35.68 | 20.34 |
| All other | 31.22 | 17.56 | 53.79 | 32.59 | 19.73 | 56.93 |

NOTES: Includes only plans offering both Parts C and D. Excludes MSA plans and dual-eligible SNPs. Excludes long-term care costs. Weighted by contract/plan/county enrollment. Excludes employer-only and Part-B only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS 2007/2008 OOP cost data and July 2007/2008 data from the Management Information Integrated Repository.

**Table 4-22b**
**Change in simulated monthly OOP costs, by census region, 2007–2008**
**(For plans offering Parts C and D)**

| Census region | 2007 to 2008 Health status, Any ($) | 2007 to 2008 Health status, Excellent ($) | 2007 to 2008 Health status, Poor ($) |
|---|---|---|---|
| Northeast | | | |
| Total | −6.69 | −4.68 | −12.44 |
| Part B premium | 2.90 | 2.90 | 2.90 |
| Part C premium | −4.19 | −4.19 | −4.19 |
| Part D premium | 2.02 | 2.02 | 2.02 |
| Outpatient Rx | −5.04 | −3.65 | −12.95 |
| Inpatient | −2.69 | −0.17 | 3.37 |
| Dental | 0.18 | −0.24 | −3.11 |
| All other | 0.12 | −1.34 | −0.49 |
| Midwest | | | |
| Total | −9.10 | −2.74 | −23.41 |
| Part B premium | 2.89 | 2.89 | 2.89 |
| Part C premium | 3.03 | 3.03 | 3.03 |
| Part D premium | −0.50 | −0.50 | −0.50 |
| Outpatient Rx | −8.70 | −5.05 | −18.83 |
| Inpatient | −5.48 | −0.94 | −2.84 |
| Dental | −0.61 | −1.54 | −3.77 |
| All other | 0.30 | −0.63 | −3.37 |
| South | | | |
| Total | −3.23 | −0.67 | −7.99 |
| Part B premium | 5.70 | 5.70 | 5.70 |
| Part C premium | 1.42 | 1.42 | 1.42 |
| Part D premium | 1.08 | 1.08 | 1.08 |
| Outpatient Rx | −10.45 | −6.33 | −22.28 |
| Inpatient | −0.13 | 1.08 | 10.10 |
| Dental | −2.35 | −3.55 | −4.50 |
| All other | 1.50 | −0.09 | 0.47 |
| West | | | |
| Total | −2.33 | −2.57 | −1.90 |
| Part B premium | 3.34 | 3.34 | 3.34 |
| Part C premium | −1.50 | −1.50 | −1.50 |
| Part D premium | 1.03 | 1.03 | 1.03 |
| Outpatient Rx | −2.55 | −3.13 | −6.08 |
| Inpatient | −1.52 | 0.35 | 7.66 |
| Dental | 0.24 | −0.48 | −3.20 |
| All other | −1.37 | −2.17 | −3.14 |

NOTES: Includes only plans offering both Parts C and D. Excludes MSA plans and dual-eligible SNPs. Excludes long-term care costs. Weighted by contract/plan/county enrollment. Excludes employer-only and Part-B only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS 2007/2008 OOP cost data and July 2007/2008 data from the Management Information Integrated Repository.

## SECTION 5
## ENROLLMENT

In this section, we present results from our descriptive analysis of Medicare Advantage (MA) enrollment during the period from 2006 to 2008. Our presentation focuses on MA enrollment in 2008 and the enrollment changes between 2007 and 2008. Our analysis sample for monitoring MA enrollment consisted of three point-in-time samples, specifically, all beneficiaries enrolled on July 1, 2006; all beneficiaries enrolled on July 1, 2007; and all beneficiaries enrolled on July 1, 2008, as indicated in the Centers for Medicare & Medicaid Services (CMS) Management Information Integrated Repository (MIIR). Our analysis sample was beneficiaries enrolled in an MA plan (e.g., health maintenance organization [HMO[28]], local preferred provider organization [PPO], regional PPO, private fee-for-service [PFFS], Medical Savings Account [MSA])[29], excluding employer-only plan enrollment,[30] Part B-only plan enrollment, and enrollment in Puerto Rico and U.S. territories.

### 5.1 Enrollment Overall and by Plan Type

Table 5-1 (a and b) show MA enrollment overall and by plan type. MA enrollment in 2008 was 7.7 million, with a penetration rate (enrollees/eligibles) of 19.0 percent. MA enrollment rose 13.9 percent from 2007 to 2008, and MA penetration increased 1.8 percentage points. The changes since 2006 are even more pronounced, with enrollment increasing by 35.4 percent between 2006 and 2008, and the penetration rate increasing by 4.3 percentage points during this period. Although HMOs were still the dominant plan type in MA in 2008, together PFFS and PPOs (local and regional) had approximately one-third of MA enrollment, which was somewhat higher than in 2007. However, there was a large increase in HMO enrollment between 2007 and 2008 (8.3 percent). There were also large increases in enrollment for PFFS (16.3 percent), regional PPO (47.6 percent), and local PPO (62.4 percent). MSA plans had an enrollment of 473 beneficiaries in 2008.[31]

The magnitude of recent increases in MA enrollment is clearly shown in Table 5-1 (a and b). From 2007 to 2008, there was an increase in MA enrollment of 941,354, with 399,161 of this increase for HMO plans. The changes since 2006 are even more pronounced, with an increase in MA enrollment of 2.0 million, with 903,506 of this increase for PFFS plans. Several factors might explain these increases in MA enrollment. One likely key factor is higher MA payments relative to fee-for-service (FFS) expenditures. This is illustrated in Figure 5-1, which shows the

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28 Includes HMO point-of-service (POS) and provider-sponsored organization (PSO) plans.

29 Note that Special Needs Plans (SNPs) are MA plans, and enrollment in a SNP does not exclude a beneficiary from our analytic sample.

30 Employer-specific plans are excluded from our analysis in this report because they are available only to retirees of specific employers. However, it should be noted that employer plan enrollment is substantial. As of July 2008, employer plan enrollment was 17 percent of total Medicare health plan enrollment (see Table 2-3).

31 In Table 5-1, MSA enrollment is reported to decrease from 2,260 in 2007 to 473 in 2008. The primary reason for this is because the status of specific MSA plans changed from “active” in 2007 to “inactive” in 2008.

**Table 5-1a**
**MA[1] enrollment by plan type, 2006–2008[2]**

| Plan type | Enrollment | % of total enrollment | % of total eligibles[3] |
|---|---|---|---|
| 2008 | | | |
| Total MA | 7,735,237 | 100.0 | 19.0 |
| Plan type | | | |
| HMO[4] | 5,212,401 | 67.4 | 12.8 |
| Local PPO | 564,692 | 7.3 | 1.4 |
| Regional PPO | 285,841 | 3.7 | 0.7 |
| PFFS | 1,671,830 | 21.6 | 4.1 |
| MSA[5] | 473 | 0.0 | 0.0 |
| 2007 | | | |
| Total MA | 6,793,883 | 100.0 | 17.2 |
| Plan type | | | |
| HMO[4] | 4,813,240 | 70.8 | 12.2 |
| Local PPO | 347,670 | 5.1 | 0.9 |
| Regional PPO | 193,713 | 2.9 | 0.5 |
| PFFS | 1,437,000 | 21.2 | 3.6 |
| MSA[5] | 2,260 | 0.0 | 0.0 |
| 2006 | | | |
| Total MA | 5,713,606 | 100.0 | 14.7 |
| Plan type | | | |
| HMO[4] | 4,585,076 | 80.2 | 11.8 |
| Local PPO | 273,797 | 4.8 | 0.7 |
| Regional PPO | 86,409 | 1.5 | 0.2 |
| PFFS | 768,324 | 13.4 | 2.0 |
| MSA[5] | — | — | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] MA eligibles are defined as Medicare beneficiaries with Parts A and B. Eligibles are calculated using a Medicare denominator file.

[4] Includes HMO, point-of-service (POS), and provider-sponsored organization (PSO) plans.

[5] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-1b**
**Change in MA[1] enrollment by plan type, 2006–2008[2]**

| Plan type | Change in enrollment | Enrollment (%) | Change in % points, % of total enrollment | Change in % points, % of total eligibles[3] |
|---|---|---|---|---|
| Change 2007 to 2008 | | | | |
| Total MA | 941,354 | 13.9 | — | 1.8 |
| Plan type | | | | |
| HMO[4] | 399,161 | 8.3 | −3.5 | 0.6 |
| Local PPO | 217,022 | 62.4 | 2.2 | 0.5 |
| Regional PPO | 92,128 | 47.6 | 0.8 | 0.2 |
| PFFS | 234,830 | 16.3 | 0.5 | 0.5 |
| MSA[5] | −1,787 | −79.1 | 0.0 | 0.0 |
| Change 2006 to 2007 | | | | |
| Total MA | 1,080,277 | 18.9 | — | 2.5 |
| Plan type | | | | |
| HMO[4] | 228,164 | 5.0 | −9.4 | 0.4 |
| Local PPO | 73,873 | 27.0 | 0.3 | 0.2 |
| Regional PPO | 107,304 | 124.2 | 1.3 | 0.3 |
| PFFS | 668,676 | 87.0 | 7.7 | 1.6 |
| MSA[5] | 2,260 | — | — | — |
| Change 2006 to 2008 | | | | |
| Total MA | 2,021,631 | 35.4 | — | 4.3 |
| Plan type | | | | |
| HMO[4] | 627,325 | 13.7 | −12.9 | 1.0 |
| Local PPO | 290,895 | 106.2 | 2.5 | 0.7 |
| Regional PPO | 199,432 | 230.8 | 2.2 | 0.5 |
| PFFS | 903,506 | 117.6 | 8.2 | 2.1 |
| MSA[5] | 473 | — | — | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

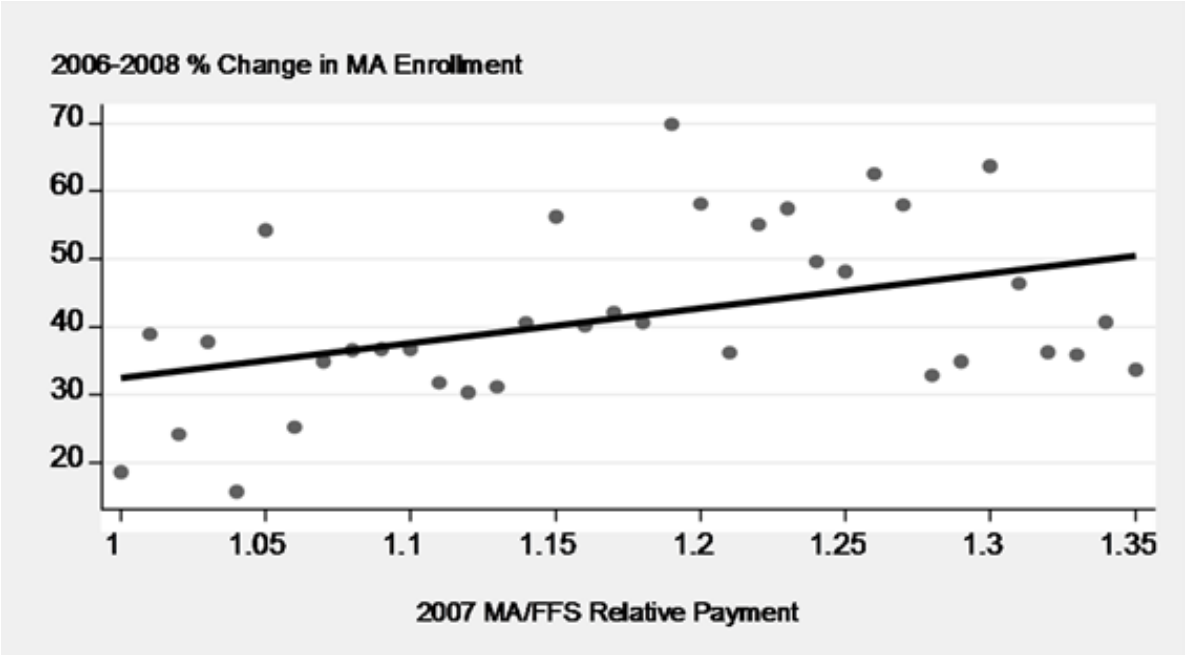
[3] MA eligibles are defined as Medicare beneficiaries with Parts A and B. Eligibles are calculated using the Medicare denominator file.

[4] Includes HMO, POS, and PSO plans.

[5] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Figure 5-1**
**MA/FFS relative payment (2007) versus**
**percentage change in MA enrollment (2006–2008)**




NOTES:

1. We define the MA/FFS relative payment as MA payments relative to (divided by) FFS expenditures, and we group counties into the following MA/FFS relative payment ranges: 1.0 (MA payment = FFS expenditures), >1.0 to 1.01, >1.01 to 1.02, …, >1.34 to 1.35, and finally, >1.35. The county groups are plotted.

2. Enrollment figures as of July 2006 and July 2008.

3. We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

4. The following regression line is plotted in the figure: (% change MA enrollment) = −18.7 (t = −0.8) + (51.4* MA/FFS Relative Payment) (t = 2.7).

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository and 2007 MA Risk Rate File.

2007 MA/FFS relative payment against the 2006 to 2008 percentage change in MA enrollment by county relative payment group.[32] As is evident from the figure, there is a significantly positive relationship between the MA/FFS relative payment and the percentage change in MA enrollment (i.e., the regression line in Figure 5-1 has a positive slope).

MA enrollment by beneficiary characteristics is presented in Table 5-2 (a and b). For 2008, the youngest elderly group (aged 65 to 74) made up the highest percentage of MA enrollment (45.9 percent), with the group aged 75 to 84 having 30.8 percent of MA enrollment. The MA take-up rate among these age groups was somewhat higher than among the oldest Medicare beneficiaries (aged 85 or older) and the Medicare beneficiaries eligible by disability (aged 0 to 64). For example, the MA take-up rate was 20.6 percent for the youngest elderly, but only 15.4 percent for Medicare beneficiaries eligible by disability. At 19.1 percent, the percentage change in enrollment from 2007 to 2008 was highest for Medicare beneficiaries eligible by disability (under age 65) compared to the other age groups.

Beneficiaries dually eligible for Medicare and Medicaid accounted for 16.7 percent of MA enrollees in 2008, but had a lower take-up rate for MA than did non-Medicaid enrollees. However, the percentage change in enrollment from 2007 to 2008 was higher than average for Medicaid enrollees (17.9 percent).[33]

## 5.2 By Urbanicity and Census Region

As shown in Table 5-3 (a and b), among 2008 MA enrollees, 87.6 percent resided in urban areas and 12.4 percent resided in rural areas. At 21.3 percent, the percentage of beneficiaries residing in urban areas that enroll in MA was much higher than for rural beneficiaries (10.9 percent). However, the percentage increase in rural enrollment from 2007 to 2008 was 25.2 percent, compared to only 12.4 percent for urban enrollment. The increase in rural enrollment is correlated with the increase in PFFS and regional PPO enrollment. In addition, as a percentage of total MA enrollment, rural enrollment increased by 1 percentage point, with urban enrollment falling by 1 percentage point.

Table 5-4 (a and b) show that in 2008, the South and the West had the highest number of MA enrollees among census regions, with 2.6 million and 2.2 million, respectively. However, the take-up rate for Medicare beneficiaries residing in the West census region was approximately one-and-a-half times that of the South census region (27.2 percent versus 16.7 percent). The Midwest and South census regions had the highest percentage changes in enrollment from 2007 to 2008, with the Midwest census region growing by 20.9 percent, and the South census region growing by 16.4 percent. Similar to the rise for rural areas, the increase for the Midwest and South census regions is related to the growth in PFFS and regional PPO enrollment.

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[32] We define the MA/FFS relative payment as MA payments relative to (divided by) FFS per capita expenditures, and we group counties into the following MA/FFS relative payment ranges: 1.0 (MA payment = FFS expenditures), >1.0 to 1.01, >1.01 to 1.02, …, >1.34 to 1.35, and finally >1.35.

[33] This increase may be linked to the high percentage increase in SNP enrollment between 2007 and 2008 (see Section 5.3).

## Table 5-2a
## MA[1] enrollment by beneficiary characteristics, 2006–2008[2]

| Beneficiary characteristics | Enrollment[3] | % of total enrollment | % of total eligibles[4] | % of subpopulation eligibles[4] |
|---|---|---|---|---|
| 2008 | | | | |
| Total MA | 7,735,237 | 100.0 | 19.0 | — |
| Age | | | | |
| Under 65 | 1,014,113 | 13.1 | 2.5 | 15.4 |
| 65–74 | 3,551,772 | 45.9 | 8.7 | 20.6 |
| 75–84 | 2,383,212 | 30.8 | 5.9 | 19.7 |
| 85 and older | 786,140 | 10.2 | 1.9 | 16.3 |
| Sex | | | | |
| Male | 3,288,671 | 42.5 | 8.1 | 18.5 |
| Female | 4,446,566 | 57.5 | 10.9 | 19.4 |
| Dual eligibility | | | | |
| Medicaid | 1,294,120 | 16.7 | 3.2 | 18.0 |
| Non-Medicaid | 6,441,117 | 83.3 | 15.8 | 19.2 |
| 2007 | | | | |
| Total MA | 6,793,883 | 100.0 | 17.2 | — |
| Age | | | | |
| Under 65 | 851,533 | 12.5 | 2.2 | 12.2 |
| 65–74 | 3,077,412 | 45.3 | 7.8 | 18.6 |
| 75–84 | 2,165,924 | 31.9 | 5.5 | 18.4 |
| 85 and older | 699,014 | 10.3 | 1.8 | 16.1 |
| Sex | | | | |
| Male | 2,866,701 | 42.2 | 7.2 | 16.7 |
| Female | 3,927,182 | 57.8 | 9.9 | 17.5 |
| Dual eligibility | | | | |
| Medicaid | 1,097,264 | 16.2 | 2.8 | 15.7 |
| Non-Medicaid | 5,696,619 | 83.8 | 14.4 | 17.5 |
| 2006 | | | | |
| Total MA | 5,713,606 | 100.0 | 14.7 | — |
| Age | | | | |
| Under 65 | 672,880 | 11.8 | 1.7 | 10.1 |
| 65–74 | 2,576,224 | 45.1 | 6.6 | 15.9 |
| 75–84 | 1,878,854 | 32.9 | 4.9 | 16.0 |
| 85 and older | 585,648 | 10.3 | 1.5 | 14.1 |
| Sex | | | | |
| Male | 2,392,417 | 41.9 | 6.2 | 14.2 |
| Female | 3,321,189 | 58.1 | 8.6 | 15.2 |
| Dual eligibility | | | | |
| Medicaid | 840,443 | 14.7 | 2.1 | 12.5 |
| Non-Medicaid | 4,873,163 | 85.3 | 12.6 | 15.3 |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, local PPO, regional PPO, PFFS, and MSA.

[4] MA eligibles are defined as Medicare beneficiaries with Part A and Part B. Eligibles are calculated using the Medicare denominator file.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

## Table 5-2b
## Change in MA[1] enrollment by beneficiary characteristics, 2006–2008[2]

| Beneficiary characteristics | Enrollment[3] % Change | % of total enrollment Change in % points | % of total eligibles[4] Change in % points | % of subpopulation eligibles[4] Change in % points |
|---|---|---|---|---|
| Change 2007 to 2008 | | | | |
| Total MA | 13.9 | — | 1.8 | — |
| Age | | | | |
| Under 65 | 19.1 | 0.6 | 0.3 | 3.2 |
| 65–74 | 15.4 | 0.6 | 1.0 | 2.0 |
| 75–84 | 10.0 | −1.1 | 0.4 | 1.3 |
| 85 and older | 12.5 | −0.1 | 0.2 | 0.2 |
| Sex | | | | |
| Male | 14.7 | 0.3 | 0.8 | 1.8 |
| Female | 13.2 | −0.3 | 1.0 | 1.8 |
| Dual eligibility | | | | |
| Medicaid | 17.9 | 0.6 | 0.4 | 2.3 |
| Non-Medicaid | 13.1 | −0.6 | 1.4 | 1.8 |
| Change 2006 to 2007 | | | | |
| Total MA | 18.9 | — | 2.5 | — |
| Age | | | | |
| Under 65 | 26.6 | 0.8 | 0.4 | 2.1 |
| 65–74 | 19.5 | 0.2 | 1.2 | 2.7 |
| 75–84 | 15.3 | −1.0 | 0.6 | 2.4 |
| 85 and older | 19.4 | 0.0 | 0.3 | 2.0 |
| Sex | | | | |
| Male | 19.8 | 0.3 | 1.1 | 2.5 |
| Female | 18.2 | −0.3 | 1.3 | 2.4 |
| Dual eligibility | | | | |
| Medicaid | 30.6 | 1.4 | 0.7 | 3.2 |
| Non-Medicaid | 16.9 | −1.4 | 1.8 | 2.2 |
| Change 2006 to 2008 | | | | |
| Total MA | 35.4 | — | 4.3 | — |
| Age | | | | |
| Under 65 | 50.7 | 1.3 | 0.8 | 5.3 |
| 65–74 | 37.9 | 0.8 | 2.1 | 4.7 |
| 75–84 | 26.8 | −2.1 | 1.0 | 3.7 |
| 85 and older | 34.2 | −0.1 | 0.4 | 2.2 |
| Sex | | | | |
| Male | 37.5 | 0.6 | 1.9 | 4.3 |
| Female | 33.9 | −0.6 | 2.3 | 4.2 |
| Dual eligibility | | | | |
| Medicaid | 54.0 | 2.0 | 1.1 | 5.5 |
| Non-Medicaid | 32.2 | −2.0 | 3.2 | 3.9 |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, local PPO, regional PPO, PFFS, and MSA.

[4] MA eligibles are defined as Medicare beneficiaries with Part A and Part B. Eligibles are calculated using the Medicare denominator file.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

## Table 5-3a
## MA[1] enrollment by urbanicity, 2006–2008[2]

| Urbanicity | Enrollment[3] | % of total enrollment | % of total eligibles[4] | % of subpopulation eligibles[4] |
|---|---|---|---|---|
| 2008 | | | | |
| Total MA | 7,735,237 | 100.0 | 19.0 | — |
| Urbanicity[5] | | | | |
| Urban | 6,771,156 | 87.6 | 16.6 | 21.3 |
| Large urban | 4,550,528 | 58.8 | 11.2 | 23.9 |
| Medium urban | 1,675,431 | 21.7 | 4.1 | 20.0 |
| Small urban | 545,197 | 7.0 | 1.3 | 12.3 |
| Rural | 962,461 | 12.4 | 2.4 | 10.9 |
| Rural–urban adjacent | 720,944 | 9.3 | 1.8 | 12.5 |
| Rural–not adjacent | 241,517 | 3.1 | 0.6 | 8.0 |
| 2007 | | | | |
| Total MA | 6,793,883 | 100.0 | 17.2 | — |
| Urbanicity[5] | | | | |
| Urban | 6,025,171 | 88.7 | 15.2 | 19.5 |
| Large urban | 4,146,339 | 61.0 | 10.5 | 22.4 |
| Medium urban | 1,442,152 | 21.2 | 3.6 | 17.7 |
| Small urban | 436,680 | 6.4 | 1.1 | 10.1 |
| Rural | 768,680 | 11.3 | 1.9 | 8.9 |
| Rural–urban adjacent | 577,812 | 8.5 | 1.5 | 10.2 |
| Rural–not adjacent | 190,867 | 2.8 | 0.5 | 6.4 |
| 2006 | | | | |
| Total MA | 5,713,606 | 100.0 | 14.7 | — |
| Urbanicity[5] | | | | |
| Urban | 5,219,075 | 91.4 | 13.5 | 17.2 |
| Large urban | 3,764,806 | 65.9 | 9.7 | 20.7 |
| Medium urban | 1,159,676 | 20.3 | 3.0 | 14.6 |
| Small urban | 294,592 | 5.2 | 0.8 | 7.1 |
| Rural | 493,158 | 8.6 | 1.2 | 5.9 |
| Rural–urban adjacent | 380,623 | 6.7 | 1.0 | 6.9 |
| Rural–not adjacent | 112,536 | 2.0 | 0.3 | 3.9 |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, local PPO, regional PPO, PFFS, and MSA.

[4] MA eligibles are defined as Medicare beneficiaries with Part A and B. Eligibles are calculated using the Medicare denominator file.

[5] Urbanicity is undefined in our analysis for a few counties (e.g., certain counties in Alaska); therefore, the sum of urban and rural enrollment is slightly less than total enrollment.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

## Table 5-3b
## Change in MA[1] enrollment by urbanicity, 2006–2008[2]

| Urbanicity | Change % Enrollment[3] | Change in % points, % of total enrollment | Change in % points, % of total eligibles[4] | Change in % points, % of subpopulation eligibles[4] |
|---|---|---|---|---|
| Change 2007 to 2008 | | | | |
| Total MA | 13.9 | — | 1.8 | — |
| Urbanicity[5] | | | | |
| Urban | 12.4 | −1.1 | 1.4 | 1.8 |
| Large urban | 9.7 | −2.2 | 0.7 | 1.5 |
| Medium urban | 16.2 | 0.4 | 0.5 | 2.3 |
| Small urban | 24.9 | 0.6 | 0.2 | 2.2 |
| Rural | 25.2 | 1.1 | 0.4 | 2.0 |
| Rural–urban adjacent | 24.8 | 0.8 | 0.3 | 2.2 |
| Rural–not adjacent | 26.5 | 0.3 | 0.1 | 1.5 |
| Change 2006 to 2007 | | | | |
| Total MA | 18.9 | — | 2.5 | — |
| Urbanicity[5] | | | | |
| Urban | 15.4 | −2.7 | 1.8 | 2.3 |
| Large urban | 10.1 | −4.9 | 0.7 | 1.7 |
| Medium urban | 24.4 | 0.9 | 0.6 | 3.1 |
| Small urban | 48.2 | 1.3 | 0.3 | 3.0 |
| Rural | 55.9 | 2.7 | 0.7 | 3.0 |
| Rural–urban adjacent | 51.8 | 1.8 | 0.4 | 3.3 |
| Rural–not adjacent | 69.6 | 0.8 | 0.2 | 2.5 |
| Change 2006 to 2008 | | | | |
| Total MA | 35.4 | — | 4.3 | — |
| Urbanicity[5] | | | | |
| Urban | 29.7 | −3.8 | 3.2 | 4.1 |
| Large urban | 20.9 | −7.1 | 1.4 | 3.2 |
| Medium urban | 44.5 | 1.4 | 1.1 | 5.4 |
| Small urban | 85.1 | 1.9 | 0.5 | 5.2 |
| Rural | 95.2 | 3.8 | 1.1 | 5.0 |
| Rural–urban adjacent | 89.4 | 2.7 | 0.7 | 5.6 |
| Rural–not adjacent | 114.6 | 1.2 | 0.3 | 4.0 |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, local PPO, regional PPO, PFFS, and MSA.

[4] MA eligibles are defined as Medicare beneficiaries with Part A and B. Eligibles are calculated using the Medicare denominator file.

[5] Urbanicity is undefined in our analysis for a few counties (e.g., certain counties in Alaska); therefore, the sum of urban and rural enrollment is slightly less than total enrollment.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-4a**
**MA[1] enrollment by census region, 2006–2008[2]**

| Census region | Enrollment[3] | % of total enrollment | % of total eligibles[4] | % of subpopulation eligibles[4] |
|---|---|---|---|---|
| 2008 | | | | |
| Total MA | 7,735,237 | 100.0 | 19.0 | — |
| Census region | | | | |
| Northeast | 1,650,271 | 21.3 | 4.1 | 20.9 |
| Midwest | 1,330,603 | 17.2 | 3.3 | 14.1 |
| South | 2,550,934 | 33.0 | 6.3 | 16.7 |
| West | 2,203,430 | 28.5 | 5.4 | 27.2 |
| 2007 | | | | |
| Total MA | 6,793,883 | 100.0 | 17.2 | — |
| Census region | | | | |
| Northeast | 1,493,699 | 22.0 | 3.8 | 19.4 |
| Midwest | 1,100,860 | 16.2 | 2.8 | 11.9 |
| South | 2,191,843 | 32.3 | 5.5 | 14.8 |
| West | 2,007,481 | 29.5 | 5.1 | 25.5 |
| 2006 | | | | |
| Total MA | 5,713,606 | 100.0 | 14.7 | — |
| Census region | | | | |
| Northeast | 1,317,785 | 23.1 | 3.4 | 17.6 |
| Midwest | 840,295 | 14.7 | 2.2 | 9.3 |
| South | 1,725,750 | 30.2 | 4.5 | 11.9 |
| West | 1,829,777 | 32.0 | 4.8 | 23.9 |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, local PPO, regional PPO, PFFS, and MSA.

[4] MA eligibles are defined as Medicare beneficiaries with Part A and B. Eligibles are calculated using the Medicare denominator file.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-4b**
**Change in MA[1] enrollment by census region, 2006–2008[2]**

| Census region | Change %, Enrollment[3] | Change in % points, % of total enrollment | Change in % points, % of total eligibles[4] | Change in % points, % of subpopulation eligibles[4] |
|---|---|---|---|---|
| Change 2007 to 2008 | | | | |
| Total MA | 13.9 | — | 1.8 | — |
| Census region | | | | |
| Northeast | 10.5 | −0.7 | 0.3 | 1.6 |
| Midwest | 20.9 | 1.0 | 0.5 | 2.2 |
| South | 16.4 | 0.7 | 0.7 | 1.9 |
| West | 9.8 | −1.1 | 0.3 | 1.6 |
| Change 2006 to 2007 | | | | |
| Total MA | 18.9 | — | 2.5 | — |
| Census region | | | | |
| Northeast | 13.3 | −1.1 | 0.4 | 1.8 |
| Midwest | 31.0 | 1.5 | 0.6 | 2.6 |
| South | 27.0 | 2.1 | 1.0 | 2.9 |
| West | 9.7 | −2.5 | 0.3 | 1.6 |
| Change 2006 to 2008 | | | | |
| Total MA | 35.4 | — | 4.3 | — |
| Census region | | | | |
| Northeast | 25.2 | −1.7 | 0.7 | 3.4 |
| Midwest | 58.3 | 2.5 | 1.1 | 4.8 |
| South | 47.8 | 2.8 | 1.8 | 4.8 |
| West | 20.4 | −3.5 | 0.6 | 3.2 |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, local PPO, regional PPO, PFFS, and MSA.

[4] MA eligibles are defined as Medicare beneficiaries with Part A and B. Eligibles are calculated using the Medicare denominator file.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

For MA enrollment broken out by plan type and urbanicity, Table 5-5 (a and b) and Table 5-6 (a and b) list column and row percentages. As shown in the tables, among HMO enrollees in 2008, only 5.0 percent (column percentage in Table 5-5a) resided in rural areas. This can be contrasted with 33.9 percent of PFFS enrollees residing in rural areas. However, 66.1 percent of PFFS enrollment was in urban areas, with approximately two-thirds of the urban PFFS enrollment in medium and small urban areas. Interestingly, the percentage of MA enrollees in large urban areas decreased by more than 7 percentage points between 2006 and 2008 (column percentage in Table 5-5b), showing that, in recent years, the distribution of MA enrollees has had some shift from urban to rural.

With PFFS accounting for 58.9 percent of rural enrollment in 2008 (row percentage in Table 5-6a), clearly PFFS has raised MA enrollment in rural areas. In addition, PFFS accounted for 51.3 percent of small urban enrollment. The distribution of MA enrollment is changing. From 2006 to 2008, the percentage of rural enrollment in PFFS plans increased by 5.7 percentage points (row percentage in Table 5-6b), and for regional PPOs the increase was almost as high as 4.7 percentage points. By contrast, the percentage for HMOs decreased by 12.0 percentage points over this time period. Similarly, the percentage of small urban enrollment in PFFS plans increased by 7.5 percentage points between 2006 and 2008, compared with a 14.2 percentage point decrease for HMOs. The Conference Report for the Medicare Modernization Act (MMA) of 2003 cited a decline in plan participation and indicated that the immediate changes to the payment methodology for the MA program were included in the law to "encourage plan entry," adding that "The goal is to increase beneficiary choice, by increasing private plan participation in Medicare." This Conference Report also referred to bringing greater health plan choices to areas not previously served by private plans, particularly rural areas.

The regional PPO option was created, in part, to provide more MA options to rural beneficiaries. In 2008, the regional PPO option drew 26.5 percent of their total enrollment from rural areas (see the column percentage in Table 5-5a), five times that of HMOs, but only three-fourths the percentage of PFFS. Regional PPOs accounted for 7.9 percent of total rural MA enrollment (see the row percentage in Table 5-6a). Over half of rural MA enrollees were in PFFS plans, with most of the remainder in HMOs. In contrast, 73.1 percent of urban MA enrollees were in HMOs, with only 16.3 percent in PFFS plans.

For MA enrollment broken out by plan type and census region, Table 5-7 (a and b) and Table 5-8 (a and b) list column and row percentages. Nearly 60 percent of regional PPO enrollment in 2008 was in the South (57.3 percent; see the column percentage in Table 5-7a) and 40.6 percent of PFFS enrollment was in the South. Regional PPOs and PFFS plans each captured less than 10 percent of their MA enrollment in the Northeast. Interestingly, the percentage of regional PPO enrollment in the Midwest increased by 3.3 percentage points from 2007 to 2008, and dropped by 2.0 percentage points in both the South and the West (see the column percentages in Table 5-7b). Among the MA enrollees residing in the Northeast census region, more than 8 out of 10 enrollees were in an HMO (81.1 percent; see the row percentage in Table 5-8a). The West region was also dominated by HMOs, with 79.1 percent of Western enrollees. This substantially differs from the Midwest and South census regions, where a higher proportion

## Table 5-5a
## MA[1] enrollment, plan type by urbanicity,[2] column percentages, 2006–2008[3]

| Urbanicity | Total (%) | HMO[4] (%) | Local PPO (%) | Regional PPO (%) | PFFS (%) | MSA[5] (%) |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Total MA | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Urban | 87.6 | 95.0 | 89.6 | 73.5 | 66.1 | 86.5 |
| Large urban | 58.8 | 73.0 | 48.0 | 39.7 | 21.6 | 33.6 |
| Medium urban | 21.7 | 18.6 | 32.2 | 21.8 | 27.8 | 45.5 |
| Small urban | 7.0 | 3.4 | 9.4 | 12.0 | 16.7 | 7.4 |
| Rural | 12.4 | 5.0 | 10.4 | 26.5 | 33.9 | 13.5 |
| Rural–urban adjacent | 9.3 | 4.5 | 9.0 | 18.7 | 23.0 | 13.5 |
| Rural–not adjacent | 3.1 | 0.6 | 1.3 | 7.8 | 10.9 | 0.0 |
| 2007 | | | | | | |
| Total MA | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Urban | 88.7 | 95.4 | 91.0 | 78.4 | 67.1 | 68.5 |
| Large urban | 61.0 | 74.3 | 51.2 | 41.9 | 21.7 | 24.4 |
| Medium urban | 21.2 | 18.0 | 31.9 | 25.2 | 29.0 | 20.5 |
| Small urban | 6.4 | 3.1 | 7.9 | 11.2 | 16.4 | 23.5 |
| Rural | 11.3 | 4.6 | 9.0 | 21.6 | 32.9 | 31.5 |
| Rural–urban adjacent | 8.5 | 4.1 | 7.6 | 15.3 | 22.6 | 19.7 |
| Rural–not adjacent | 2.8 | 0.5 | 1.4 | 6.3 | 10.3 | 11.9 |
| 2006 | | | | | | |
| Total MA | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | — |
| Urban | 91.4 | 95.8 | 91.8 | 82.1 | 65.9 | — |
| Large urban | 65.9 | 75.1 | 54.7 | 44.3 | 17.6 | — |
| Medium urban | 20.3 | 17.7 | 30.2 | 28.0 | 31.5 | — |
| Small urban | 5.2 | 3.0 | 6.9 | 9.8 | 16.8 | — |
| Rural | 8.6 | 4.2 | 8.2 | 17.9 | 34.1 | — |
| Rural–urban adjacent | 6.7 | 3.8 | 7.0 | 13.6 | 23.1 | — |
| Rural–not adjacent | 2.0 | 0.5 | 1.2 | 4.3 | 11.0 | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Urbanicity is undefined in our analysis for a few counties (e.g., certain counties in Alaska); therefore, the sum of urban and rural enrollment is slightly less than total enrollment.

[3] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[4] Includes HMO, POS, and PSO plans.

[5] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

## Table 5-5b
## Change in MA[1] enrollment, plan type by urbanicity,[2] column percentages, 2006–2008[3]

| Urbanicity | Total (%) | HMO[4] (%) | Local PPO (%) | Regional PPO (%) | PFFS (%) | MSA[5] (%) |
|---|---|---|---|---|---|---|
| Change in percentage points, 2007 to 2008 | | | | | | |
| Total MA | — | — | — | — | — | — |
| Urban | −1.1 | −0.4 | −1.3 | −4.9 | −1.0 | 18.0 |
| Large urban | −2.2 | −1.3 | −3.2 | −2.2 | −0.1 | 9.2 |
| Medium urban | 0.4 | 0.6 | 0.3 | −3.4 | −1.3 | 24.9 |
| Small urban | 0.6 | 0.3 | 1.6 | 0.7 | 0.3 | −16.1 |
| Rural | 1.1 | 0.4 | 1.3 | 4.9 | 1.0 | −18.0 |
| Rural–urban adjacent | 0.8 | 0.4 | 1.4 | 3.4 | 0.5 | −6.1 |
| Rural–not adjacent | 0.3 | 0.0 | −0.1 | 1.5 | 0.6 | −11.9 |
| Change in percentage points, 2006 to 2007 | | | | | | |
| Total MA | — | — | — | — | — | — |
| Urban | −2.7 | −0.4 | −0.9 | −3.7 | 1.3 | — |
| Large urban | −4.9 | −0.8 | −3.5 | −2.3 | 4.1 | — |
| Medium urban | 0.9 | 0.3 | 1.7 | −2.8 | −2.4 | — |
| Small urban | 1.3 | 0.1 | 0.9 | 1.4 | −0.4 | — |
| Rural | 2.7 | 0.4 | 0.9 | 3.7 | −1.3 | — |
| Rural–urban adjacent | 1.8 | 0.3 | 0.6 | 1.7 | −0.6 | — |
| Rural–not adjacent | 0.8 | 0.1 | 0.2 | 2.0 | −0.7 | — |
| Change in percentage points, 2006 to 2008 | | | | | | |
| Total MA | — | — | — | — | — | — |
| Urban | −3.8 | −0.8 | −2.2 | −8.6 | 0.2 | — |
| Large urban | −7.1 | −2.1 | −6.7 | −4.6 | 4.0 | — |
| Medium urban | 1.4 | 0.9 | 2.0 | −6.2 | −3.7 | — |
| Small urban | 1.9 | 0.4 | 2.5 | 2.2 | −0.1 | — |
| Rural | 3.8 | 0.8 | 2.2 | 8.6 | −0.2 | — |
| Rural–urban adjacent | 2.7 | 0.7 | 2.1 | 5.1 | −0.1 | — |
| Rural–not adjacent | 1.2 | 0.1 | 0.1 | 3.5 | −0.1 | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Urbanicity is undefined in our analysis for a few counties (e.g., certain counties in Alaska); therefore, the sum of urban and rural enrollment is slightly less than total enrollment.

[3] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[4] Includes HMO, POS, and PSO plans.

[5] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

## Table 5-6a
## MA[1] enrollment, plan type by urbanicity,[2] row percentages, 2006–2008[3]

| Urbanicity | Total (%) | HMO[4] (%) | Local PPO (%) | Regional PPO (%) | PFFS (%) | MSA[5] (%) |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Total MA | 100.0 | 67.4 | 7.3 | 3.7 | 21.6 | 0.0 |
| Urban | 100.0 | 73.1 | 7.5 | 3.1 | 16.3 | 0.0 |
| Large urban | 100.0 | 83.6 | 6.0 | 2.5 | 7.9 | 0.0 |
| Medium urban | 100.0 | 57.7 | 10.8 | 3.7 | 27.7 | 0.0 |
| Small urban | 100.0 | 32.6 | 9.8 | 6.3 | 51.3 | 0.0 |
| Rural | 100.0 | 27.2 | 6.1 | 7.9 | 58.9 | 0.0 |
| Rural–urban adjacent | 100.0 | 32.2 | 7.1 | 7.4 | 53.4 | 0.0 |
| Rural–not adjacent | 100.0 | 12.3 | 3.1 | 9.3 | 75.3 | 0.0 |
| 2007 | | | | | | |
| Total MA | 100.0 | 70.8 | 5.1 | 2.9 | 21.2 | 0.0 |
| Urban | 100.0 | 76.2 | 5.2 | 2.5 | 16.0 | 0.0 |
| Large urban | 100.0 | 86.2 | 4.3 | 2.0 | 7.5 | 0.0 |
| Medium urban | 100.0 | 60.0 | 7.7 | 3.4 | 28.9 | 0.0 |
| Small urban | 100.0 | 34.5 | 6.3 | 5.0 | 54.1 | 0.1 |
| Rural | 100.0 | 28.9 | 4.1 | 5.5 | 61.5 | 0.1 |
| Rural–urban adjacent | 100.0 | 34.1 | 4.6 | 5.1 | 56.1 | 0.1 |
| Rural–not adjacent | 100.0 | 13.1 | 2.6 | 6.4 | 77.7 | 0.1 |
| 2006 | | | | | | |
| Total MA | 100.0 | 80.2 | 4.8 | 1.5 | 13.4 | — |
| Urban | 100.0 | 84.1 | 4.8 | 1.4 | 9.7 | — |
| Large urban | 100.0 | 91.4 | 4.0 | 1.0 | 3.6 | — |
| Medium urban | 100.0 | 69.9 | 7.1 | 2.1 | 20.8 | — |
| Small urban | 100.0 | 46.8 | 6.5 | 2.9 | 43.9 | — |
| Rural | 100.0 | 39.1 | 4.5 | 3.1 | 53.2 | — |
| Rural–urban adjacent | 100.0 | 45.2 | 5.0 | 3.1 | 46.7 | — |
| Rural–not adjacent | 100.0 | 18.5 | 3.0 | 3.3 | 75.2 | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Urbanicity is undefined in our analysis for a few counties (e.g., certain counties in Alaska); therefore, the sum of urban and rural enrollment is slightly less than total enrollment.

[3] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[4] Includes HMO, POS, and PSO plans.

[5] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

## Table 5-6b
## Change in MA[1] enrollment, plan type by urbanicity,[2] row percentages, 2006–2008[3]

| Urbanicity | Total (%) | HMO[4] (%) | Local PPO (%) | Regional PPO (%) | PFFS (%) | MSA[5] (%) |
|---|---|---|---|---|---|---|
| Change in percentage points, 2007 to 2008 | | | | | | |
| Total MA | — | −3.5 | 2.2 | 0.8 | 0.5 | 0.0 |
| Urban | — | −3.1 | 2.2 | 0.6 | 0.3 | 0.0 |
| Large urban | — | −2.6 | 1.7 | 0.5 | 0.4 | 0.0 |
| Medium urban | — | −2.3 | 3.2 | 0.3 | −1.2 | 0.0 |
| Small urban | — | −1.9 | 3.5 | 1.3 | −2.8 | −0.1 |
| Rural | — | −1.7 | 2.0 | 2.4 | −2.6 | −0.1 |
| Rural–urban adjacent | — | −2.0 | 2.5 | 2.3 | −2.7 | −0.1 |
| Rural–not adjacent | — | −0.8 | 0.5 | 2.9 | −2.4 | −0.1 |
| Change in percentage points, 2006 to 2007 | | | | | | |
| Total MA | — | −9.4 | 0.3 | 1.3 | 7.7 | — |
| Urban | — | −7.9 | 0.4 | 1.2 | 6.3 | — |
| Large urban | — | −5.2 | 0.3 | 0.9 | 3.9 | — |
| Medium urban | — | −10.0 | 0.6 | 1.3 | 8.1 | — |
| Small urban | — | −12.3 | −0.2 | 2.1 | 10.2 | — |
| Rural | — | −10.2 | −0.5 | 2.3 | 8.3 | — |
| Rural–urban adjacent | — | −11.1 | −0.4 | 2.0 | 9.4 | — |
| Rural–not adjacent | — | −5.4 | −0.4 | 3.1 | 2.5 | — |
| Change in percentage points, 2006 to 2008 | | | | | | |
| Total MA | — | −12.9 | 2.5 | 2.2 | 8.2 | — |
| Urban | — | −11.0 | 2.7 | 1.7 | 6.6 | — |
| Large urban | — | −7.8 | 2.0 | 1.5 | 4.3 | — |
| Medium urban | — | −12.2 | 3.7 | 1.6 | 6.9 | — |
| Small urban | — | −14.2 | 3.3 | 3.4 | 7.5 | — |
| Rural | — | −12.0 | 1.5 | 4.7 | 5.7 | — |
| Rural–urban adjacent | — | −13.1 | 2.1 | 4.3 | 6.7 | — |
| Rural–not adjacent | — | −6.3 | 0.2 | 6.0 | 0.1 | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Urbanicity is undefined in our analysis for a few counties (e.g., certain counties in Alaska); therefore, the sum of urban and rural enrollment is slightly less than total enrollment.

[3] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[4] Includes HMO, POS, and PSO plans.

[5] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-7a**
**MA[1] enrollment, plan type by census regions, column percentages, 2006–2008[2]**

| Census region | Total (%) | HMO[3] (%) | Local PPO (%) | Regional PPO (%) | PFFS (%) | MSA[4] (%) |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Total MA | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Northeast | 21.3 | 25.7 | 27.7 | 4.7 | 8.5 | 66.2 |
| Midwest | 17.2 | 11.0 | 17.8 | 21.1 | 35.8 | 30.0 |
| South | 33.0 | 29.9 | 26.4 | 57.3 | 40.6 | 3.2 |
| West | 28.5 | 33.4 | 28.2 | 16.9 | 15.1 | 0.6 |
| 2007 | | | | | | |
| Total MA | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Northeast | 22.0 | 26.2 | 34.1 | 4.0 | 7.5 | 7.8 |
| Midwest | 16.2 | 10.8 | 17.5 | 17.9 | 33.8 | 8.4 |
| South | 32.3 | 28.5 | 20.2 | 59.2 | 44.1 | 64.9 |
| West | 29.5 | 34.6 | 28.2 | 18.9 | 14.6 | 18.8 |
| 2006 | | | | | | |
| Total MA | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | — |
| Northeast | 23.1 | 25.9 | 34.6 | 4.3 | 3.9 | — |
| Midwest | 14.7 | 10.8 | 17.0 | 12.1 | 37.7 | — |
| South | 30.2 | 27.9 | 21.2 | 58.3 | 43.8 | — |
| West | 32.0 | 35.4 | 27.2 | 25.3 | 14.6 | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, POS, and PSO plans.

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-7b**
**Change in MA[1] enrollment, plan type by census regions, column percentages, 2006–2008[2]**

| Census region | Total (%) | HMO[3] (%) | Local PPO (%) | Regional PPO (%) | PFFS (%) | MSA[4] (%) |
|---|---|---|---|---|---|---|
| Change in percentage points, 2007 to 2008 | | | | | | |
| Total MA | — | — | — | — | — | — |
| Northeast | −0.7 | −0.5 | −6.5 | 0.7 | 1.1 | 58.3 |
| Midwest | 1.0 | 0.2 | 0.3 | 3.3 | 1.9 | 21.6 |
| South | 0.7 | 1.4 | 6.2 | −1.9 | −3.6 | −61.7 |
| West | −1.1 | −1.1 | 0.0 | −2.0 | 0.6 | −18.2 |
| Change in percentage points, 2006 to 2007 | | | | | | |
| Total MA | — | — | — | — | — | — |
| Northeast | −1.1 | 0.2 | −0.5 | −0.3 | 3.6 | — |
| Midwest | 1.5 | 0.0 | 0.6 | 5.8 | −3.8 | — |
| South | 2.1 | 0.6 | −1.0 | 0.9 | 0.3 | — |
| West | −2.5 | −0.8 | 0.9 | −6.3 | −0.1 | — |
| Change in percentage points, 2006 to 2008 | | | | | | |
| Total MA | — | — | — | — | — | — |
| Northeast | −1.7 | −0.3 | −6.9 | 0.3 | 4.6 | — |
| Midwest | 2.5 | 0.2 | 0.8 | 9.0 | −1.9 | — |
| South | 2.8 | 2.0 | 5.2 | −1.0 | −3.2 | — |
| West | −3.5 | −1.9 | 0.9 | −8.3 | 0.5 | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, POS, and PSO plans.

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-8a**
**MA[1] enrollment, plan type by census regions, row percentages, 2006–2008[2]**

| Census region | Total (%) | HMO[3] (%) | Local PPO (%) | Regional PPO (%) | PFFS (%) | MSA[4] (%) |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Total MA | 100.0 | 67.4 | 7.3 | 3.7 | 21.6 | 0.0 |
| Northeast | 100.0 | 81.1 | 9.5 | 0.8 | 8.6 | 0.0 |
| Midwest | 100.0 | 42.9 | 7.6 | 4.5 | 45.0 | 0.0 |
| South | 100.0 | 61.2 | 5.8 | 6.4 | 26.6 | 0.0 |
| West | 100.0 | 79.1 | 7.2 | 2.2 | 11.5 | 0.0 |
| 2007 | | | | | | |
| Total MA | 100.0 | 70.8 | 5.1 | 2.9 | 21.2 | 0.0 |
| Northeast | 100.0 | 84.3 | 7.9 | 0.5 | 7.2 | 0.0 |
| Midwest | 100.0 | 47.1 | 5.5 | 3.1 | 44.2 | 0.0 |
| South | 100.0 | 62.6 | 3.2 | 5.2 | 28.9 | 0.1 |
| West | 100.0 | 82.9 | 4.9 | 1.8 | 10.4 | 0.0 |
| 2006 | | | | | | |
| Total MA | 100.0 | 80.2 | 4.8 | 1.5 | 13.4 | — |
| Northeast | 100.0 | 90.2 | 7.2 | 0.3 | 2.3 | — |
| Midwest | 100.0 | 58.8 | 5.5 | 1.2 | 34.4 | — |
| South | 100.0 | 74.2 | 3.4 | 2.9 | 19.5 | — |
| West | 100.0 | 88.6 | 4.1 | 1.2 | 6.1 | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, POS, and PSO plans.

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-8b**
**Change in MA[1] enrollment, plan type by census regions, row percentages, 2006–2008[2]**

| Census region | Total (%) | HMO[3] (%) | Local PPO (%) | Regional PPO (%) | PFFS (%) | MSA[4] (%) |
|---|---|---|---|---|---|---|
| Change in percentage points, 2007 to 2008 | | | | | | |
| Total MA | — | −3.5 | 2.2 | 0.8 | 0.5 | 0.0 |
| Northeast | — | −3.3 | 1.5 | 0.3 | 1.4 | 0.0 |
| Midwest | — | −4.2 | 2.0 | 1.4 | 0.8 | 0.0 |
| South | — | −1.4 | 2.6 | 1.2 | −2.3 | −0.1 |
| West | — | −3.7 | 2.3 | 0.4 | 1.1 | 0.0 |
| Change in percentage points, 2006 to 2007 | | | | | | |
| Total MA | — | −9.4 | 0.3 | 1.3 | 7.7 | — |
| Northeast | — | −5.9 | 0.7 | 0.2 | 4.9 | — |
| Midwest | — | −11.6 | 0.0 | 1.9 | 9.7 | — |
| South | — | −11.7 | −0.2 | 2.3 | 9.4 | — |
| West | — | −5.7 | 0.8 | 0.6 | 4.3 | — |
| Change in percentage points, 2006 to 2008 | | | | | | |
| Total MA | — | −12.9 | 2.5 | 2.2 | 8.2 | — |
| Northeast | — | −9.2 | 2.3 | 0.5 | 6.4 | — |
| Midwest | — | −15.8 | 2.0 | 3.3 | 10.5 | — |
| South | — | −13.1 | 2.5 | 3.5 | 7.1 | — |
| West | — | −9.5 | 3.1 | 1.0 | 5.3 | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, POS, and PSO plans.

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

of MA enrollees chose PFFS plans. For example, among Midwest MA enrollees, 45.0 percent were in a PFFS plan, with 42.9 percent in an HMO. Because the MA take-up rate for Midwesterners was relatively low (14.1 percent in Table 5-4a), PFFS plans appeared to be an important MA option in the Midwest.

## 5.3 By Special Needs Plans and Part D

Table 5-9 (a through g) provide special needs plans (SNP) enrollment by MA plan type. Among MA enrollees in 2008, more than 1 million (13.0 percent) were enrolled in an SNP, which was approximately one-third higher than in 2007.

Among SNP enrollees, approximately two-thirds were enrolled in a dual-eligible SNP, with 19.4 percent enrolled in a chronic-condition SNP, and 13.2 percent were enrolled in an institutional SNP. Enrollment in chronic-condition SNPs did increase substantially from 74,039 to 194,497 between 2007 and 2008. Most SNP enrollees (838,003 out of 1,002,334) were in HMOs. Approximately three-fourths of HMO SNP enrollees were in dual-eligible SNPs (76.7 percent). Interestingly, regional PPOs had the highest percentage of their enrollment in SNPs (27.4 percent), with a relatively strong chronic-condition SNP presence. HMOs and local PPOs also had a significant percentage of their enrollment in SNPs (16.1 percent and 15.2 percent, respectively). SNPs can only be offered as a coordinated care plan; therefore, an SNP cannot be offered through the PFFS or MSA models.

Finally, Table 5-10 (a through g) list Part D enrollment statistics for MA enrollees. At 93.7 percent, the vast majority of MA enrollees (7.2 million) in 2008 were enrolled in the Medicare Part D drug program. The Part D take-up rate for each plan type was approximately 90 percent, with PFFS and MSA enrollees slightly less likely to have Part D coverage than enrollees in other plan types. Almost all of the MA enrollees in Part D were enrolled in a Medicare Advantage Prescription Drug Plan (MA-PD) (92.9 percent), although 7.1 percent were enrolled in a stand-alone prescription drug plan (PDP). However, the percentage of MA enrollees in Part D that were enrolled in a stand-alone PDP increased by 3.7 percentage points between 2006 and 2008. PFFS plans are not required to offer Part D, and, if they do not, their enrollees are allowed to enroll in a stand-alone Part D drug plan. Approximately one-third of PFFS enrollees with Part D coverage in 2008 were enrolled in stand-alone drug plans.

**Table 5-9a**
**MA[1] SNP enrollment, by plan type, 2006–2008[2]**

| SNP enrollment | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA[4] |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Total MA | 7,735,237 | 5,212,401 | 564,692 | 285,841 | 1,671,830 | 473 |
| SNP[4] | 1,002,334 | 838,033 | 85,936 | 78,365 | 0 | 0 |
| Dual eligible | 675,110 | 642,425 | 19,898 | 12,787 | 0 | 0 |
| Institutional | 132,727 | 112,811 | 19,911 | 0 | 0 | 0 |
| Chronic condition | 194,497 | 82,797 | 46,127 | 65,578 | 0 | 0 |
| Non-SNP | 6,732,903 | 4,374,368 | 478,756 | 207,476 | 1,671,830 | 473 |
| % of SNP of total MA | 13.0% | 16.1% | 15.2% | 27.4% | 0.0% | 0.0% |
| Dual eligible % of SNP | 67.4% | 76.7% | 23.2% | 16.3% | 0.0% | 0.0% |
| Institutional % of SNP | 13.2% | 13.5% | 23.2% | 0.0% | 0.0% | 0.0% |
| Chronic condition % of SNP | 19.4% | 9.9% | 53.7% | 83.7% | 0.0% | 0.0% |
| Non-SNP % of total MA | 87.0% | 83.9% | 84.8% | 72.6% | 100.0% | 100.0% |
| 2007 | | | | | | |
| Total MA | 6,793,883 | 4,813,240 | 347,670 | 193,713 | 1,437,000 | 2,260 |
| SNP[4] | 746,408 | 651,650 | 45,754 | 49,004 | 0 | 0 |
| Dual eligible | 527,633 | 508,390 | 10,179 | 9,064 | 0 | 0 |
| Institutional | 144,736 | 122,903 | 21,833 | 0 | 0 | 0 |
| Chronic condition | 74,039 | 20,357 | 13,742 | 39,940 | 0 | 0 |
| Non-SNP | 6,047,475 | 4,161,590 | 301,916 | 144,709 | 1,437,000 | 2,260 |
| % of SNP of total MA | 11.0% | 13.5% | 13.2% | 25.3% | 0.0% | 0.0% |

(continued)

**Table 5-9a (continued)**
**MA[1] SNP enrollment, by plan type, 2006–2008[2]**

| SNP enrollment | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA[4] |
|---|---|---|---|---|---|---|
| Dual eligible % of SNP | 70.7% | 78.0% | 22.2% | 18.5% | 0.0% | 0.0% |
| Institutional % of SNP | 19.4% | 18.9% | 47.7% | 0.0% | 0.0% | 0.0% |
| Chronic condition % of SNP | 9.9% | 3.1% | 30.0% | 81.5% | 0.0% | 0.0% |
| Non-SNP % of total MA | 89.0% | 86.5% | 86.8% | 74.7% | 100.0% | 100.0% |
| 2006 | | | | | | |
| Total MA | 5,713,606 | 4,585,076 | 273,797 | 86,409 | 768,324 | — |
| SNP[4] | 488,725 | 460,701 | 24,659 | 3,365 | 0 | — |
| Dual eligible | 364,932 | 354,854 | 6,713 | 3,365 | 0 | — |
| Institutional | 122,303 | 104,357 | 17,946 | 0 | 0 | — |
| Chronic condition | 1,490 | 1,490 | 0 | 0 | 0 | — |
| Non-SNP | 5,224,881 | 4,124,375 | 249,138 | 83,044 | 768,324 | — |
| % of SNP of total MA | 8.6% | 10.0% | 9.0% | 3.9% | 0.0% | — |
| Dual eligible % of SNP | 74.7% | 77.0% | 27.2% | 100.0% | 0.0% | — |
| Institutional % of SNP | 25.0% | 22.7% | 72.8% | 0.0% | 0.0% | — |
| Chronic condition % of SNP | 0.3% | 0.3% | 0.0% | 0.0% | 0.0% | — |
| Non-SNP % of total MA | 91.4% | 90.0% | 91.0% | 96.1% | 100.0% | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, POS, and PSO plans.

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-9b**
**Change in %, MA[1] SNP enrollment, by plan type, 2007–2008[2]**

| SNP enrollment | % Change total | % Change HMO[3] | % Change Local PPO | % Change Regional PPO | % Change PFFS | % Change MSA[4] |
|---|---|---|---|---|---|---|
| Change 2007 to 2008 | | | | | | |
| Total MA | 13.9 | 8.3 | 62.4 | 47.6 | 16.3 | −79.1 |
| SNP[4] | 34.3 | 28.6 | 87.8 | 59.9 | — | — |
| Dual eligible | 28.0 | 26.4 | 95.5 | 41.1 | — | — |
| Institutional | −8.3 | −8.2 | −8.8 | 0.0 | — | — |
| Chronic condition | 162.7 | 306.7 | 235.7 | 64.2 | — | — |
| Non-SNP | 11.3 | 5.1 | 58.6 | 43.4 | 16.3 | −79.1 |

**Table 5-9c**
**Change in % points, MA[1] SNP enrollment, by plan type, 2007–2008[2]**

| SNP enrollment | Change in % points, total | Change in % points, HMO[3] | Change in % points, local PPO | Change in % points, regional PPO | Change in % points, PFFS | Change in % points, MSA[4] |
|---|---|---|---|---|---|---|
| Change 2007 to 2008 | | | | | | |
| % of SNP of total MA | 2.0 | 2.5 | 2.1 | 2.1 | 0.0 | 0.0 |
| Dual eligible % of SNP | −3.3 | −1.4 | 0.9 | −2.2 | 0.0 | 0.0 |
| Institutional % of SNP | −6.1 | −5.4 | −24.5 | 0.0 | 0.0 | 0.0 |
| Chronic condition % of SNP | 9.5 | 6.8 | 23.6 | 2.2 | 0.0 | 0.0 |
| Non-SNP % of total MA | −2.0 | −2.5 | −2.1 | −2.1 | 0.0 | 0.0 |

**Table 5-9d**
**Change in %, MA[1] SNP enrollment, by plan type, 2006–2007[2]**

| SNP enrollment | % Change total | % Change HMO[3] | % Change Local PPO | % Change Regional PPO | % Change PFFS | % Change MSA[4] |
|---|---|---|---|---|---|---|
| Change 2006 to 2007 | | | | | | |
| Total MA | 18.9 | 5.0 | 27.0 | 124.2 | 87.0 | — |
| SNP[4] | 52.7 | 41.4 | 85.5 | 1,356.3 | — | — |
| Dual eligible | 44.6 | 43.3 | 51.6 | 169.4 | — | — |
| Institutional | 18.3 | 17.8 | 21.7 | 0.0 | — | — |
| Chronic condition | 4,869.1 | 1,266.2 | 0.0 | 0.0 | — | — |
| Non-SNP | 15.7 | 0.9 | 21.2 | 74.3 | 87.0 | — |

**Table 5-9e**
**Change in % points, MA[1] SNP enrollment, by plan type, 2006–2007[2]**

| SNP enrollment | Change in % points, total | Change in % points, HMO[3] | Change in % points, local PPO | Change in % points, regional PPO | Change in % points, PFFS | Change in % points, MSA[4] |
|---|---|---|---|---|---|---|
| Change 2006 to 2007 | | | | | | |
| % of SNP of total MA | 2.4 | 3.5 | 4.2 | 21.4 | — | — |
| Dual eligible % of SNP | −4.0 | 1.0 | −5.0 | −81.5 | — | — |
| Institutional % of SNP | −5.6 | −3.8 | −25.1 | 0.0 | — | — |
| Chronic condition % of SNP | 9.6 | 2.8 | 30.0 | 81.5 | — | — |
| Non-SNP % of total MA | −2.4 | −3.5 | −4.2 | −21.4 | — | — |

**Table 5-9f**
**Change in MA[1] SNP enrollment, by plan type, 2006–2008[2]**

| SNP enrollment | % Change total | % Change HMO[3] | % Change Local PPO | % Change Regional PPO | % Change PFFS | % Change MSA[4] |
|---|---|---|---|---|---|---|
| Change 2006 to 2008 | | | | | | |
| Total MA | 35.4 | 13.7 | 106.2 | 230.8 | 117.6 | — |
| SNP[4] | 105.1 | 81.9 | 248.5 | 2,228.8 | — | — |
| Dual eligible | 85.0 | 81.0 | 196.4 | 280.0 | — | — |
| Institutional | 8.5 | 8.1 | 10.9 | — | — | — |
| Chronic condition | 12,953.5 | 5,456.8 | — | — | — | — |
| Non-SNP | 28.9 | 6.1 | 92.2 | 149.8 | 117.6 | — |

**Table 5-9g**
**Change in MA[1] SNP enrollment, by plan type, 2006–2008[2]**

| SNP enrollment | Change in % points, total | Change in % points, HMO[3] | Change in % points, local PPO | Change in % points, regional PPO | Change in % points, PFFS | Change in % points, MSA[4] |
|---|---|---|---|---|---|---|
| Change 2006 to 2008 | | | | | | |
| % of SNP of total MA | 4.4 | 6.0 | 6.2 | 23.5 | — | — |
| Dual eligible % of SNP | −7.3 | −0.4 | −4.1 | −83.7 | — | — |
| Institutional % of SNP | −11.8 | −9.2 | −49.6 | 0.0 | — | — |
| Chronic condition % of SNP | 19.1 | 9.6 | 53.7 | 83.7 | — | — |
| Non-SNP % of total MA | −4.4 | −6.0 | −6.2 | −23.5 | — | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, POS, and PSO plans.

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-10a**
**Part D enrollment in MA,[1] by plan type, 2006–2008[2]**

| Part D enrollment | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA[4] |
|---|---|---|---|---|---|---|
| 2008 | | | | | | |
| Total MA | 7,735,237 | 5,212,401 | 564,692 | 285,841 | 1,671,830 | 473 |
| MA enrollees in Part D | 7,247,092 | 4,961,153 | 534,664 | 272,287 | 1,478,581 | 407 |
| MA enrollees in Part D that are in MA-PD | 6,729,349 | 4,961,153 | 534,664 | 272,287 | 961,247 | 0 |
| MA enrollees in Part D that are in PDP | 517,743 | 0 | 0 | 0 | 517,334 | 407 |
| MA enrollees not in Part D | 488,145 | 251,248 | 30,028 | 13,554 | 193,249 | 66 |
| % of MA enrollees in Part D | 93.7% | 95.2% | 94.7% | 95.3% | 88.4% | 86.0% |
| % of MA enrollees in Part D that are in MA-PD | 92.9% | 100.0% | 100.0% | 100.0% | 65.0% | 0.0% |
| % of MA enrollees in Part D that are in PDP | 7.1% | 0.0% | 0.0% | 0.0% | 35.0% | 100.0% |
| % of MA enrollees not in Part D | 6.3% | 4.8% | 5.3% | 4.7% | 11.6% | 14.0% |
| 2007 | | | | | | |
| Total MA | 6,793,883 | 4,813,240 | 347,670 | 193,713 | 1,437,000 | 2,260 |
| MA enrollees in Part D | 6,316,943 | 4,549,247 | 325,903 | 183,864 | 1,256,181 | 1,748 |
| MA enrollees in Part D that are in MA-PD | 5,863,570 | 4,549,247 | 325,903 | 183,864 | 804,562 | 0 |
| MA enrollees in Part D that are in PDP | 453,373 | 0 | 0 | 0 | 451,619 | 1,748 |
| MA enrollees not in Part D | 476,940 | 263,993 | 21,767 | 9,849 | 180,819 | 512 |
| % of MA enrollees in Part D | 93.0% | 94.5% | 93.7% | 94.9% | 87.4% | 77.3% |
| % of MA enrollees in Part D that are in MA-PD | 92.8% | 100.0% | 100.0% | 100.0% | 64.0% | 0.0% |
| % of MA enrollees in Part D that are in PDP | 7.2% | 0.0% | 0.0% | 0.0% | 36.0% | 100.0% |
| % of MA enrollees not in Part D | 7.0% | 5.5% | 6.3% | 5.1% | 12.6% | 22.7% |

(continued)

**Table 5-10a (continued)**
**Part D enrollment in MA,[1] by plan type, 2006–2008[2]**

| Part D enrollment | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA[4] |
|---|---|---|---|---|---|---|
| 2006 | | | | | | |
| Total MA | 5,713,606 | 4,585,076 | 273,797 | 86,409 | 768,324 | — |
| MA enrollees in Part D | 5,309,471 | 4,301,751 | 249,855 | 79,159 | 678,706 | — |
| MA enrollees in Part D that are in MA-PD | 5,126,628 | 4,301,751 | 249,855 | 79,159 | 95,986 | — |
| MA enrollees in Part D that are in PDP | 182,843 | 0 | 0 | 0 | 182,720 | — |
| MA enrollees not in Part D | 404,135 | 283,325 | 23,942 | 7,250 | 89,618 | — |
| % of MA enrollees in Part D | 92.9% | 93.8% | 91.3% | 91.6% | 88.3% | — |
| % of MA enrollees in Part D that are in MA-PD | 96.6% | 100.0% | 100.0% | 100.0% | 73.1% | — |
| % of MA enrollees in Part D that are in PDP | 3.4% | 0.0% | 0.0% | 0.0% | 26.9% | — |
| % of MA enrollees not in Part D | 7.1% | 6.2% | 8.7% | 8.4% | 11.7% | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, POS, and PSO plans.

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

**Table 5-10b**
**Change in %, Part D enrollment in MA,[1] by plan type, 2007–2008[2]**

| Part D enrollment | % Change total (%) | % Change HMO[3] (%) | % Change Local PPO (%) | % Change Regional PPO (%) | % Change PFFS (%) | % Change MSA[4] (%) |
|---|---|---|---|---|---|---|
| Change 2007 to 2008 | | | | | | |
| Total MA | 13.9 | 8.3 | 62.4 | 47.6 | 16.3 | −79.1 |
| MA enrollees in Part D | 14.7 | 9.1 | 64.1 | 48.1 | 17.7 | −76.7 |
| MA enrollees in Part D that are in MA-PD | 14.8 | 9.1 | 64.1 | 48.1 | 19.5 | 0.0 |
| MA enrollees in Part D that are in PDP | 14.2 | 0.0 | 0.0 | 0.0 | 14.6 | −76.7 |
| MA enrollees not in Part D | 2.3 | −4.8 | 38.0 | 37.6 | 6.9 | −87.1 |

**Table 5-10c**
**Change in % points, Part D enrollment in MA,[1] by plan type, 2007–2008[2]**

| Part D enrollment | Change in % points, total (%) | Change in % points, HMO[3] (%) | Change in % points, local PPO (%) | Change in % points, regional PPO (%) | Change in % points, PFFS (%) | Change in % points, MSA[4] (%) |
|---|---|---|---|---|---|---|
| Change 2007 to 2008 | | | | | | |
| % of MA enrollees in Part D | 0.7 | 0.7 | 0.9 | 0.3 | 1.0 | 8.7 |
| % of MA enrollees in Part D that are in MA-PD | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 | 0.0 |
| % of MA enrollees in Part D that are in PDP | 0.0 | 0.0 | 0.0 | 0.0 | −1.0 | 0.0 |
| % of MA enrollees not in Part D | −0.7 | −0.7 | −0.9 | −0.3 | −1.0 | −8.7 |

**Table 5-10d**
**Change in %, Part D enrollment in MA,[1] by plan type, 2006–2007[2]**

| Part D enrollment | % Change total (%) | % Change HMO[3] (%) | % Change Local PPO (%) | % Change Regional PPO (%) | % Change PFFS (%) | % Change MSA[4] (%) |
|---|---|---|---|---|---|---|
| Change 2006 to 2007 | | | | | | |
| Total MA | 18.9 | 5.0 | 27.0 | 124.2 | 87.0 | — |
| MA enrollees in Part D | 19.0 | 5.8 | 30.4 | 132.3 | 85.1 | — |
| MA enrollees in Part D that are in MA-PD | 14.4 | 5.8 | 30.4 | 132.3 | 62.2 | — |
| MA enrollees in Part D that are in PDP | 148.1 | 0.0 | 0.0 | 0.0 | 147.2 | — |
| MA enrollees not in Part D | 18.0 | −6.8 | −9.1 | 35.8 | 101.8 | — |

**Table 5-10e**
**Change in % points, Part D enrollment in MA,[1] by plan type, 2006–2007[2]**

| Part D enrollment | Change in % points, total (%) | Change in % points, HMO[3] (%) | Change in % points, local PPO (%) | Change in % points, regional PPO (%) | Change in % points, PFFS (%) | Change in % points, MSA[4] (%) |
|---|---|---|---|---|---|---|
| Change 2006 to 2007 | | | | | | |
| % of MA enrollees in Part D | 0.1 | 0.7 | 2.5 | 3.3 | −0.9 | — |
| % of MA enrollees in Part D that are in MA-PD | −3.7 | 0.0 | 0.0 | 0.0 | −9.0 | — |
| % of MA enrollees in Part D that are in PDP | 3.7 | 0.0 | 0.0 | 0.0 | 9.0 | — |
| % of MA enrollees not in Part D | −0.1 | −0.7 | −2.5 | −3.3 | 0.9 | — |

**Table 5-10f**
**Change in %, Part D enrollment in MA,[1] by plan type, 2006–2008[2]**

| Part D enrollment | % Change total (%) | % Change HMO[3] (%) | % Change Local PPO (%) | % Change Regional PPO (%) | % Change PFFS (%) | % Change MSA[4] (%) |
|---|---|---|---|---|---|---|
| Change 2006 to 2008 | | | | | | |
| Total MA | 35.4 | 13.7 | 106.2 | 230.8 | 117.6 | — |
| MA enrollees in Part D | 36.5 | 15.3 | 114.0 | 244.0 | 117.9 | — |
| MA enrollees in Part D that are in MA-PD | 31.3 | 15.3 | 114.0 | 244.0 | 93.8 | — |
| MA enrollees in Part D that are in PDP | 183.4 | 0.0 | 0.0 | 0.0 | 183.1 | — |
| MA enrollees not in Part D | 20.8 | −11.3 | 25.4 | 87.0 | 115.6 | — |

**Table 5-10g**
**Change in % points, Part D enrollment in MA,[1] by plan type, 2006–2008[2]**

| Part D enrollment | Change in % points, total (%) | Change in % points, HMO[3] (%) | Change in % points, local PPO (%) | Change in % points, regional PPO (%) | Change in % points, PFFS (%) | Change in % points, MSA[4] (%) |
|---|---|---|---|---|---|---|
| Change 2006 to 2008 | | | | | | |
| % of MA enrollees in Part D | 0.8 | 1.4 | 3.4 | 3.6 | 0.1 | — |
| % of MA enrollees in Part D that are in MA-PD | −3.7 | 0.0 | 0.0 | 0.0 | −8.1 | — |
| % of MA enrollees in Part D that are in PDP | 3.7 | 0.0 | 0.0 | 0.0 | 8.1 | — |
| % of MA enrollees not in Part D | −0.8 | −1.4 | −3.4 | −3.6 | −0.1 | — |

[1] We exclude employer-only plans, Part B-only plans, and enrollment in Puerto Rico and U.S. territories.

[2] Enrollment figures as of July 1, 2006; July 1, 2007; and July 1, 2008.

[3] Includes HMO, POS, and PSO plans.

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2008 CMS Management Information Integrated Repository.

# SECTION 6
# IMPACT OF MEDICARE ADVANTAGE COUNTY BENCHMARK RATES

One of the primary goals of the Medicare Modernization Act (MMA) of 2003 was to expand the number and type of Medicare Advantage (MA) options available to Medicare beneficiaries, particularly in geographic areas (such as rural counties) that have traditionally been underserved by private plans. To help accomplish this goal, the MMA increased the base payment rates and raised the minimum annual rate update. Today, there is also concern from economists, members of Congress, and the current administration about excessively high payment rates to MA plans—that many MA plans are paid more for a beneficiary than it would cost Medicare if that individual was to remain in traditional Medicare (MedPAC, 2009). Some researchers argue that these "high" rates serve several purposes, such as they increase plan availability, reduce out-of-pocket (OOP) costs to the typical enrollee, and enable plans to offer additional benefits not available in traditional fee-for-service (FFS) rates (Atherly and Thorpe, 2007; Frakt, Pizer, and Feldman, 2009).

In this section, we first examine in Section 6.1 the descriptive correlation between Part C benchmark rates and FFS costs and plan availability, premiums, and OOP costs. In Section 6.2, we present a statistical analysis of the impact of the MA urban floor county payment rate on predicted MA plan enrollee OOP costs.

Medicare uses a county benchmark payment rate only for Part C (non-drug) payments. Medicare Part D (prescription drug) payments do not use county benchmark payment rates. In this section, we analyze the impact of the Part C payment benchmarks. However, the Part C payment benchmarks can affect Part D premiums and benefits because MA plans are allowed to use rebates from the Part C side to reduce Part D premiums or enhance Part D benefits.

## 6.1 Relationship of County Benchmark Rates to Plan Availability, Premiums, OOP Costs, and Enrollment

We begin with a brief overview of how plan Part C payment rates are set and the distribution of benchmark rates and benchmark rates relative to FFS costs. We then examine the descriptive correlations between benchmark rates and aspects of MA plan availability and generosity.

### 6.1.1 Part C County Benchmark Rates

Medicare Part C payments to MA plans begin with the county benchmark, although the final payment is a function of plan bidding and the demographics of the individual beneficiaries enrolled in the plans.

There have been numerous changes on how Medicare sets county payment rates over the years. In 2004, the MMA radically changed payment rates in a graduated process that will be completed by 2011. In 2004, the MMA established four payment rates for each county: a floor (urban or rural), a blended rate, 100 percent of FFS, and a minimum update that is the maximum of 2 percent or the national growth percentage. Beginning in 2005, the MMA updated rates to be the maximum of 100 percent of FFS or the minimum update; however, the Centers for Medicare

& Medicaid Services (CMS) is only required to update the FFS rates once every 3 years. As a result, in 2006 and 2008, CMS did not recalculate the FFS rate and all county rates were increased by the minimum update.

Under the MMA, the county benchmark is a function of the demographic rate, the county risk rate, and an adjustment for budget neutrality. The proportion of the benchmark that was risk adjusted grew from 50 percent in 2005 to 100 percent in 2007, so that in 2007, the county demographic rates were no longer directly used in the calculation of the county benchmark payment rate. After setting this benchmark rate, each county rate receives a budget neutrality adjustment (or hold harmless adjustment) because of the risk adjustment. The budget neutrality adjustment is multiplicative and will be fully phased out in 2011. Each county receives the same budget neutrality adjustment. For example, in 2008, the budget neutrality adjustment added 1.69 percent to each county benchmark.

Bidding

The county benchmark is not the plan payment rate. Beginning in 2006, plans are required to submit bids to CMS for the cost of providing Parts A and B benefits to the average Medicare beneficiary.[34] If the plan's bid is above the benchmark, then the plan receives the benchmark and must charge an enrollee premium equal to the difference between the plan bid and the benchmark. If the plan's bid is below the benchmark, then the plan receives its bid plus a rebate of 75 percent of the difference between the benchmark and the bid. CMS retains the other 25 percent. However, plans cannot keep the rebate; instead, they must use the rebate to offer additional benefits or to reduce the Medicare Part B premium.

Finally, plan payment rates are adjusted for individual enrollee payment characteristics.

In this section, we focus on the 2008 county benchmarks. Although regional preferred provider organizations (PPOs) are included in our analyses, we exclude regional benchmarks from the analyses because they affect so few plans.[35] We use 2008 payment rates to be consistent with the remainder of the report. However, because CMS did not recalculate county FFS rates for 2008, we extrapolated them from the 2007 FFS rates. To do this, we simply multiplied the 2007 FFS rates by the same minimum update received by all counties in 2008, 5.71 percent.

2008 County Benchmarks

We first examine the after budget neutrality county benchmarks. The benchmark information is from the rate calculation data on the CMS Web site. There is a large variation in county benchmarks throughout the country, from $716.25 to $1,323.40. However, there are two mass points: $716.25 (1,401 counties) and $791.62 (614 counties). These mass points correspond

34 The bids also include reasonable profits and administrative costs.

35 See Section 1858(f) of the statute – The benchmark for each MA region (for RPPOs) is an average of a "statutory" amount (average of county benchmarks) and a "plan bid" amount (average of plan bids in the MA region).

to counties that had been at the rural and urban floors in 2004 and did not move to the FFS rate in a subsequent year.

Table 6-1 shows the variation in benchmarks throughout the United States and also breaks it down by urbanicity and census region. Table 6-1 shows that more than 70 percent of rural counties and fewer than 25 percent of urban counties had a benchmark rate of less than $750. There is also a difference across census regions. More than 10 percent of counties in the South have a benchmark higher than $900, but only 6 percent in the Northeast, which we typically think of as a high cost/high payment area, do. In the South, we expect Florida to have high benchmarks, but many of the highest benchmark counties are also found in Louisiana and Texas. In fact, of the 20 highest benchmark counties, 8 are in Louisiana; 8 are in Texas, 1 is in Florida, and none are in New York.[36]

The third row of Table 6-1 shows the percentage of Medicare eligibles by county benchmark rate. Only 22 percent of eligible Medicare beneficiaries resided in a county with a benchmark rate below $750 despite the fact that over half of counties had a benchmark rate below $750. At the other end of the payment rate range, although only 6 percent of counties had a benchmark rate higher than $900, 14 percent of Medicare beneficiaries lived in these counties. This is consistent with the fact that most low rate counties are rural, whereas the higher rate counties tend to be more urban and populous. As shown in the fourth row of Table 6-1, relative to Medicare eligible percentages, MA enrollee percentages are skewed toward the highest-benchmark, large urban counties, and away from the lower-benchmark, rural counties.

2008 FFS Rate Ratio

There is a significant amount of discussion about overpayment of private plans relative to traditional FFS rates. Therefore, we also looked at the ratio of the county benchmark to the Medicare FFS rate, which is based on FFS per capita expenditures in the county[37]. For this, we used the rates before budget neutrality to simplify the tables, so that counties with MA benchmarks at the FFS rate have a ratio of 1. This does not change the interpretation of any of the tables because the benchmark rates after budget neutrality are just the benchmark rates before adjustment multiplied by 101.69 percent. Therefore to get the "true" ratio of MA benchmark to FFS rate, the ratios would need to be increased by 1.69 percent. In Table 6-2, we show the distribution of the 2008 MA county benchmark to FFS rate ratio.

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36 Virginia, Mississippi, and California also have 1 county among the 20 highest paid. The highest paid county in New York is the Bronx (Number 22) at $1,080.66.

37 At the time the FFS rates were calculated, current law assumptions were used; specifically it was assumed that the sustainable growth rate fix would not be implemented because the "physician fix" was not yet passed by Congress. This physician fix when passed increased FFS costs in practice. Thus, the true gap between MA rates and actual FFS expenditures is overstated. However, it is beyond the scope of this report to correct FFS rates for the physician fix.

**Table 6-1**
**Distribution of counties by 2008 MA county benchmark rates**

| County type | Less than $750 | $750–800 | $800–850 | $850–900 | $900+ | All payment rates |
|---|---|---|---|---|---|---|
| Total number of counties | 1,660 | 921 | 207 | 130 | 193 | 3,111 |
| Percentage of counties | 53.4% | 29.6% | 6.7% | 4.2% | 6.2% | 100.0% |
| Percentage of Medicare eligibles | 22.5% | 43.4% | 12.9% | 7.0% | 14.2% | 100.0% |
| Percentage of MA enrollees | 13.7% | 45.3% | 12.4% | 8.2% | 20.4% | 100.0% |
| Urbanicity | | | | | | |
| Urban | 241 | 629 | 82 | 52 | 84 | 1,088 |
| Large urban | 0 | 277 | 55 | 30 | 51 | 413 |
| Medium urban | 0 | 285 | 12 | 8 | 19 | 324 |
| Small urban | 241 | 67 | 15 | 14 | 14 | 351 |
| Rural | 1,419 | 291 | 125 | 77 | 109 | 2,021 |
| Rural adjacent | 730 | 157 | 66 | 44 | 62 | 1,059 |
| Rural non-adjacent | 689 | 134 | 59 | 33 | 47 | 962 |
| Census region | | | | | | |
| Northeast | 92 | 81 | 19 | 11 | 13 | 216 |
| Midwest | 724 | 263 | 41 | 14 | 10 | 1,052 |
| South | 585 | 467 | 123 | 91 | 156 | 1,422 |
| West | 259 | 110 | 24 | 14 | 14 | 421 |

NOTES:
1. Alaska counties are aggregated.
2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI International (RTI) analysis of CMS MA rate data from the CMS Web site.

Nationally, the MA benchmark equals FFS expenditures in only 3 percent of counties, and it is greater than 25 percent in 12 percent of counties. The distribution of eligible Medicare beneficiaries is slightly skewed to the lower ratio counties; most eligible beneficiaries are in counties with benchmark to FFS rate ratios less than 1.2. Relative to eligibles, the distribution of MA enrollees is slightly skewed towards higher benchmark to FFS ratio counties. Table 6-2, in contrast with Table 6-1, shows that the highest relative benchmark counties are spread across urban–rural and census regions. But a higher proportion of urban, Northeastern, and Western counties are in this category.

**Table 6-2**
**Distribution of counties by 2008 ratio of MA county benchmark rate to FFS payment rate**

| County type | 1 | 1 to 1.05 | 1.05 to 1.1 | 1.1 to 1.15 | 1.15 to 1.2 | 1.2 to 1.25 | Greater than 1.25 | All rate ratios |
|---|---|---|---|---|---|---|---|---|
| Total number of counties | 87 | 591 | 618 | 639 | 507 | 306 | 363 | 3,111 |
| Percent of counties | 2.8% | 19.0% | 19.9% | 20.5% | 16.3% | 9.8% | 11.7% | 100.0% |
| Percent of Medicare eligibles | 3.0% | 25.8% | 20.4% | 19.3% | 14.5% | 7.6% | 9.3% | 100.0% |
| Percent of MA enrollees | 4.0% | 22.9% | 18.8% | 20.0% | 13.8% | 9.0% | 11.4% | 100.0% |
| Urbanicity | | | | | | | | |
| Urban | 21 | 156 | 200 | 234 | 190 | 118 | 169 | 1,088 |
| Large urban | 3 | 67 | 85 | 98 | 81 | 33 | 46 | 413 |
| Medium urban | 1 | 21 | 40 | 56 | 54 | 59 | 93 | 324 |
| Small urban | 17 | 68 | 75 | 80 | 55 | 26 | 30 | 351 |
| Rural | 66 | 435 | 417 | 404 | 317 | 188 | 194 | 2,021 |
| Rural adjacent | 34 | 227 | 222 | 216 | 170 | 93 | 97 | 1,059 |
| Rural non-adjacent | 32 | 208 | 195 | 188 | 147 | 95 | 97 | 962 |
| Census region | | | | | | | | |
| Northeast | 3 | 49 | 31 | 38 | 34 | 20 | 41 | 216 |
| Midwest | 23 | 194 | 187 | 235 | 190 | 108 | 115 | 1,052 |
| South | 52 | 291 | 327 | 278 | 216 | 128 | 130 | 1,422 |
| West | 9 | 57 | 73 | 88 | 67 | 50 | 77 | 421 |

NOTES:
1. Alaska counties are aggregated.
2. The county benchmark rate is before budget neutrality.
3. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS MA rate data from the CMS Web site.

Comparison with MedPAC Plan Payment Rate Analysis

In this chapter we use 2008 county benchmark rates. This differs from the 2009 MedPAC analysis which used 2009 actual plan bids and payment rates (MedPAC, 2009). As a result, our findings differ slightly from MedPAC's. One key finding from the MedPAC report which helps to illustrate why using benchmarks and actual plan payment rates may lead to slightly different results is that the plan payment to FFS ratio was on average 4 percent less than the benchmark to FFS ratio.[38] However, this discrepancy with the benchmark to FFS ratio varied across plan types from a difference of 5 percent for HMO plans to less than 2 percent for PFFS plans. As a result, our benchmark to FFS ratios are larger than the actual payment to FFS ratios.

[38] See Chart 10-7, p. 155 in MedPAC (2009). Plan payments are less than the benchmark on average because if plans bid less than the benchmark, they are paid less than the benchmark. See the discussion of "bidding" in Section 6.1.1.

Another comparison with MedPAC is in weighting of results. Both we and MedPAC weight by Medicare eligibles when analyzing beneficiary access to plans. MedPAC weights by number of MA enrollees when estimating excess Medicare payments for MA enrollees versus what these beneficiaries would have cost in traditional FFS Medicare. We do not estimate excess Medicare payments for MA enrollees. But we weight by MA enrollees when analyzing the premiums and out of pocket costs of MA enrollees.

### 6.1.2 Plan Availability, Premiums, OOP Costs, and Enrollment

In this section, we discuss the relationships between payment rates, FFS costs, plan availability, premiums, and OOP costs.

Plan Availability

Section 3 discusses plan availability in depth, while in this section we look at how beneficiary choice and potential competition among plans varies with the MA county benchmark rate and the relationship between the benchmark rate and FFS per capita costs. Higher benchmarks allow plans to put in higher bids and receive higher payment rates (or plan revenues). Historically, Congress has increased plan payment rates in order to entice plans to enter a county and increase the availability of MA pans to beneficiaries, especially those in rural areas.

The first question we analyze is how the benchmark and ratio to FFS rate impact beneficiary access to plans. To answer this question, we look at how many eligible beneficiaries have access to a plan, what type of MA plans, and how many plans. Table 6-3 presents the average number of MA contracts available to a beneficiary in a county by plan type and benchmark range. The availability of HMO plans exhibits a strong correlation with the MA benchmark, rising from less than one contract available on average at the lowest payment rates to more than 11 contracts on average at the highest payment rates. However, for other plan types including PFFS, high payment rates do not necessarily correlate with increased availability.

One reason that increased beneficiary access to plans may not be strongly correlated with the benchmark for all plan types is that plan availability may also be impacted by the cost at which medical services can be obtained in local physician and hospital markets. Because of regional variations in underlying medical costs, what constitutes a high payment rate in Kansas City may be a very low payment rate in New York City. What may be important for some plan types is how the Medicare payment rate compares to the underlying FFS costs in the local market.

In Table 6-4, we present the average number of contracts in a county by plan type and 2008 benchmark to FFS rate ratio. As in Table 6-3 the number of contracts is weighted by eligible beneficiaries to show the number of plans available to the average beneficiary. Table 6-4 shows beneficiary access to plans independent of whether they chose to enroll in an MA plan. Table 6-4 shows that the availability of health maintenance organizations (HMOs) does not increase (and even decreases) with a higher benchmark rate relative to FFS costs, whereas the availability of private fee-for-service (PFFS) plans does increase, from an average of 4.4 plans in counties at 100 percent of FFS to 10.7 plans in counties where the benchmark exceeds 125 percent of FFS.

**Table 6-3**
**Average number of MA contracts by plan type and 2008 MA county benchmark rate**

| Plan type | Less than $750 | $750–$800 | $800–$850 | $850–$900 | $900+ | All payment rates |
|---|---|---|---|---|---|---|
| Total MA contracts | 9.6 | 15.8 | 13.9 | 16.4 | 21.5 | 15.0 |
| Coordinated care contracts | 2.6 | 7.0 | 7.9 | 9.9 | 14.2 | 7.3 |
| HMO | 0.9 | 3.9 | 5.3 | 7.3 | 11.2 | 4.7 |
| Local PPO | 0.6 | 1.8 | 1.5 | 1.5 | 1.6 | 1.4 |
| Regional PPO | 1.1 | 1.2 | 1.1 | 1.1 | 1.3 | 1.2 |
| Private fee-for-service (PFFS) | 7.0 | 8.8 | 5.9 | 6.5 | 7.2 | 7.6 |

NOTES:
1. Weighted by Medicare-eligible beneficiaries.
2. The rate range is based on the county benchmark after budget neutrality adjustment.
3. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System and CMS MA rate data from the CMS Web site.

To summarize, the availability of HMOs is positively correlated with the level of the MA county benchmark, whereas the availability of PFFS plans is positively correlated with the ratio of the MA benchmark to county FFS rate. This suggests that MA payment generosity needs to be measured in different ways for these two different plan types.

Premiums

This section analyzes the premiums of MA plans in 2008 in relation to the MA county benchmark and its ratio to the FFS rate. In this section, we switch from analyzing the access of all beneficiaries to plans and instead examine the premiums paid by beneficiaries enrolled in an MA plan. Therefore, the premiums in our tables are weighted by MA plan enrollment, rather than all Medicare eligibles, and reflect average premiums charged to enrollees. Higher county benchmarks—or a higher ratio to FFS—may lead to more plans bidding lower relative to the benchmark, which reduces the plan beneficiary premium.

Table 6-5 presents the average weighted premium by plan type and county benchmark. Table 6-6 presents the average weighted premium by plan type and county benchmark to FFS cost ratio. Both tables show combined Part C+D premiums and therefore MA only plans are excluded. The tables show the combined premiums because plans may use the gap (rebate) between the payment rate (their bid) and the benchmark to buy back the Part D premiums.

**Table 6-4**
**Average number of MA contracts by plan type and ratio of 2008 MA county benchmark rate to FFS rate**

| Plan type | 1 | 1 to 1.05 | 1.05 to 1.1 | 1.1 to 1.15 | 1.15 to 1.2 | 1.2 to 1.25 | Greater than 1.25 | All rate ratios |
|---|---|---|---|---|---|---|---|---|
| Total MA contracts | 20.7 | 13.9 | 14.3 | 15.2 | 15.7 | 15.9 | 15.2 | 15.0 |
| Coordinated care contracts | 16.3 | 9.1 | 7.3 | 6.6 | 5.5 | 5.1 | 5.5 | 7.3 |
| HMO | 12.6 | 6.7 | 4.4 | 4.1 | 3.1 | 2.8 | 2.8 | 4.7 |
| Local PPO | 2.4 | 1.3 | 1.7 | 1.3 | 1.2 | 1.3 | 1.7 | 1.4 |
| Regional PPO | 1.3 | 1.2 | 1.2 | 1.3 | 1.2 | 1.1 | 0.9 | 1.2 |
| PFFS | 4.4 | 4.8 | 7.0 | 8.5 | 10.1 | 10.7 | 9.7 | 7.6 |

NOTES:
1. Weighted by Medicare eligible beneficiaries.
2. The FFS ratio is based on the county benchmark before budget neutrality so that counties with a ratio of 1 receive the 2007 FFS rate with 2008 minimum update. To calculate the after budget neutrality ratio, add 1.69 percent.
3. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System and CMS MA rate data from the CMS Web site.

Tables 6-5 and 6-6 reveal a different relationship between the benchmark and premiums depending on plan type. Table 6-5 shows a strong negative correlation between the benchmark and premiums for HMOs and to a lesser extent for PPOs, but no simple relationship for PFFS plans. The average Parts C + D premium for PPOs fell from $71.07 in counties with a benchmark below $750 to $50.25 in counties with a benchmark above $900. The drop is even more precipitous for HMO plans with the average Parts C + D premium falling from $70.09 in the lowest benchmark counties to $7.94 in the highest benchmark counties, but PFFS premiums are $23.32 in the lowest benchmark counties and $38.81 in the highest benchmark ones.

Table 6-5 also shows premiums separately for urban and rural counties. There is a similar pattern for premiums. HMO premiums for both urban and rural counties decrease with the benchmark while there is no clear relationship between the benchmark and premiums for PPO or PFFS plans. Table 6-5 also shows that with the exception of counties with benchmarks below $750, urban counties tend to have lower premiums than rural counties in HMO plans, but not necessarily for PPO or PFFS plans.

**Table 6-5**
**Average 2008 Parts C and D premiums by plan type and MA county benchmark**

| Plan type | Less than $750 ($) | $750–$800 ($) | $800–$850 ($) | $850–$900 ($) | $900+ ($) | All payment rates ($) |
|---|---|---|---|---|---|---|
| Total | 41.97 | 40.02 | 39.90 | 26.54 | 11.70 | 32.70 |
| Open access | 43.96 | 42.64 | 42.59 | 29.18 | 10.50 | 34.89 |
| HMO (no SNP) | 70.09 | 43.00 | 36.49 | 25.46 | 7.95 | 31.67 |
| PPO (no SNP) | 71.06 | 58.51 | 61.22 | 55.07 | 50.20 | 60.24 |
| PFFS | 23.32 | 29.62 | 86.38 | 61.64 | 38.81 | 31.75 |
| SNP | 27.87 | 22.81 | 20.69 | 13.72 | 16.46 | 20.19 |
| Urban | | | | | | |
| Total | 48.34 | 39.73 | 39.76 | 26.25 | 11.56 | 31.85 |
| HMO (no SNP) | 72.28 | 42.78 | 36.47 | 25.39 | 7.97 | 30.48 |
| PPO (no SNP) | 76.72 | 58.95 | 61.31 | 55.72 | 50.59 | 59.73 |
| PFFS | 27.11 | 27.91 | 90.53 | 66.39 | 38.11 | 34.18 |
| Rural | | | | | | |
| Total | 39.05 | 46.73 | 44.01 | 37.84 | 23.24 | 40.09 |
| HMO (no SNP) | 68.86 | 48.93 | 36.59 | 28.72 | 3.61 | 57.71 |
| PPO (no SNP) | 67.74 | 49.57 | 61.2 | 48.74 | 40.58 | 63.26 |
| PFFS | 21.78 | 52.23 | 54.62 | 42.71 | 41.58 | 26.46 |

NOTES:

1. Weighted by MA plan enrollment.
2. PPO includes both local and regional PPOs.
3. The rate range is based on the county benchmark after the budget neutrality adjustment.
4. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Excludes MA plans offering only Part C benefits.

SOURCE: RTI analysis of CMS Health Plan Management System and CMS MA rate data from the CMS Web site.

**Table 6-6**
**Average 2008 Parts C and D premiums by plan type and ratio of MA county benchmark to FFS rate**

| Plan type | 1 ($) | 1 to 1.05 ($) | 1.05 to 1.1 ($) | 1.1 to 1.15 ($) | 1.15 to 1.2 ($) | 1.2 to 1.25 ($) | Greater than 1.25 ($) | All rate ratios ($) |
|---|---|---|---|---|---|---|---|---|
| Total | 9.93 | 29.68 | 39.9 | 27.21 | 34.24 | 31.39 | 46.84 | 32.70 |
| Open access | 8.96 | 32.03 | 42.97 | 29.01 | 36.08 | 33.19 | 48.89 | 34.89 |
| HMO (no SNP) | 2.73 | 24.92 | 37.72 | 25.85 | 40.40 | 35.47 | 58.48 | 31.67 |
| PPO (no SNP) | 53.87 | 58.77 | 66.18 | 49.13 | 53.54 | 64.21 | 69.06 | 60.24 |
| PFFS | 51.95 | 83.92 | 48.48 | 30.98 | 20.60 | 16.07 | 10.47 | 31.75 |
| SNP | 14.31 | 17.46 | 25.19 | 16.82 | 22.14 | 19.83 | 27.02 | 20.19 |
| Urban | | | | | | | | |
| Total | 8.68 | 27.59 | 39.18 | 25.81 | 35.15 | 31.29 | 48.41 | 31.85 |
| HMO (no SNP) | 2.53 | 23.68 | 36.75 | 24.26 | 40.43 | 32.72 | 58.00 | 30.48 |
| PPO (no SNP) | 54.42 | 57.97 | 66.37 | 46.42 | 50.48 | 64.54 | 70.55 | 59.73 |
| PFFS | 54.24 | 95.26 | 55.73 | 34.50 | 22.67 | 17.61 | 10.4 | 34.18 |
| Rural | | | | | | | | |
| Total | 31.20 | 57.27 | 45.56 | 38.68 | 26.76 | 32.07 | 34.02 | 40.09 |
| HMO (no SNP) | 9.20 | 63.48 | 55.63 | 60.26 | 38.37 | 74.69 | 64.62 | 57.71 |
| PPO (no SNP) | 49.88 | 62.01 | 64.66 | 65.61 | 71.86 | 62.32 | 56.08 | 63.26 |
| PFFS | 50.68 | 61.80 | 37.36 | 24.82 | 14.73 | 12.47 | 10.24 | 26.46 |

NOTES:
1. Weighted by MA plan enrollment.
2. PPO includes both local and regional PPOs.
3. FFS ratio is based on county benchmark before budget neutrality so that counties with a ratio of 1 receive the 2007 FFS rate with 2008 minimum update. To calculate the after budget neutrality ratio, add 1.69 percent.
4. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Excludes MA plans offering only Part C benefits.

SOURCE: RTI analysis of CMS Health Plan Management System and CMS MA rate data from the CMS Web site.

Conversely, Table 6-6 shows a negative correlation between PFFS premiums and the ratio of the county benchmark to FFS costs, but no simple relationship for HMO or PPO plans. Average Parts C + D PFFS premiums are greater than $40 when the ratio of benchmark to FFS costs is less than 1.10. But when the benchmark exceeds FFS costs by more than 25 percent, the average PFFS premium is only $10.36. Table 6-6 shows a similar pattern in premiums for urban and rural counties, although urban HMO premiums tend to be lower for any given ratio while PFFS premiums tend to be lower in rural areas.

To better understand the premium results in Tables 6-5 and 6-6, it helps to understand which counties fall into which benchmark and ratio ranges. While both urban and rural counties can have high benchmark rates, the highest benchmark to FFS ratios are typically in more rural areas. The relationship between the benchmark and rate ratio is very weak among urban, and particularly large urban counties, which are more likely to have HMO plans. In fact some of the highest benchmark large urban counties have fairly low rate ratios. For example, of the 10 largest counties by number of Medicare eligibles, 5 had benchmarks greater than $900 and only one, Maricopa County, Arizona had a benchmark less than $800 ($791). However, 7 of the 10 largest counties had a benchmark to FFS ratio less than 1.05 and only one, Harris County, Texas, had a ratio greater than 1.15. In these large urban counties, 94 percent of the MA enrollment is in HMO plans with average premiums less than $10 in all but two of the counties.

However, among the 10 counties with the highest benchmark to FFS ratios, all greater than 1.49, six have benchmarks below $800, 4 at updated urban floors, and 2 at updated rural floors. While three counties—Glasscock, Texas; Alpine, California; and Issaquena, Mississipi—had benchmarks above $1,000, fewer than 500 Medicare eligibles and no HMO enrollees resided in these three counties combined. In fact, of the 10 counties with the highest benchmark to FFS ratios only 5 had any HMO enrollment, and within the counties with HMO enrollment two counties—Polk, Oregon and Marshall, Iowa—had average HMO premiums greater than $50 but PFFS premiums less than $20.

The premium results are therefore consistent with the plan availability results. HMO availability is positively related to the county benchmark level, and HMO premiums are negatively related to the benchmark level. PFFS plan availability is positively related to the ratio of benchmark to FFS costs, and PFFS plan premiums are inversely related to this ratio.

OOP Costs

This section analyzes simulated total monthly OOP costs of MA plans as a function of the 2008 benchmark and ratio of benchmark to FFS rate. As in Section 4.4, OOP costs includes Parts C and D premiums, Part B premium reductions, if any, cost sharing, and certain non-Medicare–covered benefits (e.g., dental). Plans with higher benchmark rates may be able to offer lower premiums or cost sharing to beneficiaries, extra benefits, or caps on annual OOP costs. Similarly, in areas where the county benchmark is significantly higher than FFS costs, plans might use some of the "extra" money to reduce premiums or cost sharing of enrollees or to provide them with extra benefits. Tables 6-7 and 6-8 present OOP costs by plan type and 2008 benchmark and benchmark to FFS rate ratios, respectively.

Tables 6-7 and 6-8 present a similar story for OOP costs as we saw with premiums. Table 6-7 shows a negative relationship between the county benchmark and OOP costs for HMOs, but no simple correlation for PPOs or PFFS plans. Interestingly, there is also a negative relationship between the county benchmark and OOP costs for SNPs, many of which are HMOs. As with premiums, Table 6-8 shows a negative correlation between simulated OOP costs and the ratio of the county benchmark to FFS rate for PFFS plans, for both urban and rural plans, but not for HMOs, PPOs, or SNPs.

**Table 6-7**
**Simulated monthly OOP costs ($) by plan type and 2008 MA benchmark**
**(Any health status or age)**

| Plan type | Less than $750 | $750–800 | $800–850 | $850–900 | $900+ | All payment rates |
|---|---|---|---|---|---|---|
| Number of counties | 1,660 | 921 | 207 | 130 | 193 | 3,111 |
| Total | $309.37 | $311.82 | $312.98 | $294.54 | $257.44 | $298.50 |
| Open access | $308.24 | $313.03 | $313.90 | $297.00 | $256.65 | $299.43 |
| HMO (no SNP) | $339.53 | $319.05 | $310.81 | $294.13 | $253.06 | $298.00 |
| PPO (no SNP) | $319.76 | $309.73 | $321.73 | $322.58 | $305.59 | $313.33 |
| PFFS | $290.20 | $294.16 | $338.32 | $314.27 | $309.11 | $296.28 |
| SNP | $332.20 | $285.00 | $284.74 | $272.57 | $267.16 | $282.16 |
| Urban | | | | | | |
| Total | $314.68 | $311.59 | $313.00 | $294.29 | $257.30 | $297.43 |
| HMO (no SNP) | $343.56 | $318.77 | $310.97 | $294.12 | $253.28 | $296.73 |
| PPO (no SNP) | $318.13 | $310.36 | $322.45 | $325.05 | $305.94 | $313.09 |
| PFFS | $294.00 | $292.72 | $340.43 | $313.94 | $307.78 | $297.81 |
| Rural | | | | | | |
| Total | $307.86 | $306.94 | $317.26 | $312.11 | $305.98 | $269.05 |
| HMO (no SNP) | $326.53 | $337.25 | $328.65 | $303.07 | $294.58 | $221.41 |
| PPO (no SNP) | $314.71 | $320.72 | $297.48 | $302.21 | $290.77 | $295.74 |
| PFFS | $293.09 | $288.75 | $313.96 | $322.87 | $315.61 | $314.93 |

NOTES:
1. Weighted by MA plan enrollment.
2. The OOP cost is out-of-pocket costs.
3. The OOP simulation only included plans offering both Parts C and D.
4. PPO includes both local and regional PPOs.
5. Dual-eligible special needs plans (SNPs) are not in the file, only institutional (Inst) and chronic condition (CC) SNPs.
6. The rate range is based on county benchmarks after budget neutrality.
7. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Excludes MA plans offering only Part C benefits.

SOURCE: RTI analysis of CMS Health Plan Management System, CMS/Fu Associates OOP cost data and CMS MA rate data from the CMS Web site.

**Table 6-8**
**Simulated monthly OOP cost by plan type and ratio of 2008 MA county benchmark to FFS rate (Any health status or age)**

| Plan type | 1 ($) | 1 to 1.05 ($) | 1.05 to 1.1 ($) | 1.1 to 1.15 ($) | 1.15 to 1.2 ($) | 1.2 to 1.25 ($) | Greater than 1.25 ($) | All rate ratios ($) |
|---|---|---|---|---|---|---|---|---|
| Total | 246.81 | 284.19 | 304.40 | 301.84 | 312.25 | 301.29 | 317.45 | 298.50 |
| Open access | 244.73 | 284.81 | 305.24 | 303.01 | 313.08 | 302.31 | 318.48 | 299.43 |
| HMO (no SNP) | 236.08 | 277.10 | 300.16 | 304.66 | 327.46 | 311.90 | 335.22 | 298.00 |
| PPO (no SNP) | 300.67 | 314.49 | 328.23 | 303.40 | 301.97 | 307.67 | 316.15 | 313.33 |
| PFFS | 323.34 | 340.42 | 310.05 | 295.94 | 285.33 | 282.27 | 280.72 | 296.28 |
| SNP | 274.72 | 275.82 | 287.47 | 283.85 | 295.98 | 278.12 | 276.95 | 282.16 |
| Urban | | | | | | | | |
| Total | 243.44 | 281.62 | 303.12 | 301.06 | 314.23 | 301.09 | 319.52 | 297.43 |
| HMO (no SNP) | 234.84 | 275.85 | 298.75 | 303.13 | 327.86 | 309.41 | 335.81 | 296.73 |
| PPO (no SNP) | 298.78 | 316.01 | 331.15 | 302.24 | 297.93 | 303.8 | 316.07 | 313.09 |
| PFFS | 331.17 | 348.49 | 314.62 | 299.12 | 286.33 | 283.11 | 281.01 | 297.81 |
| Rural | | | | | | | | |
| Total | 301.27 | 318.9 | 314.08 | 308.18 | 296.93 | 302.4 | 300.92 | 307.86 |
| HMO (no SNP) | 276.16 | 318.15 | 326.07 | 338.29 | 317.5 | 347.57 | 326.09 | 326.53 |
| PPO (no SNP) | 312.77 | 308.89 | 311.81 | 310.2 | 325.53 | 333.38 | 316.86 | 314.71 |
| PFFS | 319.27 | 324.98 | 303.19 | 290.58 | 282.65 | 280.41 | 279.76 | 293.09 |

NOTES:
1. Weighted by MA plan enrollment.
2. OOP cost is out-of-pocket costs.
3. The OOP cost simulation only included plans offering both Parts C and D.
4. PPO includes both local and regional PPOs.
5. Dual-eligible SNPs are not in the file, only institutional (Inst) and chronic condition (CC) SNPs.
6. The FFS ratio is based on county benchmark before budget neutrality so that counties with a ratio of 1 receive the 2007 FFS rate with 2008 minimum update. To calculate the after budget neutrality ratio, add 1.69 percent.
7. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. Excludes MA plans offering only Part C benefits.

SOURCE: RTI analysis of CMS Health Plan Management System, CMS/Fu Associates OOP cost data, and CMS MA rate data from the CMS Web site.

Enrollment and Penetration

In Section 5, we discuss MA enrollment in depth, and while in this subsection, we focus on the penetration of MA plans in 2008 in relation to the MA benchmark rate and its ratio to FFS costs. We define MA penetration as MA enrollment divided by eligible Medicare beneficiaries.

Earlier in this section, we analyzed the relationship between plan availability, the benchmark rate, and its ratio to FFS costs. However, simply because a plan is available does not mean that beneficiaries choose to enroll in the plan; premiums, benefits, and personal preferences all factor into the decision (Town and Liu, 2003).

Table 6-9 presents MA penetration by plan type and county benchmark. Table 6-10 presents MA penetration by plan type and county benchmark to FFS cost ratio.

Tables 6-9 and 6-10 reveal a different relationship between the benchmark rate and enrollment penetration depending on plan type. Table 6-9 shows that HMO penetration increases in counties with higher benchmarks, from 2.8 percent in the lowest benchmark counties to 26.3 percent in counties with a benchmark greater than $900. PFFS plans, however, show a negative relationship between the benchmark and penetration. PFFS penetration in highest in counties with a benchmark less than $650 at 7 percent but fall to only 1.1 percent in counties with benchmark rates greater than $900. This is consistent with the pattern of plan availability observed in Table 6-3. In that table, HMO plan availability was highest in urban counties with higher benchmark rates, whereas PFFS plans were more common in rural counties with lower payment rates.

Conversely, Table 6-10 shows a positive relationship between PFFS penetration and the ratio of the county benchmark to FFS costs, but a relatively flat relationship for HMO plans. PFFS plan penetration increases steadily from less than 1 percent in counties at the FFS rate to more than 8 percent in counties with a benchmark rate more than 20 percent above the FFS rate. HMO penetration is more uniformly distributed, although highest in the small number of counties at the FFS rate. PFFS penetration is consistent with the pattern of plan availability observed in Table 6-4. PFFS plan availability increased with the ratio of benchmark to FFS costs. However, HMO penetration is not consistent with the pattern of HMO plan availability in Table 6-4. Although HMO penetration is fairly constant across the ratio of benchmark to FFS costs, HMO plan availability steadily declined with the ratio.

### 6.1.3 Conclusions

Many factors potentially impact plan availability, premiums, OOP costs, and benefits, such as county benchmark rates or rates relative to the cost of treating a beneficiary in FFS. Previous research has considered the impact of urbanicity, local provider networks, local commercial managed care markets, population density, and regulation, among other factors, to help explain plan availability and generosity (Cawley, Chernew, and McLaughlin, 2005; Biles, Adrion, and Guterman, 2008; Pizer and Frakt, 2002).

**Table 6-9**
**2008 MA penetration by plan type and 2008 MA county benchmark rate**

| | Less than $750 (%) | $750–800 (%) | $800–850 (%) | $850–900 (%) | $900+ (%) | All payment rates (%) |
|---|---|---|---|---|---|---|
| All MA plans | 11.5 | 19.8 | 18.3 | 22.4 | 27.4 | 19.0 |
| Coordinated care plans | 4.5 | 15.1 | 16.7 | 20.7 | 26.3 | 14.9 |
| HMO | 2.8 | 12.4 | 14.7 | 19.3 | 25.1 | 12.8 |
| Local PPO | 0.9 | 2.0 | 1.4 | 0.7 | 0.7 | 1.4 |
| Regional PPO | 0.8 | 0.7 | 0.7 | 0.8 | 0.5 | 0.7 |
| PFFS | 7.0 | 4.7 | 1.6 | 1.7 | 1.1 | 4.1 |

NOTES:
1. Rate range is based on the county benchmark after budget neutrality adjustment.
2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories

SOURCE: RTI analysis of CMS Health Plan Management System and CMS MA rate data from the CMS Web site.

**Table 6-10**
**2008 MA penetration by plan type and ratio of 2008 MA county benchmark rate to FFS rate**

| Penetration | 1 (%) | 1 to 1.05 (%) | 1.05 to 1.1 (%) | 1.1 to 1.15 (%) | 1.15 to 1.2 (%) | 1.2 to 1.25 (%) | Greater than 1.25 (%) | All rate ratios (%) |
|---|---|---|---|---|---|---|---|---|
| All MA plans | 24.8 | 16.9 | 17.5 | 19.7 | 18.1 | 22.5 | 23.4 | 19.0 |
| Coordinated care plans | 23.9 | 15.6 | 14.7 | 15.4 | 11.8 | 13.6 | 15.4 | 14.9 |
| HMO | 21.6 | 14.1 | 12.3 | 13.4 | 10.1 | 11.2 | 11.7 | 12.8 |
| Local PPO | 1.4 | 0.7 | 1.5 | 1.3 | 1.1 | 1.9 | 3.2 | 1.4 |
| Regional PPO | 0.9 | 0.7 | 0.9 | 0.7 | 0.6 | 0.5 | 0.5 | 0.7 |
| PFFS | 0.9 | 1.3 | 2.8 | 4.3 | 6.3 | 8.8 | 8.1 | 4.1 |

NOTES:
1. The FFS ratio is based on county benchmark before budget neutrality so that counties with a ratio of 1 receive the 2007 FFS rate with 2008 minimum update. To calculate the after budget neutrality ratio, add 1.69 percent.
2. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories

SOURCE: RTI analysis of CMS Health Plan Management System, CMS/Fu Associates OOP cost data and CMS MA rate data from the CMS Web site.

However, as this section shows, the type of the private plan may interact with payment rates and costs in affecting plan availability and generosity. PFFS plans typically do not have provider networks from which enrollees must obtain care. As their name suggests, PFFS plans offer similar provider access and benefits as the traditional Medicare FFS program. It is plausible that the medical costs of PFFS plans are highly correlated with traditional Medicare FFS costs in an area. In fact, PFFS plans pay providers at least the Medicare FFS rate. Hence, the relevant measure of MA payment generosity for PFFS plans is the ratio of the MA payment benchmark to local FFS costs. When this ratio is high, PFFS plans are more likely to be offered and lower premiums and OOP costs are more likely to be charged to enrollees.

Conversely, HMOs rely on networks of physicians and hospitals from which enrollees must obtain care. HMOs guarantee access to their network providers, often charge enrollees relatively low cost sharing for in-network care, and manage enrollee utilization of services more aggressively. Thus, HMO costs may vary considerably less across areas than costs in the traditional Medicare FFS program (CBO, 2004), with its wide variations in practice patterns and intensity of care (The Dartmouth Atlas of Healthcare; Sutherland, Fisher, and Skinner, 2009). Furthermore, in areas with relatively more competitive physician and hospital markets, which are often high-cost urban areas, HMOs can take advantage of the provider competition to bargain for lower provider payments in exchange for providers being in the HMO's network. In lower-cost rural areas, HMOs are at a disadvantage in bargaining with locally dominant hospitals and physician groups and may not be able to obtain favorable provider payment rates. Thus, the competitive situation in the provider market further tends to even out HMO costs across areas. With more uniform costs across areas, the relevant payment generosity measure for HMOs is not the ratio of MA payment to traditional Medicare FFS costs; instead, it is closer to the absolute level of MA payment. When the absolute level of payment is high, HMOs are more likely to be offered and lower premiums and OOP costs are more likely to be charged to enrollees.

An implication of this analysis is that PFFS plans will be especially responsive to payment policies—such as floors on payment rates—that raise MA payments relative to FFS costs in an area, even if the absolute level of payment remains low. When MA rates are higher relative to FFS costs, PFFS plans are more likely to be offered and are more generous to beneficiaries. In contrast, HMOs are more responsive to payment policies affecting the absolute level of MA payments. For example, making FFS per capita costs the minimum for MA payments will ensure high MA payments in high FFS cost areas. Responding to these high absolute payment rates, many generous HMO plans are likely to be offered to Medicare beneficiaries in high-FFS-cost areas.

In this section, we have documented significant variations in MA county benchmarks and ratios to FFS costs and correlated variations in plan availability, premiums, OOP costs, and enrollment. One goal of payment policy might be to lessen these disparities across areas. This may be difficult to achieve with formula-driven payment, as evidenced by the complexity of the current payment system. The MA plan bidding mechanism could provide a means of eliciting information about plan costs in different areas. If the plan bids were allowed to affect the payment benchmarks, payments might track costs more closely across areas, lessening disparities in MA availability and generosity.

## 6.2 Effect of Urban County Floor Rates on Plan Generosity

The analysis in this subsection complements the descriptive trend analyses earlier in this section and elsewhere in this report by a multivariate analysis of the effects of MA county benchmark payment rates on plan generosity (premiums and benefits). The discontinuity in payment rates created by the urban floor rate is used to determine the impact of variation in payment rates on plan generosity, independent of other factors. This "regression discontinuity" (RD) design allows a causal interpretation of the relationship between payment rates and plan generosity. The specific aspects of plan generosity affected by payment rates—premiums versus cost sharing—are also explored.

The analysis in Section 6.1 provides a lot of information about the relationship of the county benchmarks to plan availability and costs. Tables 6-7 and 6-8 showed OOP costs of plans, and the findings included a negative relationship between the county benchmark payment rate and OOP cost for HMOs, but no simple correlation for PPOs or PFFS plans. We provide a plausible explanation for these findings that depends on the fact that the costs of PFFS plans in a county are likely more strongly correlated with overall local Medicare FFS costs than the costs of HMO plans are. However, we know that the benchmark payment rate depends on more than simply the FFS costs in a county, as shown by the wide variation in the ratio of the benchmark to FFS costs. This makes it difficult to determine the exact effect of the benchmark rate independent of other related factors, such as urbanicity and plan availability. The RD design allows us to rigorously detect this effect, by identifying counties that are very similar in urbanicity, FFS costs, and other characteristics, but nonetheless have substantial variation in benchmark rates. This allows us to identify the effect of the benchmark rate alone.

Rigorous efforts have been made to evaluate the effect of the MA payment rates (and the payment rates in the program under its former name, Medicare+Choice) on a number of different outcomes, such as mortality rates (Gowrisankaran and Town, 2004), the net benefits received by beneficiaries (Town and Liu, 2003), and insurance plan participation (Abraham et al., 2000; Cawley, Chernew, and McLaughlin, 2005). However, attempts to look at the relationships between MA payment rates and many other outcomes have largely been descriptive, such as research showing that enrollment increased with higher benchmark rates (Zarabozo and Harrison, 2009; Gold, 2007).

The only study we know of that rigorously identifies a causal relationship between payment rates and benefits provided from Pizer and colleagues (2003). The researchers use the change in payment rates legislated by the Benefits Improvement and Protection Act (BIPA) of 2000 to determine that the benefits provided by zero premium plans were more sensitive to changes in payment rate than the benefits in plans that charge non-zero premiums. They also found that higher payment rates reduce the likelihood of charging a premium. However, this study was conducted using very particular changes that occurred in a very short time period and data from 2001. The present analysis studies similar outcomes, using current data and an effect generated by a policy that has remained relatively constant since 2001.

### 6.2.1 Regression Discontinuity Approach

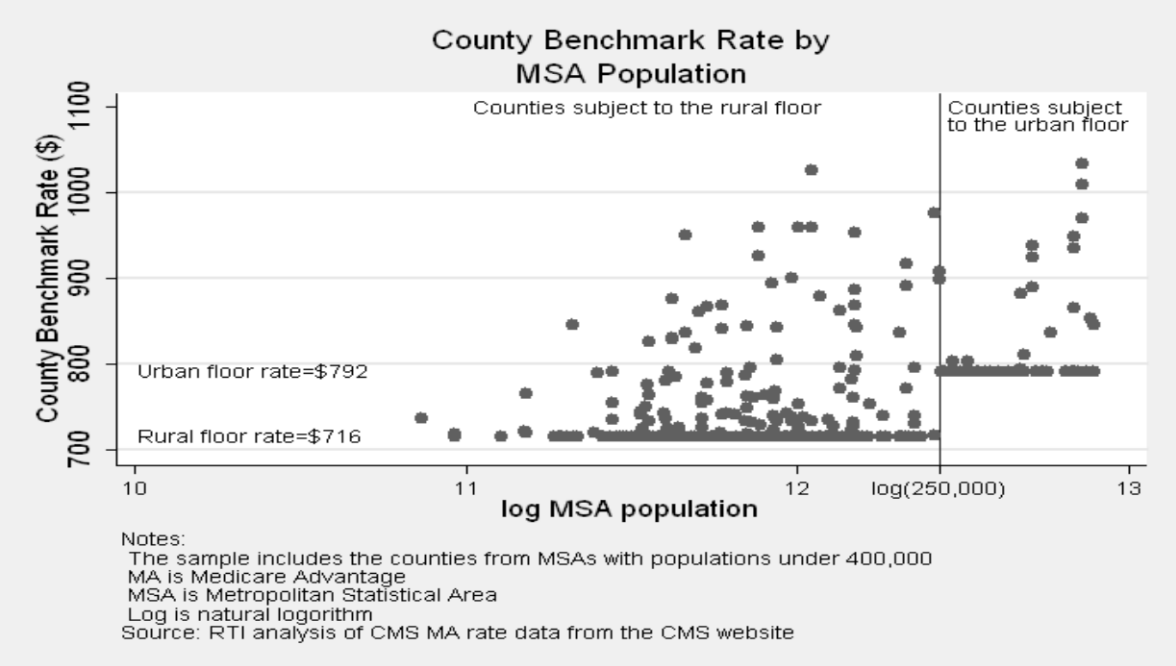
The descriptive analysis in previous sections does not allow us to identify a causal relationship. Simply regressing OOP cost on benchmark rates and other factors among all counties

will come closer to identifying the relationship, but it leaves some questions. This is because of the (circular) influence of county costs on MA payment rates and the considerable differences across the full range of counties in many factors that may affect OOP cost. The RD design allows us to improve on a simple regression by carefully studying a small group of counties that are very similar except for one difference, in benchmark rates, caused by the exogenous rules setting the rates. This design allows us to attribute the differences in OOP cost between counties directly to the differences in benchmarks, as the counties are very similar in all other factors.

The policy rule used here is the division between "urban floor" and "rural floor" counties. As discussed in Section 6.1, one factor in the calculation of payment rates for MA plans is the floor rate, which is the minimum benchmark payment for a county. The BIPA modified the calculation of payment rates in several ways, including resetting the floor rate beginning in March 2001 and creating a second higher urban floor for counties within Metropolitan Statistical Areas (MSAs) with at least 250,000 people. The rural and urban floor rates were initially set at $475 and $525; however, these rates have risen over the years to $716.25 and $791.62, respectively, in 2008 due to a number of legislative updates and automatic increases.

This difference in benchmark floors creates a discontinuity in county-level benchmark rates at the cutoff between counties subject to the urban and rural floors (an MSA population of 250,000) as shown in Figure 6-1. We limit our sample to counties that are close to this cutoff—in this case, counties in MSAs with total populations between 100,000 and 400,000, a range of 150,000 on either side of the urban/rural floor population cutoff. In 2008, the average benchmark rate of counties in MSAs with a population between 100,000 and 250,000 was $744, whereas the average rate for those with a population between 250,000 and 400,000 was $804. As shown in Table 6-11, the unweighted means of other variables are overall very similar between the two groups, although, not surprisingly, there are other statistically significant differences such as population size and density. (Each of the variables in Table 6-11 is described in detail below.) All county characteristics variables, as shown here and as used in the analysis, are either 0–1 indicators or have been standardized to have a mean of zero and a standard deviation of 1 to make the coefficients more directly comparable. (The OOP cost measures have not been standardized.) Limiting our sample in this way thus allows us focus our attention on the sudden jump in benchmark rates that occurs at an MSA population of 250,000.

**Figure 6-1**
**County benchmark rate by MSA population**




NOTES:
1. MSA is Metropolitan Statistical Area.
2. The sample includes the counties from MSAs with populations under 400,000.
3. The log is a natural logarithm.

SOURCE: RTI analysis of CMS Medicare Advantage rate data from the CMS Web site.

## Table 6-11
## Characteristics of analysis sample counties subject to the rural and urban payment floors—standardized variables

*The analysis sample is counties in metropolitan areas with populations between 100,000 and 400,000. The urban payment rate floor is applied to counties in metropolitan areas with populations of at least 250,000; the rural floor is applied to other counties.*

| Dependent/independent variables | Rural floor counties, Mean | Rural floor counties, SE | Urban floor counties, Mean | Urban floor counties, SE | p-value of difference |
|---|---|---|---|---|---|
| N (counties) | 308 | 308 | 135 | 135 | — |
| **Dependent variables** | | | | | |
| Total OOP cost | 312.93 | *1.64* | 296.96 | *1.64* | 0.00 |
| Part B premium | 96.31 | *0.04* | 95.60 | *0.04* | 0.00 |
| Part C premium | 27.65 | *1.20* | 15.82 | *1.20* | 0.00 |
| Part D premium | 18.10 | *0.57* | 12.69 | *0.57* | 0.00 |
| Cost-sharing | 170.88 | *0.94* | 172.85 | *0.94* | 0.26 |
| **Independent variables** | | | | | |
| Log MSA population | −0.54 | *0.04* | 1.24 | *0.02* | 0.00 |
| FFS rate | 0.00 | *0.06* | 0.00 | *0.09* | 0.95 |
| GAF | −0.17 | *0.05* | 0.38 | *0.11* | 0.00 |
| Log wage index | −0.06 | *0.06* | 0.14 | *0.09* | 0.05 |
| Log MDs per capita | −0.01 | *0.06* | 0.03 | *0.08* | 0.69 |
| Non-zero MDs per capita | 0.98 | *0.01* | 1.00 | *0.00* | 0.08 |
| Log beds per capita | 0.02 | *0.06* | −0.05 | *0.08* | 0.51 |
| Non-zero beds per capita | 0.77 | *0.02* | 0.79 | *0.04* | 0.59 |
| HHI | 0.13 | *0.06* | −0.30 | *0.08* | 0.00 |
| Log HMO penetration | −0.11 | *0.06* | 0.25 | *0.07* | 0.00 |
| Non-zero HMO penetration | 0.92 | *0.02* | 0.95 | *0.02* | 0.32 |
| CSA | 0.23 | *0.02* | 0.27 | *0.04* | 0.32 |
| Log density | −0.13 | *0.06* | 0.29 | *0.08* | 0.00 |
| Percent poverty | 0.06 | *0.06* | −0.13 | *0.09* | 0.08 |
| Percent Medicare-eligible | 0.01 | *0.06* | −0.03 | *0.08* | 0.68 |
| Medicare-eligible population | 3,629,153 | 3,629,153 | 2,742,943 | 2,742,943 | — |
| MA enrollment | 251,411 | 251,411 | 323,871 | 323,871 | — |

NOTES:
1. All variables other than the OOP cost (dependent) variables are standardized to have a mean of zero and standard deviation of one within the analysis sample. These are the values used in the regression.
2. SE is standard error.
3. MSA is Metropolitan Statistical Area.
4. FFS rate is county fee-for-service per capita expenditures.
5. GAF is Medicare Physician Fee Schedule Geographic Adjustment Factor.
6. Wage index is Medicare Hospital Acute Inpatient PPS Urban Wage Index.
7. MDs are physicians.
8. Beds per capita is hospital beds per capita.
9. HHI is Herfindahl-Hirschman index of hospital market concentration.
10. HMO is health maintenance organization.
11. CSA is Consolidated Statistical Area.
12. Density is population density.
13. Percent poverty is the percentage of the county population below the poverty line.

SOURCE: RTI analysis of 2007 Area Resource File, American Hospital Association, and Medicare program data.

It is important to note that the variable we use is whether the county is eligible for the urban floor or the rural floor, rather than whether the county benchmark is actually at either of those floor rates. Which floor a county is eligible for is a very clear, transparent, and easily interpretable measure, that only depends on whether or not the county is part of a metropolitan area with a population of 250,000 or more. Whether the county benchmark is at the floor rate, depends on a variety of other factors that may be directly related to OOP cost, particularly the county FFS costs. Using eligibility for the floor rate, rather than the actual county benchmark, allows us to fully isolate the effect of exogenous changes in the benchmark (such as the floor rates), separately from the other factors that in part determine the benchmark.

To conduct an RD analysis of these data, we run an ordinary least squares regression of the outcome variable (OOP costs and the components of OOP cost) on a variable indicating whether the county is a rural floor or an urban floor county, together with other county characteristics (controls). The coefficient on the urban/rural floor indicator will then indicate the difference in OOP cost caused by the jump in benchmark rates due to the urban floor rate. Because the variable of interest (i.e., urban/rural floor) has been carefully chosen to be uncorrelated with other factors, including controls, this should change the coefficient minimally, if at all. Controls are included because they increase the precision of the estimate—by absorbing much of the variation in OOP cost caused by other factors, they allow us to more precisely identify the variation caused by the urban floor.

### 6.2.2 Data and Variable Construction

The MSA population is calculated based on the 2000 census population values and the most current MSA definitions listed on the U.S. Census Bureau's Web site (available at: http://www.census.gov/population/www/cen2000/briefs/phc-t29/index.html).[39] This results in a sample of 444 counties in MSAs with a population of 100,000 to 400,000, or 14 percent of the 3,108 counties in the United States. Our sample counties encompass a total Medicare-eligible population of 6.4 million, or 17 percent of the total Medicare-eligible population. As shown in Table 6-12, the characteristics of this sample are quite similar to national characteristics. They are all counties that are part of or near small cities, so the MSA population is smaller than the average MSA, but the average population density of the counties in the analysis sample is greater than the national average county population density.

[39] Using these definitions agrees with the urban/rural floor definition used by CMS for 91 percent of cases in our initial analysis sample, based on the floor indicated in the CMS Web site (available at: http://www.cms hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp#TopOfPage). Because of the imperfect match, we explored whether we would get a better match using other population data (more recent estimates) or an older MSA definition. Because we were unable to achieve a substantially better match using other approaches attempted, we used the most up-to-date MSA definition and dropped the 42 counties for which our calculated MSA population results in a different urban/rural floor classification from that used by CMS. Thus, all of the counties are categorized using the CMS classification, and all have matching MSA population values that can be used as a control variable. All results presented are very similar if the analysis is conducted with these 42 counties included.

**Table 6-12**
**Characteristics of United States and analysis sample counties**

| Dependent/independent variables | U.S. Mean | U.S. SE | Analysis sample Mean | Analysis sample SE |
|---|---|---|---|---|
| N (counties) | 3,108 | 3,108 | 444 | 444 |
| **Dependent variables** | | | | |
| Total OOP cost | 307.14 | *0.581* | 308.08 | *1.424* |
| Part B premium | 96.12 | *0.030* | 96.09 | *0.086* |
| Part C premium | 24.33 | *0.391* | 24.06 | *1.009* |
| Part D premium | 16.14 | *0.187* | 16.45 | *0.498* |
| Cost-sharing | 170.55 | *0.321* | 171.48 | *0.809* |
| **Independent variables** | | | | |
| Log MSA population | 13.33 | *0.02* | 12.11 | *0.02* |
| FFS Rate | 671.52 | *1.42* | 662.96 | *3.32* |
| GAF | 0.91 | *0.00* | 0.92 | *0.00* |
| Log Wage Index | −0.14 | *0.00* | −0.10 | *0.00* |
| Log MDs per capita | −7.12 | *0.02* | −6.78 | *0.05* |
| Non-zero MDs per capita | 0.96 | *0.00* | 0.98 | *0.01* |
| Log beds per capita | −6.49 | *0.03* | −6.57 | *0.08* |
| Non-zero beds per capita | 0.80 | *0.01* | 0.78 | *0.02* |
| HHI | 0.32 | *0.00* | 0.42 | *0.01* |
| Log HMO penetration | −3.81 | *0.05* | −3.36 | *0.11* |
| Non-zero HMO penetration | 0.88 | *0.01* | 0.93 | *0.01* |
| CSA | 0.56 | *0.01* | 0.24 | *0.02* |
| Log density | −3.18 | *0.03* | −2.42 | *0.05* |
| Percent poverty | 15.33 | *0.12* | 14.63 | *0.25* |
| Percent Medicare-eligible | 0.18 | *0.00* | 0.16 | *0.00* |
| Medicare-eligible population | 40,688,062 | 40,688,062 | 6,372,096 | 6,372,096 |
| MA enrollment | 5,653,119 | 5,653,119 | 575,282 | 575,282 |

NOTES:

1. The analysis sample is counties in metropolitan areas with 100,000 to 400,000 population.
2. SE is standard error.
3. MSA is Metropolitan Statistical Area.
4. FFS rate is fee for service county per capita expenditures.
5. GAF is Medicare Physician Fee Schedule Geographic Adjustment Factor.
6. Wage index is Medicare Hospital Acute Inpatient PPS Urban Wage Index.
7. MDs are physicians.
8. Beds per capita is hospital beds per capita.
9. HHI is Herfindahl-Hirschman index of hospital market concentration.
10. HMO is health maintenance organization.
11. CSA is Consolidated Statistical Area.
12. Density is population density.
13. Percent poverty is the percentage of the county population below the poverty line.

SOURCE: RTI analysis of 2007 Area Resource File, American Hospital Association, and Medicare program data.

The outcome variable analyzed here is the enrollment-weighted county average of health plan enrollee predicted OOP costs, which is described in Section 2 and analyzed descriptively in Section 4. The OOP cost is a measure of the overall generosity of health insurance plans for a typical Medicare beneficiary. As in Section 4, the average includes all non-SNP plans that offer both Part C and Part D coverage.

The number of physicians, number of hospitals, poverty rate, number of Medicare-eligible individuals, and county population come from the primary data source (i.e., the 2007 Area Resource File, which can be found at the Health Resources and Services Administration's Web site at http://arf.hrsa.gov/). These data were used to calculate the variables: physicians per capita, hospital beds per capita, poverty rate, the percentage of the population that is Medicare eligible, and the population density. All of these variables control for many of the contextual differences among counties that are related to the supply of (i.e., physicians per capita, hospital beds per capita) and demand for (i.e., poverty rate, the percentage of the population that is Medicare eligible) MA plans.

The FFS rates (FFS county per capita expenditures) used are those on which the 2008 MA payment rates are based (see the CMS Web site at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/), and the wage index is the 2008 Acute Inpatient PPS Urban Wage Index (as obtained from this Web site at http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage).

The Geographic Adjustment Factor is the 2006 value used in the Medicare physician payment calculation for that year, which was taken from data derived for a previous RTI project (Adamache, Pope, and Zuckerman, 2008). Although these data are not from 2008, they are the most recent and readily available to us, and they remain highly relevant. These three variables account for county-level contextual differences that will affect the cost of MA plans, including variations in input prices and local medical practice patterns.

Our final control variables are two measures of competition. One is the HMO penetration rate, or the percentage of non-Medicare beneficiaries who are enrolled in HMOs in a county in 2002, based on InterStudy data (Interstudy, 2002). Greater competition in the insurance market could lower health plan enrollee OOP cost. The hospital Herfindahl-Hirschman index was calculated by the authors of this report based on hospital system information regarding the length of stays for 2004. Greater competition among hospitals could lower the cost at which health plans are able to purchase medical care for their enrollees, some of which may be passed through to enrollees as lower OOP costs. All control variables are either 0–1 indicators or have been standardized to have a mean of zero and a standard deviation of 1 to make the coefficients more directly comparable. When appropriate, based on the distribution of the variables, the log of a variable was used and indicators were added for zero values.[40]

### 6.2.3 Results

Main Results

The first column of results in Table 6-13 shows the central regression of this analysis. Average predicted OOP cost of MA plans offered in a county is regressed on an indicator for counties in MSAs with a population higher than 250,000 and other (control) variables that may affect OOP costs. The coefficient on the indicator for counties in MSAs with a population higher than 250,000 is −13.47, meaning that the plans offered to MA enrollees in the counties just

[40] The natural logarithm was used when the distribution was closer to lognormal (indicating that the log has a normal distribution).

above the urban floor cutoff (i.e., in counties in MSAs with populations higher than 250,000) have expected OOP costs that are $13.47 lower than those offered to enrollees in counties just below the cutoff. This number is very precise and statistically significant. Many of the variables used as controls are important as well, allowing the regression to account for nearly 22 percent of the variation in MA plan generosity in the sample.[41]

Columns 2 through 5 of Table 6-13 show that the difference in Part C premiums ($10.67) accounts for more than three-quarters of the urban floor difference in plan generosity. There is also a small difference in the Part B premium, net of any plan Part B premium reduction. This small difference in Part B premiums is not surprising because Part B premiums are rarely reduced by plans (see Section 4). The differences in the Part D premium (recall, that all plans included offer Part D) and the non-premium cost-sharing aspects of the insurance plans (deductibles, co-payments, co-insurance) are small and not statistically significant, although they are both in the expected direction. (Cost-sharing remains insignificant if its components are analyzed separately.)

Sensitivity Analysis

An alternative interpretation of the results could be that counties subject to the urban floor are simply different than those subject to the rural floor, and the results arise from that difference rather than the change in benchmarks. Table 6-14 shows several alternative regressions to explore other possibilities. Column 1 is the same regression as the first column of Table 6-13. Column 2 is the same regression with all control variables except for the log MSA population removed. The coefficient on counties in MSAs with a population higher than 250,000 remains very similar when the controls are removed; if that coefficient was simply picking up the general differences between the two groups, we would expect the coefficient to vary substantially depending on which controls are included.

The regressions in Columns 3 and 4 are similar to the one in Column 2, except with a slight change in the MSA population variable. The regression in Column 1 includes an indicator for whether the county is in an MSA with a total population of 250,000 or more, whereas the regressions in Columns 2 and 3 include indicators for MSAs with populations higher than 200,000 and more than 300,000, respectively. If the MSA population higher than 250,000 cutoff indicated a general difference rather than the urban payment floor policy difference under study, other similar indicators such as MSA populations higher than 200,000 and more than 300,000 would generate similar results. However, the coefficients on these alternative MSA population variables are very small and statistically insignificant, indicating that the more than 250,000 indicator is measuring the effect of the urban payment floor.

[41] The individual control variable coefficients are not shown in Tables 6-13 through 6-15. Tables 6-13A to 6-15A in the appendix to Section 6 show the full regressions corresponding to Tables 6-13 through 6-15.

**Table 6-13**
**Regressions of average county MA plan predicted OOP costs on an urban floor county indicator and other factors**

*The sample is counties in metropolitan areas with populations between 100,000 and 400,000. The urban payment rate floor is applied to counties in metropolitan areas with a population of at least 250,000.*

| Explanatory variable | Dependent variable, Total OOP cost ($) | Dependent variable, Part B Premiums ($) | Dependent variable, Part C Premiums ($) | Part D Premiums ($) | Dependent variable, cost-sharing ($) |
|---|---|---|---|---|---|
| MSA population of more than 250,000 (urban floor) | −13.40*** | −0.72** | −10.65*** | −1.27 | −0.76 |
| Log MSA population | −5.56** | 0.06 | −2.81* | −3.55*** | 0.73 |
| Control variables | Yes | Yes | Yes | Yes | Yes |
| $R^2$ | 0.22 | 0.07 | 0.20 | 0.15 | 0.04 |
| N | 443 | 443 | 443 | 443 | 443 |

* p<0.10.
** p<0.05.
*** p<0.01.

NOTES:
1. MSA is Metropolitan Statistical Area.
2. Controls included in all regressions are: county FFS per capita expenditures, the Medicare Physician Fee Schedule Geographic Adjustment Factor, the natural logarithm (log) of the Medicare Hospital Acute Inpatient PPS Urban Wage Index, the log of physicians per capita, the log of hospital beds per capita, the Herfindahl-Hirschman index of hospital market concentration, the log of HMO penetration, an indicator of a CSA, and the log of population density.
3. For each log variable, if there are zero values in the original variable, an indicator of non-zero values is also included.
4. All variables, except the dependent variables and the urban floor indicator, are standardized to have a mean of zero and standard deviation of 1.

SOURCE: RTI analysis of CMS/Fu Associates OOP cost, the Area Resource File, and Medicare program data.

**Table 6-14**
**Regressions of average county MA plan total predicted OOP cost on county MSA population indicators—sensitivity analysis**

*The sample is counties in metropolitan areas with populations between 100,000 and 400,000. The urban payment rate floor is applied to counties in metropolitan areas with population of at least 250,000. (Table entries are in dollars.)*

| Explanatory variable | (1) Over 250,000 + log population + other controls[1] | (2) Over 250,000 + log population[1] | (3) Over 200,000 + log population[1] | (4) Over 300,000 + log population[1] |
|---|---|---|---|---|
| MSA population | | | | |
| Over 250,000 (urban floor) | −13.40*** | −12.13** | — | — |
| Over 200,000 | — | — | −2.90 | — |
| Over 300,000 | — | — | — | −2.14 |
| Log MSA population | −5.56** | −2.15 | −5.51** | −6.14*** |
| Control variables | Yes | No | No | No |
| $R^2$ | 0.22 | 0.06 | 0.05 | 0.05 |
| N | 443 | 444 | 444 | 444 |

* p<0.10.
** p<0.05.
*** p<0.01.

[1] MSA population indicator and other explanatory variables included in regression.

NOTES:
1. MSA is Metropolitan Statistical Area.
2. Controls included in all regressions are: county FFS per capita expenditures, Medicare Physician Fee Schedule Geographic Adjustment Factor, the natural logarithm (log) of the Medicare Hospital Acute Inpatient PPS Urban Wage Index, the log of physicians per capita,; the log of hospital beds per capita, the Herfindahl-Hirschman index of hospital market concentration, the log of HMO penetration, an indicator of a CSA, and the log of population density.
3. For each log variable, if there are zero values in the original variable, an indicator of non-zero values is also included.
4. All variables except the dependent variables and the urban floor indicator are standardized to have a mean of zero and standard deviation of 1.

SOURCE: RTI analysis of CMS/Fu Associates OOP Cost, Area Resource File, and Medicare program data.

## Analysis by Plan Type

Section 6.1 showed and discussed many important differences in the effects of the benchmark rate by plan type. Thus, we chose to extend the RD analysis to study the two types of MA plans with the largest enrollment and largest differences found in Section 6.1—HMO and PFFS. We began by calculating new dependent variables that measured the OOP costs for only the particular plan type (i.e., HMO or PFFS). We then conducted an analysis using only counties that included at least one plan of the given type. The results found in this analysis, shown in Table 6-15, were consistent with those found in Section 6.1.

- Because every county in the sample has a PFFS plan, the sample for this analysis is the same as for the combined plan types analysis. We found that for PFFS plans, the

relationship between the benchmark rate and OOP cost was somewhat stronger than what was found in the overall analysis. The coefficient of interest in the total OOP cost regression was $17 here (versus $13 in the regression including combined plans), and similar to the main analysis, this is mostly accounted for by a drop in the Part C premium (of $14). One difference is that there is also a drop of $5 in the Part D premium in this group. All of these coefficients are significant at the 1-percent level.

- Because HMO plans only exist in slightly over half of the sample counties, the sample was reduced from 444 counties to only 238 for this analysis. As a result, although the main coefficients of interest were not substantially smaller (a decrease of $12 overall and a decrease of $8 for the Part D premium), they are not statistically significant here, even at the 10-percent level. However, there is a small but significant decrease of $1.47 in Part B premiums.

### 6.2.4 Conclusion

Although MA health plans in the urban floor counties of our sample are eligible for per member per month payments that are on average $60 higher than those in the rural floor counties, the plans are only more generous by $12 to $13, mostly through Part C premiums that are approximately $10 lower. These numbers are striking, but not as extreme as they appear at first glance. The following are some reasons why we would expect the change in the OOP costs studied here to be less than the difference in benchmark rates:

1. The difference of $60 is in the benchmark rates, not in the actual Medicare payments. Because of the bidding process described in Section 6.1.1 that is part of the determination of payment rates, differences in the actual payments to the insurance companies are smaller than the difference in benchmark rates. MedPAC (2009) found that although MA benchmarks are 18 percent higher than FFS costs on average, final payments only exceed FFS costs by 14 percent.

2. The OOP costs are estimated assuming that choice of plan is not affected by the particular health problems experienced by a beneficiary, and that the healthcare received is in turn unrelated to the generosity of the chosen plan (Fu Associates, Ltd., 2006). However, as described by Sangl (2000), an individual is more likely to choose a plan that provides generous coverage for the types of benefits that he or she expects to use. Thus, because MA plans cannot discriminate based on pre-existing conditions, a patient taking an expensive medication may choose a plan based on the co-pay required for that particular drug. A plan providing a low co-pay will then change that beneficiary's costs far more than is accounted for in the simulated OOP costs, as that is calculated based on population averages. If many beneficiaries make such choices, then changes in actual OOP cost could be substantially larger than those accounted for in the simulated OOP costs.

**Table 6-15**
**Regressions, by plan type, of average county MA plan predicted OOP costs on an urban floor county indicator and other factors**

*The sample is counties in metropolitan areas with populations between 100,000 and 400,000 that have at least one plan of the given type. The urban payment rate floor is applied to counties in metropolitan areas with populations of at least 250,000.*

| Explanatory variable | Total cost ($)[1] | Part B Premiums ($)[1] | Part C Premiums ($)[1] | Part D Premiums ($)[1] | Cost-sharing ($)[1] |
|---|---|---|---|---|---|
| **HMOs** | | | | | |
| Over 250,000 MSA population (urban floor) | −12.17 | −1.47** | −8.16 | 1.32 | −3.87 |
| Log MSA population | −2.35 | 0.22 | −3.76 | −2.68 | 3.87 |
| Control variables | Yes | Yes | Yes | Yes | Yes |
| $R^2$ | 0.18 | 0.13 | 0.29 | 0.085 | 0.07 |
| N | 238 | 238 | 238 | 238 | 238 |
| **PFFS Plans** | | | | | |
| Over 250,000 MSA population (urban floor) | −17.15*** | −0.15 | −14.27*** | −5.37*** | 2.63 |
| Log MSA population | −6.73*** | −0.03 | −2.28 | −3.00*** | −1.43 |
| Control variables | Yes | Yes | Yes | Yes | Yes |
| $R^2$ | 0.42 | 0.01 | 0.36 | 0.34 | 0.09 |
| N | 443 | 443 | 443 | 443 | 443 |

* p<0.1.
** p<0.05.
***p<0.01.

[1] Dependent variable.

NOTES:
1. MSA is Metropolitan Statistical Area.
2. HMO is health maintenance organization.
3. PFFS is private fee for service.
4. Controls included in all regressions are: county FFS per capita expenditures, Medicare Physician Fee Schedule Geographic Adjustment Factor, the natural logarithm (log) of the Medicare Hospital Acute Inpatient PPS Urban Wage Index, the log of physicians per capita, the log of hospital beds per capita, the Herfindahl-Hirschman index of hospital market concentration, the log of HMO penetration, an indicator of a CSA, and the log of population density.
5. For each log variable, if there are zero values in the original variable, an indicator of non-zero values is also included.
6. All variables except the dependent variables and the urban floor indicator are standardized to have a mean of zero and standard deviation of 1.

SOURCE: RTI analysis of CMS/Fu Associates OOP Cost, Area Resource File, and Medicare program data.

3. The simulated OOP costs exclude the costs of long-term care services and of non-Medicare-covered hearing, vision, preventive screening, chiropractic, routine physical exam, and podiatry services. Although few, if any, MA plans will be offering long-term care services, the other excluded services are fairly common possible extra MA benefits. As shown in Table 4-18a, 84 percent of MA enrollees had vision coverage and 69 percent had hearing exam coverage through their MA plans in 2008.

4. There are other changes that an insurance company may make to improve a plan without lowering costs to the enrollee. In particular, an HMO could be improved by expanding the network of providers, thus providing more choice and increasing the likelihood that a given patient's preferred physicians are included. This change could thus be of great value to plan enrollees, but would not appear in our calculations.

5. Another change that could be caused by the higher benchmark rate is an increase in the number of plans offered. Evidence of this change can be observed with 72 percent of the urban floor counties having at least one HMO plan compared to only 46 percent of the rural floor counties. Because this factor changes the composition of plans, it complicates the interpretation of the difference in OOP costs.

In addition, our results apply specifically to counties in MSAs with populations between 100,000 and 400,000, which may not generalize to all counties.[42]

There are many possibilities for fruitful extensions of this research. Studying each of the caveats previously listed could create a more accurate estimate of how much of the benchmark increase is passed on to enrollees in benefits. Analysis of the first reason—difference in the benchmark rates, not in the actual Medicare payments—would require data on the actual payment rates or plan bids; however, the third and fourth reasons—changes in plans not accounted for in the simulated OOP costs—can be analyzed in a straight-forward manner, using existing data on plan benefits, to get a more complete picture of the benefit changes that result from an increase in the benchmark payment rate. Finally, further work will be necessary to determine how we might evaluate the remaining two issues: (1) the behavioral change in plan choice and (2) the increased number of plans. Comparing zero premium versus non-zero premium plans can also give us a more precise picture of how the plans change. We expect there are more zero premium plans in the urban floor counties, and those plans are more likely to offer more attractive cost-sharing because once premiums are zero, any other improvements that need to be made must occur through cost-sharing. These extensions would allow us to understand in more detail the results of the differences in benchmarks and payment rates for MA plans by county and their policy implications.

[42] Limiting the analysis sample in this way allows us to claim a causal interpretation for our results.

# APPENDIX TABLES FOR SECTION 6

## Appendix Table 6-11A
## Regressions of average county MA plan predicted OOP costs on an urban floor county indicator and other factors

*The sample is counties in metropolitan areas with populations between 100,000 and 400,000. The urban payment rate floor is applied to counties in metropolitan areas with populations of at least 250,000.*

| Explanatory variable | Total cost ($)[1] | Part B Premiums ($)[1] | Part C Premiums ($)[1] | Part D Premiums ($)[1] | Cost-sharing ($)[1] |
|---|---|---|---|---|---|
| More than 250,000 MSA population (urban floor) | −13.40*** | −0.72** | −10.65*** | −1.27 | −0.76 |
| Log MSA population | −5.56** | 0.06 | −2.81* | −3.55*** | 0.73 |
| FFS rate | 5.33*** | −0.34*** | 4.78*** | 1.33*** | −0.44 |
| GAF | 5.20*** | −0.26** | 1.97 | 2.79*** | 0.69 |
| Log wage index | 5.14*** | 0.19* | 2.88** | −0.67 | 2.74*** |
| Log MDs per capita | −6.33*** | 0.24 | −1.75 | −1.71** | −3.10** |
| Non-zero MDs per capita | −2.52 | −0.36 | −4.37 | −0.13 | 2.35 |
| Log beds per capita | −1.56 | −0.19 | −4.34* | −1.88 | 4.85** |
| Non-zero beds per capita | 10.78 | 0.46 | 15.37*** | 6.24** | −11.29** |
| HHI | −1.92 | 0.00 | −0.35 | −0.43 | −1.14 |
| Log HMO penetration | 6.46*** | 0.03 | 5.07*** | 1.06 | 0.30 |
| Non-zero HMO penetration | −17.91** | −0.47 | −10.34* | −3.52 | −3.59 |
| CSA | 5.37* | 0.33* | 2.77 | 1.05 | 1.23 |
| Log density | 1.75 | −0.08 | −0.44 | 0.28 | 1.98* |
| Percent poverty | 0.31 | 0.04 | −0.98 | −0.04 | 1.29 |
| Percent Medicare eligible | −0.33 | −0.12 | 1.71* | 0.33 | −2.24*** |
| Intercept | 321.42 | 96.66*** | 28.5*** | 15.10*** | 181.15*** |
| $R^2$ | 0.22 | 0.07 | 0.20 | 0.15 | 0.04 |
| N | 443 | 443 | 443 | 443 | 443 |

* p<.1.
** p<.05.
*** p<.01.

[1] Dependent variable.

NOTES:
1. MSA is Metropolitan Statistical Area.
2. FFS rate is county fee for service per capita expenditures.
3. GAF is Medicare Physician Fee Schedule Geographic Adjustment Factor.
4. Wage index is Medicare Hospital Acute Inpatient PPS Urban Wage Index.
5. MDs are physicians.
6. Beds per capita is hospital beds per capita.
7. HHI is Herfindahl-Hirschman index of hospital market concentration.
8. HMO is health maintenance organization.
9. CSA is Consolidated Statistical Area.
10. Density is population density.
11. Log is natural logarithm.

SOURCE: RTI analysis of CMS/Fu Associates OOP Cost, Area Resource File, and Medicare program data.

## Appendix Table 6-12A
## Regressions of average county MA plan total predicted OOP cost on county MSA population indicators—sensitivity analysis

*The sample is counties in metropolitan areas with populations between 100,000 and 400,000. The urban payment rate floor is applied to counties in metropolitan areas with populations at least 250,000. Table entries are in dollars.*

| Explanatory variable | (1) Over 250,000 + log population + other controls[1] | (2) Over 250,000 + log population[1] | (3) Over 200,000 + log population[1] | (4) Over 300,000 + log population[1] |
|---|---|---|---|---|
| MSA population | | | | |
| Over 250,000 (urban floor) | −13.40*** | −12.13** | — | — |
| Over 200,000 | — | — | −2.90 | — |
| Over 300,000 | — | — | — | −2.14 |
| Log MSA population | −5.56** | −2.15 | −5.51** | −6.14*** |
| FFS rate | 5.33*** | — | — | — |
| GAF | 5.20*** | — | — | — |
| Log wage index | 5.14*** | — | — | — |
| Log MDs per capita | −6.33*** | — | — | — |
| Non-zero MDs per capita | −2.52 | — | — | — |
| Log beds per capita | −1.56 | — | — | — |
| Non-zero beds per capita | 10.78 | — | — | — |
| HHI | −1.92 | — | — | — |
| Log HMO penetration | 6.46*** | — | — | — |
| Non-zero HMO penetration | −17.91** | — | — | — |
| CSA | 5.37* | — | — | — |
| Log density | 1.75 | — | — | — |
| Percent poverty | 0.31 | — | — | — |
| Percent Medicare eligible | −0.33 | — | — | — |
| Intercept | 321.42*** | 311.77*** | 309.22*** | 308.49*** |
| $R^2$ | 0.22 | 0.06 | 0.05 | 0.05 |
| N | 443 | 444 | 444 | 444 |

* p<.1.
** p<.05.
*** p<.01.

[1] MSA population indicator and other explanatory variables included in regression.

NOTES:
1. MSA is Metropolitan Statistical Area.
2. FFS rate is county fee for service per capita expenditures.
3. GAF is Medicare Physician Fee Schedule Geographic Adjustment Factor.
4. Wage index is Medicare Hospital Acute Inpatient PPS Urban Wage Index.
5. MDs are physicians.
6. Beds per capita is hospital beds per capita.
7. HHI is Herfindahl-Hirschman index of hospital market concentration.
8. HMO is health maintenance organization.
9. CSA is Consolidated Statistical Area.
10. Density is population density.
11. Log is natural logarithm.

SOURCE: RTI analysis of CMS/Fu Associates OOP Cost, Area Resource File, and Medicare program data.

## Appendix Table 6-13A
## Regressions by plan type of average county MA plan predicted OOP costs on an urban floor county indicator and other factors

*The sample is counties in metropolitan areas with populations between 100,000 and 400,000. The urban payment rate floor is applied to counties in metropolitan areas with populations of at least 250,000.*

| Explanatory variable | Total cost ($)[1] | Part B Premiums ($)[1] | Part C Premiums ($)[1] | Part D Premiums ($)[1] | Cost-sharing ($)[1] |
|---|---|---|---|---|---|
| **HMOs** | | | | | |
| More than 250,000 MSA population (urban floor) | −12.17 | −1.47 | 8.16 | 1.32 | −3.87 |
| Log MSA population | −2.35 | 0.22 | −3.76 | −2.68 | 3.87 |
| FFS rate | −2.86 | −0.59*** | −0.43 | 0.08 | −1.92 |
| GAF | −2.27 | −0.87*** | −7.13** | 2.23 | 3.50 |
| Log Wage Index | 16.53*** | 0.40 | 15.24*** | −1.29 | 2.18 |
| Log MDs per capita | −7.17* | 0.46 | −1.57 | −1.77 | −4.29 |
| Non-zero MDs per capita | −3.29 | −1.82 | 5.39 | 16.98 | −23.86 |
| Log beds per capita | −6.20 | −0.23 | 2.48 | −1.35 | −7.10 |
| Non-zero beds per capita | 19.90 | 0.83 | 3.88 | 4.69 | 10.49 |
| HHI | −0.32 | −0.29 | 2.00 | 1.74* | −3.77 |
| Log HMO penetration | 11.10*** | 0.46 | 8.01*** | 4.90*** | −2.28 |
| Non-zero HMO penetration | −33.60* | −2.26 | −18.04 | −8.87 | −4.43 |
| CSA | 8.70 | 1.04** | 8.47** | 3.58* | −4.39 |
| Log density | 3.27 | −0.13 | −3.19 | −1.01 | 7.60** |
| Percent poverty | 3.27 | 0.08 | −5.28** | −0.25 | 8.71*** |
| Percent Medicare eligible | 1.52 | −0.53*** | 2.89 | 1.47 | −2.30 |
| Intercept | 342.63*** | 99.39*** | 38.45 | −1.10 | 205.91*** |
| $R^2$ | 0.18 | 0.13 | 0.29 | 0.08 | 0.07 |
| N | 238 | 238 | 238 | 238 | 238 |

(continued)

## Appendix Table 6-13A (continued)
## Regressions by plan type of average county MA plan predicted OOP costs on an urban floor county indicator and other factors

| Explanatory variable | Total cost ($)[1] | Part B Premiums ($)[1] | Part C Premiums ($)[1] | Part D Premiums ($)[1] | Cost-sharing ($)[1] |
|---|---|---|---|---|---|
| **PFFS Plans** | | | | | |
| More than 250,000 MSA population (urban floor) | −17.15*** | −0.15 | −14.27*** | −5.37*** | 2.63 |
| Log MSA population | −6.73*** | −0.03 | −2.28 | −3.00*** | −1.43 |
| FFS rate | 17.26*** | −.082* | 10.61*** | 4.40*** | 2.33*** |
| GAF | 6.07*** | −0.06 | 3.13** | 3.35*** | −0.35 |
| Log Wage Index | −3.16* | 0.09 | −1.57 | −0.91 | −0.78 |
| Log MDs per capita | −6.28*** | 0.04 | −3.65** | −2.17*** | −0.50 |
| Non-zero MDs per capita | −2.87 | −0.26 | −1.09 | 0.58 | −2.10 |
| Log beds per capita | −4.66 | −0.17 | −2.28 | −1.80 | −0.41 |
| Non-zero beds per capita | 14.14* | 0.38 | 5.75 | 5.80** | 2.21 |
| HHI | −3.46** | 0.04 | −1.99** | −1.12** | −0.38 |
| Log HMO penetration | 0.93 | 0.01 | 0.90 | 0.38 | −0.36 |
| Non-zero HMO penetration | −5.87 | −0.23 | −4.21 | −1.88 | 0.46 |
| CSA | −1.43 | −0.02 | −1.39 | −0.21 | 0.19 |
| Log density | 5.25*** | 0.04 | 3.89*** | 1.12 | 0.20 |
| Percent poverty | 2.31* | −0.05 | −0.18 | 0.88* | 1.66*** |
| Percent Medicare eligible | 2.59* | 0.04 | 1.73* | 0.40 | 0.41 |
| Intercept | 313.57*** | 96.47*** | 26.18*** | 16.15*** | 174.76*** |
| $R^2$ | 0.42 | 0.01 | 0.36 | 0.34 | 0.09 |
| N | 443 | 443 | 443 | 443 | 443 |

* p<.1.
** p<.05.
*** p<.01.

[1] Dependent variable.

NOTES:
1. HMO is health maintenance organization.
2. PFFS is private fee for service.
3. MSA is Metropolitan Statistical Area.
4. FFS rate is county fee for service per capita expenditures.
5. GAF is Medicare Physician Fee Schedule Geographic Adjustment Factor.
6. Wage index is Medicare Hospital Acute Inpatient PPS Urban Wage Index.
7. MDs are physicians.
8. Beds per capita is hospital beds per capita.
9. HHI is Herfindahl-Hirschman index of hospital market concentration.
10. CSA is Consolidated Statistical Area.
11. Density is population density.
12. Log is natural logarithm.

SOURCE: RTI analysis of CMS/Fu Associates OOP Cost, Area Resource File, and Medicare program data

# SECTION 7
# CONCLUSIONS

The Medicare Advantage (MA) program has undergone major changes in the past few years. Most prominently, an important new benefit, outpatient prescription drugs through Medicare Part D, was added to the Medicare program in 2006, impacting the traditional fee-for-service (FFS) program and MA. New plan types have been introduced or encouraged in MA, including local and regional preferred provider organizations (PPOs), private fee-for-service (PFFS), special needs plans (SNPs), and MSAs. Some of these new plans, particularly PFFS and SNPs options, have continued to grow and expand access to Medicare beneficiaries. Regional PPOs have certainly contributed to choice in many areas, but they have not continued to expand during the past 2 years. Medical Savings Accounts (MSAs), originally available in most counties, have not proven very successful and their availability has significantly decreased in 2008. MA payment rates have been substantially enhanced in many areas since the spring 2004 implementation of the Medicare Modernization Act (MMA)-mandated MA payment methodology changes. The continuing impact of these changes was experienced through 2008. This report captures the plan availability, premiums, benefits, and enrollment patterns associated with the Medicare Advantage payment policies that were in effect through 2008. The Patient Protection and Affordable Care Act, enacted in March 2010, restructures payments to MA plans. Continued monitoring of the impacts of the new changes on plan availability, premiums and benefits, and beneficiary enrollment, will be conducted.

To conclude this report, we highlight some notable findings from each of the three aspects of MA that we monitored empirically—plan availability, premiums and benefits, enrollment, and payment rates—and from our analysis of aspects of MA benchmark payment rates and their impacts.

## 7.1 Plan Availability

MA plan availability—already improving between 2006 and 2007—improved even further in 2008. Noteworthy improvements in availability in 2008 included the continued universal availability of PFFS plans, continued expansions of HMOs and new local PPOs, and the substantial improvement in the availability of SNPs, both outside of large urban areas and with different target populations. HMO options continue to dominate the MA program, and an additional 55 contracts were offered in 2008. Access to at least one PFFS plan improved in 2008 to all counties. PFFS options remained more available to beneficiaries residing in rural and small urban counties than either HMO or local PPO options. Access to local PPOs, which had improved rapidly from 2003 to 2006, leveled off in 2007 as the MMA-mandated moratorium on new local PPO plans was in effect. This plateau turned out to be temporary, as an additional 23 local PPO contracts entered the MA program in 2008.

The availability of SNPs grew the fastest of any plan category from 2007 to 2008. Nationally, in 2007, SNPs were available in 46.5 percent of counties and concentrated mostly in urban counties. This increased markedly to availability in 81.5 percent of counties by 2008, suggesting that SNPs continue to gain popularity rapidly. Offerings of chronic-condition SNPs grew especially rapidly.

MSA plans, initially available in a majority of counties of all urbanicity classifications in their 2007 introductory year, were only available in limited counties by 2008 due to the withdrawal of contracts. In 2007, MSAs were offered by two regular contracts and one demonstration contract and were available in 71 percent of counties nationally, including broadly across urban and rural areas and different regions. By late 2008, only two MSA contracts remained active, covering only 3.1 percent of counties.

Improvements were also made during 2008 in terms of sheer number of plan sponsors to choose from. In 2006, only 25 percent of Medicare beneficiaries had access to more than 10 contracts. This figure rose significantly in 2007 to more than 60 percent of Medicare beneficiaries. By 2008, 86 percent of beneficiaries had access to 10 or more contracts, more than three times the level from 2006. Even in rural areas, the percentage of beneficiaries with access to 10 or more contracts rose to 63 percent in 2008 from under 3 percent in 2006.

## 7.2 Premiums and Benefits

Overall, changes in MA premiums from 2007 to 2008 were modest, but varied by Part C versus Part D and by plan type. The 2008 average monthly enrollment-weighted MA total (Part C + D) premium rose 1.1 percent from 2007. The 2008 average Part C premium was down 2.3 percent from 2007, but the 2008 average Part D premium was up 9.8 percent. PFFS plan total premiums rose by 36 percent from 2007 to 2008, and HMO and local PPO total premiums fell. PFFS total premiums more than doubled from 2006 to 2008, and HMO total premiums rose a modest 3 percent. The result was that after considerably underpricing HMOs in 2006, by 2008 PFFS total premiums had reached parity with HMO total premiums. PFFS Part C premiums were still lower than HMO Part C premiums in 2008, but PFFS Part D premiums were higher. Overall, between 2006 and 2008, average MA total premiums rose by 10 percent. Although most MA enrollees paid zero or modest premiums in 2008, more than one-fifth paid a total monthly premium of $75 or greater and 11 percent paid $100 or more.

From 2007 to 2008, the urban-rural premium gap widened as urban premiums fell by 1 percent, whereas rural premiums rose by 9 percent. Regional premium differences remained pronounced in 2008. Average monthly total premiums were highest in the Northeast ($56.29) and lowest in the South ($16.05).

In 2008, MA enrollees' prescription drug benefits improved significantly in several respects. From 2007 to 2008, the percentage of enrollees with plan-provided integrated enhanced drug coverage rose from 65 percent to 75 percent.[43] More than three-quarters of HMO and PPO enrollees had enhanced integrated coverage, as did the majority of PFFS enrollees. The proportion of MA enrollees with enhanced drug coverage rose by 18 percentage points in the West from 2007 to 2008 and by 14 percentage points in the Northeast.

Coverage of the Part D coverage gap or "donut hole" also improved significantly. In 2008, 63 percent of MA-PD enrollees (excluding SNPs) were in plans with some form of gap coverage, up substantially from 34 percent in 2007. Approximately 85 percent of PFFS Medicare Advantage Prescription Drug Plan (MA-PD) enrollees had gap coverage, which is a huge

[43] These percentages are of all MA enrollees, including those in MA plans not offering Part D.

increase from 8 percent in 2007. Typically gap coverage was for generic drugs only (39 percent of non-SNP MA-PD enrollees), but the percentage of enrollees with some brand gap coverage nearly tripled from 2007 to 2008 (from 9 percent to 25 percent).[44] These benefit improvements may have been one factor behind the 14-percent increase in average non-SNP MA plan Part D premiums from 2007 to 2008 and the 49-percent rise in average PFFS MA-PD premiums.

In terms of cost sharing provisions, from 2007 to 2008, an increasing portion of MA enrollees were paying co-insurance and a falling proportion co-payments for primary care visits. The percentage of enrollees with no ($0) co-payment rose from 10 percent to 19 percent between 2007 and 2008, whereas the percentage with co-insurance rose from 4 percent to 11 percent. The greater proportion with co-insurance was driven by the increase in PFFS plans, whereas the higher proportion with no co-payment resulted from changes among HMOs and local PPOs.

Nearly half (46 percent) of MA enrollees had an out-of-pocket (OOP) maximum in 2008, approximately the same as in 2007. The most common OOP maximum in 2008 was in the $3,001 to $4,000 range. The median OOP maximum was $3,200 in 2008, up from $3,100 in 2007 and $3,000 in 2006. OOP maximums were least common in HMOs—only 35 percent of HMO enrollees had one in 2008. All regional PPO and MSA enrollees and nearly two-thirds of PFFS and local PPO enrollees had an OOP maximum.

Total average monthly simulated OOP costs for all plan types and any health status enrollees fell by $5 (or 2 percent) from 2007 to 2008. Greater generosity of outpatient prescription drug coverage more than offset a rise in the Medicare Part B premium. Local PPO OOP costs decreased the most between 2007 and 2008, by $24 per month, or 7 percent.

## 7.3 Enrollment

Consistent with increased availability of MA options to a greater proportion of Medicare beneficiaries, enrollment in MA plans has also steadily increased, rising to 19 percent of all eligible beneficiaries in 2008. From 2007 to 2008, MA enrollment grew by 941,354, or 13.9 percent, with 399,161 of this increase (42 percent) in HMO plans; 234,830 (25 percent) in PFFS plans; and 217,022 (23 percent) in local PPO plans. Although the enrollment change between 2006 and 2007 was broadly similar (1,080,277), it was primarily due to an increase of 668,676 (62 percent) in PFFS enrollment. HMOs were still the dominant plan type in MA, but together PFFS and PPOs (local and regional) had approximately one-third of 2008 MA enrollment. Compared to the HMO increase in enrollment of 8 percent from 2007 to 2008, the local PPO increase was 62 percent, PFFS increased by 16 percent, and the regional PPO increase was 48 percent. Active MSA contracts had an enrollment of 473 beneficiaries in 2008.

MA enrollment retained its bias towards urban areas in 2008, but the rate of enrollment growth was much stronger in rural areas. Among 2008 MA enrollees, 88 percent resided in urban areas, and 12 percent resided in rural areas. At 21 percent versus 11 percent, the MA penetration rate was approximately double for urban compared to rural beneficiaries. However, the

[44] The brand gap coverage percentages assume that the MA-PD reporting category “all formulary drugs” includes some brand drugs.

percentage increase in rural enrollment from 2007 to 2008 was 25 percent, compared to only 14 percent for urban enrollment.

In 2008, the MA penetration rate was 27 percent in the West, 21 percent in the Northeast, 17 percent in the South, and 14 percent in the Midwest. However, the Midwest and South had the highest percentage growth in MA enrollment from 2007 to 2008, with the Midwest growing by 21 percent and the South by 16 percent. This compares to 11 percent MA growth in the Northeast and 10 percent in the West.

In 2008, HMOs accounted for 73 percent of urban MA enrollment and PFFS plans 16 percent. In contrast, PFFS plans accounted for 59 percent of rural MA enrollment and HMOs 27 percent. PPOs accounted for slightly greater than 10 percent of MA enrollment in both urban and rural areas and 2008. Regional PPO enrollment was heavily concentrated in the South in 2008 (57 percent). More than three-quarters of PFFS enrollment was in the South or Midwest (41 percent and 36 percent, respectively). In 2008, MA enrollment in the Northeast and West was dominated by HMOs, comprising approximately 80 percent of enrollment in each of these regions. This differs substantially from the Midwest and South, where PFFS plans were much more popular (comprising 45 percent and 27 percent of enrollment, respectively).

Also consistent with the substantial improvement in availability of SNP programs, enrollment in SNPs increased rapidly in 2008. Among MA enrollees in 2008, 1,002,334 (13 percent) were enrolled in an SNP, which was a 34 percent increase over 2007. Among SNP enrollees, two-thirds were enrolled in a dual-eligible SNP, with 13 percent in a chronic-condition SNP and 19 percent in an institutional SNP. Enrollment in chronic-condition SNPs rose substantially from 74,039 in 2007 to 194,497 in 2008. Most SNP enrollees (838,033 out of 1,002,334) were in HMOs in 2008. The majority of HMO SNP enrollees were in dual-eligible SNPs (77 percent). Regional PPOs had the highest percentage of their enrollment in SNPs (27 percent), with a relatively strong chronic-condition SNP proportion. Local PPOs also had a high percentage of their enrollment in SNPs (15 percent), as did HMOs (16 percent).

## 7.4 Medicare Advantage Payment Rates and Impacts

County benchmark payment rates, which serve as a basis for MA payment to plans, are one influence on the number, plan type, premiums, and benefits offered to beneficiaries. There is a large variation in MA county benchmark payment rates, ranging from a low of $716.25 to a high of $1,323.40 in 2008. In 2008, nearly two-thirds of counties' benchmark payment rates were updated 2004 floor rates. The South accounted for approximately 80 percent of the counties with the highest benchmark rates—those over $900. More than 16 percent of counties had benchmark payment rates more than 25 percent higher than the FFS rate (FFS per capita expenditures).

HMO plan availability, premiums, and OOP costs were correlated with the county benchmark payment rate. HMO plan availability increased on average from less than 1 contract in counties with benchmark rates below $750, to more than 11 contracts in counties with benchmark rates more than $900. Part C premiums fell from $49.35 to $5.79 as the benchmark payment rate increased from less than $750 to more than $900 and simulated OOP costs fell from $339.53 to $253.06. PPO plan availability, premiums, and OOP costs did not appear to be

correlated with either the county benchmark payment rate or the benchmark to FFS payment rate ratio.

The relationship of PFFS contract characteristics to county benchmark payment rates is of significant interest to policy makers, given the enormous growth of this contract type. PFFS contract availability, premiums, and OOP costs were correlated with a higher benchmark to FFS payment ratio, but not with a higher county benchmark payment rate. PFFS plan availability increased from an average of less than 5 contracts in counties with a benchmark to FFS payment rate ratio less than 1.05 to approximately 10 contracts in counties with a ratio greater than 1.15. PFFS Part C premiums fell steadily from $31.38 to $6.64 as the benchmark to FFS payment rate ratio increased from 1 to more than 1.25.

We also analyzed the impact of the discontinuity in MA county benchmark payment rates created by the urban floor rate. We found that the higher payment rates in counties subject to the urban floor were related to lower average MA plan simulated OOP costs. This relationship was especially strong for PFFS plans; however, the average difference in OOP costs was much smaller than the average difference in benchmark rates ($13 average reduction in OOP costs versus $60 average increase in benchmark payments in counties subject to the urban floor). There are several potential reasons for this disparity, including differences in plan costs and benefits that are not accounted for in our measure of OOP costs. The decrease in average simulated OOP costs associated with the urban floor rate results primarily from a decrease in Part C premiums.

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## COMPUTER OUTPUT LIST

Chapter 2 Tables

**Table 2-1—Creation of analysis sample of MA contracts, 2008**

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**Table 2-2—Creation of analysis sample of MA plans, 2008**

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**Table 2-3—Enrollment (HPMS and MIIR) in analysis sample of MA plans, 2008**

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Chapter 3 Tables

**Table 3-1—Number of MA contracts by plan type**

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**Table 3-2—Percent of counties with at least one MA contract, by plan type**

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**Table 3-3—Number and percent of Medicare beneficiaries with access to MA plans**

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**Table 3-4—Percent of counties with at least one MA contract, by plan type and urbanicity**

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**Table 3-5—Percent of counties with at least one MA contract, by plan type and region**

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**Table 3-6—Percentage of beneficiaries and counties with access to MA plans**

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**Table 3-7—Percentage of beneficiaries and counties with access to MA plans, by urbanicity**

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**Table 3-8—Percentage of beneficiaries and counties with access to MA plans, by region**

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**Table 3-9—Percentage of MA contracts , by number of contracts and urbanicity**

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**Table 3-10—Percentage of MA contracts , by number of contracts and region**

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**Table 3-11—Number of special needs contracts by plan type and target beneficiaries**

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**Table 3-12—Number of special needs plans, by plan type and target beneficiaries, 2008-2006**

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Chapter 4 Tables

**Table 4-1—Mean monthly premiums of MA plans, by plan type**

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**Table 4-2—Percent of MA enrollees in zero premium plans, by plan type**

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**Table 4-3—Percent of enrollees in MA plans , by premium range**

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**Table 4-4—Mean monthly premiums of MA plans, by urbanicity**

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**Table 4-5—Percent of MA enrollees in zero premium plans, by urbanicity**

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**Table 4-6—Mean monthly premiums of MA plans, by region**

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**Table 4-7—Percent of MA enrollees in zero premium plans, by region**

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**Table 4-8—Part B premium reduction, by MA plan type, urbanicity and region, percent of enrollees**

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**Table 4-9—Prescription drug benefits, by MA plan type, percent of enrollees**

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**Table 4-10—Prescription drug benefits of MA enrollees, by urbanicity, percent of enrollees**

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**Table 4-11—Prescription drug benefits of MA enrollees by region, percent of enrollees**

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**Table 4-12—Cost sharing before the initial coverage limit, by type of MA prescription drug plan; percent of enrollees**

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**Table 4-13—Common cost sharing structures in MA prescription drug plans, median copayments or coinsurance by drug tier**

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denominator is from:
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2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_request6_nov11 log
denominator is from:
H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_request7_nov11.log

**Table 4-14—Initial coverage limit in MA prescription drug plans, by plan and geographic characteristics**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_icl_snp.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request1_nov06.log

**Table 4-15—Gap coverage in MA prescription drug plans, by plan and geographic characteristics**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\gp_gap_filling_request1a.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request1_nov06.log

**Table 4-16—Selected mandatory supplemental benefits in MA plans, percent of enrollees with benefit**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_bd_request3_oct22.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request2_oct29.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_gp_request5_nov10.log

**Table 4-17—Cost sharing for selected MA plans**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_bd_request3_oct22.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request2_oct29.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_gp_request5_nov10.log

**Table 4-18—Out of pocket (OOP) maximums in Medicare Advantage plans, percent of enrollees**

Computer Output:
2006 H:\project\07964\017fama\pgm\ykaganova\Programs\new_gp_request_may1.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request1_nov06.log

**Table 4-19—Out of pocket maximums in MA plans, by plan type, urbanicity and region**

Computer Output:
2006 H:\project\07964\017fama\pgm\ykaganova\Programs\new_gp_request_may1.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request1_nov06.log

**Table 4-20—Monthly out-of-pocket costs, by plan type**

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\oopc_2007\new_gp_request2_march17.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\oopc_2008\new_gp_request2_nov13.log

**Table 4-21—Monthly out-of-pocket costs, by urbanicity**

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\oopc_2007\new_gp_request2_march17.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\oopc_2008\new_gp_request2_nov13.log

**Table 4-22—Monthly out-of-pocket costs, by census region**

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\oopc_2007\new_gp_request2_march17.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\oopc_2008\new_gp_request2_nov13.log

Chapter 5 Tables

**Table 5-1—Medicare Advantage Enrollment by plan type, 2008-2006**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request6_add_sep08.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2007 K:\Project\07964\017 FAMA\pgm\vakhmerova\programs\DEN2007.LOG.
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log
2008 K:\Project\07964\017 FAMA\pgm\vakhmerova\programs\DEN2008E.LOG

**Table 5-2—Medicare Advantage by beneficiary characteristics, 2008-2006**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request6_add_sep08.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2007 K:\Project\07964\017 FAMA\pgm\vakhmerova\programs\DEN2007.LOG.
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log
2008 K:\Project\07964\017 FAMA\pgm\vakhmerova\programs\DEN2008E.LOG

**Table 5-3—Medicare Advantage Enrollment by Urbanicity, 2008- 2006**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request3.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2007 K:\Project\07964\017 FAMA\pgm\vakhmerova\programs\DEN2007.LOG
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log
2008 K:\Project\07964\017 FAMA\pgm\vakhmerova\programs\DEN2008E.LOG

**Table 5-4—Medicare Advantage Enrollment by Census Region, 2008-2006**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request3.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2007 K:\Project\07964\017 FAMA\pgm\vakhmerova\programs\DEN2007.LOG.
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log
2008 K:\Project\07964\017 FAMA\pgm\vakhmerova\programs\DEN2008E.LOG

**Table 5-5—Medicare Advantage enrollment, plan type by urbanicity, column percentages, 2008-2006**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request5.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log

**Table 5-6—Medicare Advantage enrollment, plan type by urbanicity, row percentages, 2008-2006**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request5.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log

**Table 5-7—Medicare Advantage enrollment, plan type by urbanicity and census region, column percentages, 2008-2006**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request5.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log

**Table 5-8—Medicare Advantage enrollment, plan type by urbanicity and census region, row percentages, 2008-2006**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request5.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log

**Table 5-9—Special Needs Plan Enrollment, by Plan Type, 2006-2008**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request6.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log

**Table 5-10—Part D Enrollment in Medicare Advantage by Plan Type, 2006-2008**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_jk_enrollment_request6.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request2_march06.log
2008 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_jk_request2_dec04.log

## Chapter 6 Tables

**Table 6-1—Distribution of 2008 MA county benchmark payment rates**

Computer Output:
H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_risk_rate_2008_graph.do
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request3_feb15_raterange.log
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request3_feb15_raterange_v3.log

**Table 6-2—The 2008 ratio of MA county benchmark payment rate to FFS payment rate**

Computer Output:
H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request3_feb15_ffsratio.log
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request3_feb15_ffsratio_v3.log

**Table 6-3—Weighted average number of MA contracts by plan type and 2008 MA county benchmark payment rate**

Computer Output:
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request3_feb15_raterange_v2.log

**Table 6-4—Weighted average number of MA contracts by plan type and ratio of 2008 MA county benchmark payment rate to FFS rate**

Computer output:
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request3_feb15_ffsratio_v2.log

**Table 6-5—Average enrollment-weighted premiums by plan type and 2008 MA county benchmark payment rate**

Computer output:
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request4_feb20_2008_v2.log

**Table 6-6—Average enrollment-weighted premiums by plan type and ratio of 2008 MA county benchmark payment rate to FFS rate**

Computer output:
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request4_feb20_2008_v2.log

**Table 6-7—Simulated monthly OOP costs ($) by plan type and 2008 MA benchmark payment rate (Any health status or age)**

Computer output:
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request6_march03_oopc.logs

**Table 6-8—Simulated monthly OOP cost by plan type and ratio of 2008 MA county benchmark payment rate to FFS rate (Any health status or age)**

Computer output:
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request6_march03_oopc.logs

**Table 6-9—2008 MA penetration by plan type and 2008 MA county benchmark payment rate**

Computer output:
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fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request3_feb15_raterange_v3.log
H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_ss_request10_may12_no42.log
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_ss_request10_may12_no42_add.log

**Table 6-10—2008 MA penetration by plan type and ratio of 2008 MA county benchmark payment rate to FFS rate**

Computer output:
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_dh_request3_feb15_ffsratio_v3.log
H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_ss_request10_may12_no42.log

H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_ss_request10_may12_no42_add.log

### Table 6-11—Characteristics of analysis sample counties subject to the rural and urban payment floors—standardized variables

Computer output:
H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2008\new_ss_request10_may12_no42.log
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_ss_request10_may12_no42_add.log

### Table 6-12— Characteristics of United States and analysis sample counties

Computer output:
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H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_ss_request10_may12_no42_add.log

### Table 6-13—Regressions of average county MA plan predicted OOP costs on an urban floor county indicator and other factors

Computer output:
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fama\pgm\ykaganova\Programs\hpms_july2008\new_ss_request10_may12_no42_add_hmo.log
H:\project\07964\017
fama\pgm\ykaganova\Programs\hpms_july2008\new_ss_request10_may12_no42_add_pffs.log