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# Medicare Advantage Plan Availability, Premiums and Benefits, and Beneficiary Enrollment in 2007

## Report

Prepared for

**Melissa Montgomery, Ph.D.**
Centers for Medicare & Medicaid Services
Office of Research, Development, and Information
Mail Stop C3-19-26
7500 Security Boulevard
Baltimore, MD 21244-1850

Prepared by

**Gregory C. Pope, M.S.**
**Leslie Greenwald, Ph.D.**
**John Kautter, Ph.D.**
**Brian Dulisse, Ph.D.**
**Adam Block, Ph.D.**
**Nathan West, M.A.**
RTI International
Health, Social, and Economics Research
Waltham, MA 02451-1623

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RTI INTERNATIONAL

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Authors: Gregory C. Pope, M.S.
Leslie Greenwald, Ph.D.
John Kautter, Ph.D.
Brian Dulisse, Ph.D.
Adam Block, Ph.D.
Nathan West, M.A.

Project Director: Gregory Pope, M.S.

Associate Project Director: Leslie Greenwald, Ph.D.

Federal Project Officer: Melissa Montgomery, Ph.D.

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## EXECUTIVE SUMMARY

This report presents findings on Medicare Advantage (MA) plan availability, premiums and benefits, and beneficiary enrollment in 2007. In addition, we summarize perspectives of selected MA plans on recent developments in MA, as gained from interviews we conducted with plan representatives.[1] This report focuses especially on key recently implemented features of MA, 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 new Medical Savings Account (MSA) option. In light of these continued changes in the MA program, 2007 is yet another important year in which to monitor these elements of the program. We identify changes from 2006 to 2007 and, for plan availability, put the 2007 developments in a longer-run context of trends documented for 2000 to 2005 in the prior work of this project.

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 special needs plans, 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.[2] 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[3]

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 again in 2007 to a total of 458, from 408 in July 2006. The gain in total contracts from 2006 to 2007 slowed to 50, down from about 100 more total contracts per year in 2005 and in 2006. (Table 3-1)

- HMOs added 37 new contracts in 2007. New entry of local PPOs was under a Congressionally imposed moratorium in 2007. The number of PPO contracts decreased in 2007 relative to 2006, with 13 fewer local PPO contracts, although 3

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1 Plan perspectives are not summarized in this Executive Summary. Please see Section 6 of the report for plan perspectives.

2 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.

3 In addition to this Executive Summary, the concluding Section 7 of this report provides a (shorter) four-page summary of findings.

additional regional PPOs participated in MA. Substantial growth in Private Fee-for-Service (PFFS) contracts continued, with an almost doubling (from 21 to 41) of the number of contracts between 2006 and 2007. (Table 3-1)

- HMOs remained the dominant plan type of MA contract, but alternative types have grown in importance. In 2007, 64 percent of MA contracts were HMOs, compared to 98 percent in 2000. Local PPOs grew from 1 to 107 contracts from 2000 to 2007 and comprised 23 percent of MA contracts in 2007. 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)

- Virtually all Medicare beneficiaries had access to at least one MA option in 2007. HMO availability continued to increase significantly to include at least one plan in 40 percent of counties. Local PPO availability was reduced slightly to 30 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, offered for the first time under MA in 2007, were available in 71 percent of counties under three contracts (including a demonstration contract). (Table 3-2)

- By 2007, all MA plan types were available to a majority of Medicare beneficiaries. 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. (Table 3-3)

- In 2007, PFFS plans, regional PPOs, and MSAs were widely available throughout urban and rural areas. Access to PFFS plans improved in 2007 to 100 percent of large urban counties from 87 percent of such counties in 2006. HMOs, local PPOs, and SNPs were more widely available in large and medium urban areas. The availability of SNPs doubled from 25 percent of counties in 2006 to 47 percent in 2007. SNPs were available in over one-third of rural counties in 2007 compared to only 16 percent of rural counties in 2006. (Table 3-4)

- HMOs, local PPOs, and SNPs were most widely available in the Northeast. SNP availability rose significantly outside the Northeast from 2006 to 2007, especially in the South. PFFS plans were available almost everywhere in 2007, 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 were extensively, though not universally, available in all regions. (Table 3-5)

*2) Access to multiple MA plan types and contracts in 2007*

- From 2006 to 2007, the percentage of beneficiaries with access to all three major plan types—HMOs, PPOs (including regional PPOs), and PFFS—rose from 54 to 75 percent. Primarily this occurred because PFFS plans were first offered in 2007 in

certain large urban areas where previously only HMOs and PPOs were available. Another 22 percent of beneficiaries had access to at least one PPO and one PFFS plan in 2007, but no HMO. All three major plan types were available in 39 percent of counties in 2007; 55 percent of counties had access to PPOs and PFFS, but not HMOs. (Table 3-6)

- In urban areas, 86 percent of beneficiaries had access to all three major plan types (HMOs, PPOs, and PFFS). Only about a third of rural beneficiaries had access to all three plan types due primarily to the paucity of HMO offerings in rural areas. But 59 percent of rural beneficiaries had access to PFFS plans and PPOs, if not HMOs. (Table 3-7)

- 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 2007 as PFFS plans was more widely available in these regions in 2007. (Table 3-8)

- More than 64 percent of Medicare beneficiaries had access to 10 or more MA contracts in 2007, a significant increase over 2006 when just under 25 percent had this extensive plan choice. In rural areas, the percentage of beneficiaries with access to 7 or more contracts rose to 71 percent in 2007 from 13 percent in 2006, and the percentage that had 3 or fewer MA contracts to choose from fell from 46 percent in 2006 to less than 2 percent in 2007. (Table 3-9)

- A majority of beneficiaries in all census regions had a choice among 10 or more MA contract options in 2007, compared to between 19 and 39 percent in 2006. (Table 3-10)

- In 2007, SNPs were offered through both HMO and PPO contracts, including six regional PPOs that offered SNPs. Eighty-eight percent of contracts offering SNPs were HMOs. About 42%of the contracts offering at least one SNP in 2007 specialized in offering SNPs only. The total number of MA contracts offering SNPs rose from 158 in 2006 to 215 in 2007, with 54 additional HMO and 3 additional regional PPO contracts offering at least one SNP. (Table 3-11)

- There was a 45 percent growth in the total number of SNPs from 2006 to 2007. Growth occurred in all three types of SNPs—institutional, dual Medicare/Medicaid eligible, and chronic condition. The number of chronic condition SNPs increased from only 10 in 2006 to 57 in 2007, surpassing the number of institutional SNPs. Despite growth in the other two types, dual eligible SNPs still comprised 70 percent of total SNPs in 2007.

- The HMO plan type was the most common for all three types of SNPs in 2007, but about 28% of institutional SNPs were local PPOs, and about one-third of chronic

condition SNPs were offered through regional PPO contracts. Overall, 65 percent of 2007 SNPs were HMOs targeted at dual-eligible beneficiaries.

Premiums and benefits[4,5]

*1) Premiums*

- Half (51.4 percent) of MA enrollees received their Part C and Part D benefits at zero additional premium in 2007, a slight decline from 2006. (Table 4-2)

- The 2007 average monthly MA total (Part C + D) premium was $32.35, 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. (Table 4-1)

- PFFS plan total premiums rose by 57 percent, from an average of $14.80 in 2006 to an average of $23.20 in 2007. HMO and local PPO total premiums rose more modestly, by 8 and 12 percent, respectively, to $33.11 and $76.58, respectively, in 2007. (Table 4-1)

- Although most MA enrollees paid zero or modest premiums, nearly one-quarter (22 percent) paid a total monthly premium of $75 or greater and 11 percent paid $100 or more. (Table 4-3)

- The urban–rural difference in MA premiums was relatively modest: the average MA total monthly premium of urban MA enrollees was $32.08 and of rural MA enrollees was $36.85. Urban premiums rose 9 percent and rural premiums 5 percent from 2006 to 2007. (Table 4-4)

- Regional premium differences were pronounced. Average premiums were highest in the Northeast ($58.51) and lowest in the South ($13.49). Over 7 of 10 Southern MA enrollees paid no total premium, while 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 MA Part D plans, only 24 percent, compared to at least 49 percent in the other regions. From 2006 to 2007, total premiums rose at the lowest rate in the Northeast (6 percent) and at the highest rate in the West (14 percent). (Tables 4-6 and 4-7)

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

5 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.

- In 2007, 3.4 percent of MA enrollees had their Part B premium reduced, by an average of $52.71. More than 7 percent of Southern enrollees and more than 4 percent of PFFS plan enrollees had their Part B premium reduced. The percentage of MA enrollees with a premium reduction decreased very slightly from 3.5 percent in 2006 to 3.4 percent in 2007. (Table 4-8)

*2) Part D benefits*

- About 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. (Tables 4-9 and 4-10)

- In 2007, 65 percent of MA enrollees had an enhanced Part D benefit, up slightly from 63 percent in 2006.[6] 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 declined and the percentage with basic coverage rose. (Table 4-9)

- Northeastern MA enrollees were least likely to have enhanced drug coverage (55 percent), while about 70 percent of Midwestern and Southern enrollees had enhanced coverage in 2007. However, the proportion of MA enrollees with enhanced drug coverage rose by 12 percentage points from 2006 to 2007 in the Northeast and fell by 7 percentage points in the South. (Table 4-11)

- The vast majority (90 percent) of MA prescription drug plan (MA-PD) enrollees paid no Part D deductible in 2007, up slightly from 86 percent in 2006. (Table 4-12)

- About 92 percent of 2007 MA-PD enrollees were in plans with drug co-payment tiers before the initial coverage limit. The number of co-payment tiers was usually 3, but some enrollees had 2. More than 82 percent of MA-PD enrollees were in plans with one or two coinsurance tiers (usually employed for specialty, injectable, or expensive drugs). More than half (55 percent, up from 28 percent in 2006) of MA-PD enrollees were in plans with three co-payment and one coinsurance tiers. (Tables 4-12 and 4-13)

- Typical (median) Rx co-payments were fairly stable between 2006 and 2007. In the most common 3 copayment/1 coinsurance tier structure, the median co-payment for tier 1 (generics) fell from $5 to $4; for tier 2 (preferred brand) rose from $28 to $29;

6 These percentages are of *all* MA enrollees, including those in MA plans not offering Part D.

and for tier 3 (nonpreferred brand) rose from $58 to $60. [7] Median co-insurance rose from 25 to 33 percent. (Table 4-13)

- Eighty-six percent of 2007 MA-PD enrollees were in plans with the standard $2,400 initial coverage limit (ICL), up from 76 percent in 2006 (when the standard limit was $2,250). In 2007, about 8 percent of enrollees had a lower ICL than standard, and about 6 percent a higher ICL than standard. (Table 4-14)

- 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), but the percentage of enrollees with some brand gap coverage doubled 2006 to 2007—from 5 to 9 percent. (Table 4-15)

- In 2007, only 8 percent of PFFS MA-PD enrollees had gap coverage, compared to 39 percent of HMO MA-PD enrollees. Eleven percent of HMO MA-PD enrollees had some brand gap coverage, but few enrollees in other plan types had brand gap coverage. (Table 4-15)

- Urban MA-PD enrollees were more than twice as likely as rural enrollees to have gap coverage (35 percent versus 17 percent) and were much more likely to have some brand gap coverage (9.6 percent versus 2.5 percent). (Table 4-15)

- In 2007, gap coverage was most common in the Northeast (42 percent) and South (39 percent) and least common in the Midwest (26 percent) and West (27 percent). Generics-only gap coverage was most common in the Northeast, where 40 percent of MA-PD enrollees had it. Some brand gap coverage was most common in the South (15 percent) and West (12 percent). From 2006 to 2007, generics-only gap coverage grew strongly in the Northeast and Midwest at the expense of no gap coverage. In the West, no gap coverage rose at the expense of generics-only gap coverage. In the South, some brand gap coverage grew at the expense of no or generics-only gap coverage. (Table 4-15)

*3) Other benefits and cost sharing*

- In 2007, 79 percent of MA enrollees had vision coverage (eye exams and glasses). About two-thirds of MA enrollees had coverage for hearing exams, one-third dental coverage, about one-quarter coverage for podiatry, and 5 percent for chiropractic treatment. The percentages of MA enrollees with these benefits in 2007 did not change much from 2006, with the exception of a slight decline in the proportion of enrollees with vision coverage. The proportion of PFFS enrollees with vision and dental benefits rose strongly from 2006 to 2007 but still lagged the provision of these benefits in other non-MSA plan types. (Table 4-16)

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

- In 2007, as in 2006, most MA enrollees faced co-payments of $5 to $15 for primary care physician visits. But the co-payment distribution shifted upward from 2006 to 2007. For example, 29 percent of MA enrollees' co-payments were in the $10.01 to $15 range in 2007 versus 25 percent in 2006. In 2007, 10 percent of enrollees had no primary care co-payment, while another 9 percent paid more than $15. (Table 4-17)

- The most common specialist physician visit co-payment amounts in 2007 were in the $25.01 to $35 range, up from the $15.01 to $25 range in 2006. Emergency department co-payments were almost always about $50. More than 85 percent of MA enrollees faced co-payments or coinsurance for hospital services, either acute inpatient admissions or outpatient care. More than three-quarters were charged co-payments or coinsurance for X-ray and clinical laboratory services. The proportion of MA enrollees charged co-payments or coinsurance for these services rose slightly from 2006 to 2007. (Table 4-17)

- 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. (Tables 4-18 and 4-19)

- OOP maximums were least common in HMOs—only one-third of HMO enrollees had one in 2007. All MSA enrollees and most PFFS enrollees (77 percent) had an OOP maximum, as did about half of local PPO and three-quarters of regional PPO enrollees. Of enrollees with an OOP maximum, local PPO enrollees had the lowest (in network) 2007 median OOP maximum of only $1,000 (down $500 from 2006). Enrollees in MSA plans had a median OOP maximum of $2,500, HMO and regional PPO enrollees about $3,000, and PFFS plan enrollees, $5,000. (Table 4-19)

- Urban enrollees were less likely to have OOP cost maximums than rural enrollees, but when they existed, urban maximums were typically slightly lower, with the urban–rural gap narrowing substantially from 2006 to 2007. Regionally, about two-thirds of Midwestern enrollees had OOP cost maximums in 2007, but only one-fifth of Northeastern enrollees did. About half of Southern and Western enrollees were in plans with a maximum. When a maximum existed in 2007, the median was either $3,000 or $3,100 in the Northeast, Midwest, and South, but $4,000 in the West, a $1,000 increase from 2006. (Table 4-19)

*4) Simulated Medicare Advantage enrollee out of pocket costs*

- Across all MA enrollees, 2007 average OOP costs were simulated to be $303 per month. About 30 percent of total OOP cost was the Medicare Part B premium; 11 percent comprised the plan Part C and Part D premiums; 31 percent represented outpatient drug expenses (even with prescription drug coverage through Medicare Parts D and B); and 28 percent was payments for inpatient (8 percent), dental (8 percent), and all other services (11 percent). (Table 4-20)

- Simulated OOP costs are 80 percent greater, $426 versus $237 per month, for MA enrollees in poor health compared to enrollees in excellent health. The largest contributor to higher OOP costs with poor health is increased outpatient prescription drug expenses, accounting for 57 percent of the total increase. The remaining 43 percent is higher expenses for inpatient and other medical services. (Table 4-20)

- 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 14 percent for enrollees in average health. Most plan type differences are related to variations in average Part C premiums. (Table 4-20)

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

- Across regions, simulated average OOP costs range from 12 percent below the national average in the South to 7 percent above 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 4-22)

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.

- Nearly all 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. (Tables 5-1 and 5-9)

- Although HMOs were still the dominant plan type in MA, together PFFS and PPOs (local and regional) had about 29 percent of 2007 MA enrollment, which was about 10 percentage points 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. (Table 5-1)

- Among 2007 MA enrollees, 89 percent resided in urban areas, and 11 percent in rural areas. At 20 versus 9 percent, the MA penetration rate was double for urban compared to rural beneficiaries. However, the percentage increase in rural enrollment from 2006 to 2007 was 56 percent, compared to only 15 percent for urban enrollment. (Table 5-3)

- In 2007, the MA penetration rate was 26 percent in the West, 19 percent in the Northeast, 15 percent in the South, and 12 percent in the Midwest. However, the Midwest and South had the highest percentage growth in MA enrollment from 2006 to 2007, with the Midwest growing by 31 percent and the South by 27 percent. This

compares to 13 percent MA growth in the Northeast and 10 percent in the West. (Table 5-4)

- Only 4.6 percent of MA HMO enrollees and 9 percent of local PPO enrollees resided in rural areas in 2007. This contrasted with 33 percent of PFFS enrollees, 32 percent of MSA enrollees, and 22 percent of regional PPO enrollees. (Table 5-5)

- In 2007, HMOs accounted for 76 percent of urban MA enrollment and PFFS plans 16 percent. In contrast, PFFS plans accounted for 62 percent of rural MA enrollment and HMOs 29 percent. PPOs accounted for less than 10 percent of MA enrollment in both urban and rural areas and 2007 MSA enrollment were negligible. (Table 5-6)

- Regional PPO and initial MSA enrollment was heavily concentrated in the South in 2007 (59 and 65 percent, respectively). Over three-quarters of PFFS enrollment was in the South or Midwest (44 and 34 percent, respectively). (Table 5-7)

- In 2007, MA enrollment in the Northeast and West was dominated by HMOs, comprising more than 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 44 and 29 percent of enrollment, respectively). (Table 5-8)

- Among MA enrollees in 2007, 746,408 (11 percent) were enrolled in a SNP, which was a 53 percent increase over 2006. Among SNP enrollees, 71 percent were enrolled in a dual-eligible SNP, with 10 percent in a chronic condition SNP, and 19 percent in an institutional SNP. Enrollment in chronic condition SNPs rose substantially from 1,490 in 2006 to 74,039 in 2007. (Table 5-9)

- Most SNP enrollees (651,650 out of 746,408) were in HMOs. The majority of HMO SNP enrollees were in dual-eligible SNPs (78 percent). Regional PPOs had the highest percentage of their enrollment in SNPs (25 percent), with a relatively strong chronic condition SNP proportion. Local PPOs also had a high percentage of their enrollment in SNPs (13 percent), with a relatively strong institutional SNP proportion. (Table 5-9)

- At 93 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 rate for each plan type (except for MSA at 77 percent) was approximately 90 percent, with PFFS enrollees slightly less likely to have Part D coverage than enrollees in other non-MSA plan types. Almost 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. However, the percentage of MA enrollees in Part D that were enrolled in a stand-alone drug plan increased by 3.7 percentage points between 2006 and 2007. About 36 percent of PFFS enrollees with Part D coverage were enrolled in stand-alone drug plans. (Table 5-10)

# 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 health care 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 doctors, 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 change. In 1997, in the Balanced Budget Act of 1997 (BBA), the 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." The conferees also noted the goal of making these options "available to beneficiaries nationwide."[8] Subsequently, in 2003, the Congress made changes in the payment methodology, explaining that "The goal is to increase beneficiary choice, by increasing private plan participation in Medicare." 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."[9] The current phase in the evolution of the MA program is particularly eventful with the continued integration of Part D (prescription drug) benefits, the introduction of regional PPO plans, and the expansion of PFFS.

This report documents 2007 MA plan availability, premiums, benefits, cost sharing, and enrollment. Changes from 2006 to 2007 (and for plan availability trends since 2000) are described. 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, Program of All-Inclusive Care for the Elderly (PACE), and other non-MA Medicare private health plans, as well as plans located in Puerto Rico and the U.S. territories.[10] Other sources that

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8 Conference Report for Balanced Budget Act of 1997, Report 105-217, page 585.

9 Conference Report for Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Report 108-391, pages 527 and 531.

10 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.

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. The first phase of this project 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 (Balanced Budget Refinement Act of 1999 [BBRA] and 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.[11] The Report to Congress analyzed trends in the MA program from 2000 through 2005.

The second, and current, phase of this project focuses on monitoring the MA program from 2006 through 2008. This second interim report presents analyses of the program in 2007 in three key areas: plan availability, plan premiums and benefits, and beneficiary enrollment. Selected MA plan perspectives as gained from our interviews with plan personnel are also presented. The next section, 1.2, briefly reviews the key findings from the first phase of this project (2000 to 2005) and from our first interim report for the second project phase (2006) as background for this report. Section 1.3 describes the major legislated changes in the MA program taking effect in 2007; 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 data sources that were used for this report. Sections 3 to 5 present the empirical findings. Section 3 presents findings on plan availability, Section 4 on premiums and benefits, and Section 5 on beneficiary enrollment. Section 6 summarizes the results of interviews we conducted with selected MA plan personnel. Section 7 provides brief conclusions.

## 1.2 Review of Key Project Findings 2000 to 2006

### 1.2.1 Project Phase One: 2000 to 2005

Historically, payments to Medicare health plans were tied to local FFS per capita costs. The Balanced Budget Act of 1997 (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/local rate, and limited rate updates in counties with higher rates in an attempt to narrow geographic payment differences. Following 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 developments, Congress enacted several laws to refine and modify the payment provisions of the BBA, including the BBRA of 1999 and the Benefits Improvement Protection Act of 2000. However, the next fundamental change in the Medicare health plans program was the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). 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. In previous

[11] The basis of the Report to Congress, with some subsequent updating, is available as the final report of the first phase of this project (Pope et al., 2006).

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 plans did not improve until after the MMA.

- 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 throughout this time period. Enrollment in rural counties improved slightly as of 2005, though overall rural enrollment remained small.

### 1.2.2 Project Phase Two, First Interim Report: 2006

Several important changes occurred in the MA program in 2006. The MMA added a major new benefit to the basic Medicare benefit package in 2006, 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.

New types of plans were created by the MMA or earlier BBA of 1997 that offer alternative provider access, premiums, and benefits to beneficiaries. These 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 on a service-by-service basis the plan's terms and conditions for payment; and special needs plans (SNPs), which are targeted at beneficiaries with special needs.

Also 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 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 update of the greater of the national Medicare expenditure growth percentage or 2 percent. Another significant payment change is that the phase-in of risk adjustment continued; 75 percent of plan payments were risk adjusted in 2006.

In our Project Phase Two, First Interim Report (Pope et al., 2007), the following key developments in the MA program in 2006 were documented:[12]

Plan Availability

- Almost all Medicare beneficiaries had access to at least one MA option in 2006. The policy goal of extending access to MA plans to all areas, including rural areas, had largely succeeded by 2006.

- Each MA plan type was available in more counties in 2006 than in 2005. In 2006, HMOs were available in just over a 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 23 percent of counties.

- 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.

Plan Premiums, Benefits, and Cost Sharing

- Over half (53 percent) of MA enrollees received their Part C and Part D benefits at zero additional premium in 2006.

- The average monthly MA Part C premium in 2006 was $19.71, the average Part D premium was $11.63, and the average total (Parts C + D) premium was $30.43.

[12] Some corrections in data, and changes in the sample of MA plans, occurred after our report on MA in 2006 was completed. This report on the MA program in 2007 and our subsequent report on the status of the MA program in 2008 (Pope et al., 2010) were revised to reflect the latest methods and data for 2006–2008. Results presented in our reports on the MA program in 2007 and in 2008 are therefore consistent, but may differ in usually minor ways from the results of our report on the MA program in 2006 (Pope et al., 2007) that are summarized in this section.

- Sixty-two percent[13] of MA enrollees had an enhanced Part D benefit. Defined standard Part D coverage was uncommon, except in SNPs. About 11 percent of MA enrollees were in plans without a Part D benefit.

- About 27 percent of MA prescription drug plan (MA-PD) enrollees were in plans with some form of gap coverage in 2006. Overwhelmingly, gap coverage was for generic drugs only (84 percent of all enrollees with gap coverage had generics only).

- In 2006, 83 percent of MA enrollees had vision coverage (eye exams and glasses). About two-thirds of MA enrollees had coverage for hearing exams, one-third dental coverage, about one-quarter coverage for podiatry, and only 6 percent for chiropractic treatment.

- Most MA enrollees faced co-payments of $5 to $15 for primary care physician visits and $15 to $25 per specialist visit. More than 85 percent of MA enrollees faced co-payments or coinsurance for hospital services, either acute inpatient admissions, or outpatient care. About three-quarters were charged co-payments or coinsurance for X-ray and clinical laboratory services.

- About 42 percent of MA enrollees had an out-of-pocket (OOP) maximum. A typical OOP maximum was $3,000, and most maximums ranged from $1,000 to $5,000.

Enrollment

- There was a significant increase in MA enrollment between 2005 and 2006, with an overall increase in enrollment of 31 percent.

- PFFS enrollment rose substantially between 2005 and 2006, by 682,345 beneficiaries. PFFS enrollment grew by nearly as many beneficiaries as HMO enrollment, despite starting from a much smaller base than HMOs.

- MA enrollment in July 2006 was 5.5 million, with a penetration rate of 14.2 percent of MA-eligible beneficiaries. Although HMOs are still the dominant players in MA, together PFFS and PPOs (local and regional) comprised about 20 percent of MA enrollment.

- Among MA enrollees, 91 percent resided in urban areas, and 9 percent in rural areas. At 17 percent, the percentage of beneficiaries residing in urban areas taking up an MA plan was triple that of the beneficiaries residing in rural areas (6 percent).

In short, the context for developments in 2007 is that the MA program had declined in the early years of this decade but had rebounded in 2005 and 2006 following the passage and implementation of the MMA.

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[13] This percentage is of *all* MA enrollees, including those in MA plans not offering Part D.

## 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. This section describes MA-related provisions taking effect in 2007.

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 our 2006 interim report (Pope et al., 2007, Section 1.3). Changes to the MA program in 2007 were more modest but included some continuations of payment rate method changes and the introduction of another new plan option: MSA plans.

**Payment Rate Methodologies**—Changes to the MA payment rate methodology in 2007 were limited to modifications to ongoing elements. Risk adjustment under the CMS-HCC system continued, although as of 2007 payments are now subject to 100 percent risk adjustment. As required by the Deficit Reduction Act, 2007 is the first of four phase-out years for the MA budget neutrality adjustment, which has the effect of lowering MA capitation payment rates compared to what they would have otherwise been. Additional changes in MA rates were made through a series of adjustments and corrections. The relative risk factors in the CMS-HCC risk adjustment model were recalibrated in 2007. CMS used more recent diagnosis and claims data to update the relative risk factors used to produce risk scores for all Medicare beneficiaries. The recalibrated model reflected more recent trends in utilization and coding. Because of the CMS-HCC recalibration, the MA risk ratebooks were restandardized in 2007. CMS restandardizes the risk rates whenever the risk adjustment model is recalibrated. Finally, the FFS component of MA rates was rebased in 2007. By rebasing, CMS recalculates the per capita FFS expenditures for each county so that the FFS rates reflect more recent county growth trends in FFS expenditures. For the 2007 rates, the geographic index for each county (the ratio of county to national per capita county FFS expenditures) was based on the average of 5 years of FFS data (2000 through 2004).

The Medicare Part D payment methodology continued to evolve in 2007 from its 2006 base year. Part D defined standard benefit parameters such as the deductible, the initial coverage limit, and the OOP threshold were updated for Medicare drug expenditure inflation. In calculating the national average monthly bid amount, an enrollment-weighted plan average was introduced, but only as a transitional blend with the 2006 equal-weighted average. An abrupt transition to the full enrollment-weighted average would have lowered Part D plan direct subsidies and might have resulted in significant increases in Part D beneficiary premiums. The 2006 unweighted plan average methodology was retained for the 2007 regional low-income benchmark premiums because moving immediately to enrollment-weighted averages could have caused significant disruption in assigning low-income subsidy enrollees to qualifying Part D plans.[14]

[14] A transition to an enrollment-weighted methodology was begun in 2008.

**Implementation and Proliferation of New Plan Types**—Effective in 2007, the MMA introduced another new plan type that operates under different implementation rules and modified payment methodologies: MSAs. Originally authorized as a limited demonstration program in the BBA of 1997, the MSA option combines a high-deductible health plan with an account MSA that beneficiaries can access to pay for noncatastrophic expenses. Enrollees of Medicare MSA plans can initially use their savings account to help pay for health care; then they will have coverage through a high-deductible insurance plan once they reach their deductible. This option is being offered both in the regular MA program and in a demonstration program. In demonstration MSA plans, some MSA provisions are waived—notably, demonstration plans can have deductibles lower than their OOP cost limits, with cost sharing for expenses between the deductible and OOP limit, and differential in-network versus out-of-network cost sharing—to make the plans more like other consumer-directed health plans, such as health savings accounts (HSAs) available in the private sector.

We also note that the MMA-established moratorium on new local PPO plans continued from 2006 into 2007, its last year. Existing local PPOs were permitted to offer new products within their existing service areas. This provision was intended to encourage the entry of regional PPOs.

## 1.4 Goals of this Report

Implementation of the 2007 legislative mandates for the MA program, as well as the continued influence of past legislative mandates, has impacted the MA program. The goal of this report is to document MA plan availability, premiums and benefits, and beneficiary enrollment in 2007 as they evolved in response to these legislative changes and other factors. We identify changes from 2006 to 2007 and, for availability analyses, put the 2007 developments in a longer-run context of trends documented for 2000 to 2005 in the Phase One work of this project. This report focuses especially on key recently implemented features of MA in 2007, including Part D prescription drug benefits, MSAs, more widely available SNP plans, and other new MA plan options mandated under the MMA. To inform the secondary data analysis and gain additional perspective on recent developments in MA, we also interviewed personnel from a selection of MA plans. These plan perspectives are also summarized in this report.

# SECTION 2
# METHODOLOGY

## 2.1 Overview

In this section, we provide an overview of our empirical methodological approach for monitoring the MA program in 2007. Additional methodological detail specific to certain analyses is presented in subsequent sections of this report. Our quantitative analyses were performed on CMS administrative data. We describe here the primary methodological definitions, approaches, issues, challenges, samples, and data sources used in our analyses. The methodology for our plan interviews is described in Section 6, along with the results of the interviews.

## 2.2 Contracts and Plans

In the 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—for example, 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, since 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, HMO, local PPO, regional PPO, PFFS, or MSA. Each MA contract contains only one of these plan types (although a contract may contain multiple plans of the same type). So contracts, as well as 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 HMO-like plans that are sponsored by a provider organization rather than an insurer.

One important type of MA plan—special needs plans or 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 nonemployer-only MA plans must enroll any beneficiary eligible for MA. We therefore refer to nonemployer-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 such as total MA, HMOs, etc. PFFS plans cannot offer a 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)**—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.[15]

- **Local Preferred Provider Organizations (local PPOs)**—PPOS are a variant of coordinated care contracts in which no network health care 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)**—Regional PPOs are coordinated care plans and were new to Medicare in 2006. Like 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 a uniform product(s), at the same premium(s), 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)—**SNPs are coordinated care plans that target beneficiaries with special needs. They 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 (PFFS)**—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 FFS basis, at the traditional Medicare payment rates or higher.

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[15] As noted, we also group the uncommon "provider sponsored organization" (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 see out-of-network providers willing to accept the payment terms of the PFFS plan, but they 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 (MSA)**—New for 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 is 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 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 nondemonstration MSA plans in our analysis.

In general, we did not include non-MA plans in our analyses. Non-MA plans include demonstration,[16] 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.[17] In practice, this meant that we included several contracts that had demonstration status

[16] 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.

[17] At the time of the final revision of this report, data on MA in 2008 were available to us so we defined our plan sample for this report (for MA in 2007 and earlier) consistently with how it was defined for our report on MA in 2008 (Pope et al., 2010).

in 2006 and/or 2007, but became regular MA plans—primarily SNPs—in 2008.[18] We excluded employer-only plans from our analyses because these types 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 MA contracts that offered a mix of employer-only and nonemployer plans. Finally, we included only plans that were Part A/B plans and excluded plans located in Puerto Rico and the U.S. Territories.

## 2.4 Enrollment Weighting of Premiums and Benefits

Unless otherwise noted, our analyses of MA plan premiums and benefits are weighted by plan enrollment. They 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 one enrollee the same as a plan with one 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 examined HMOs because we wanted to examine 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 and 2007 include HMOs, PPOs, and PFFS and include all 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 Phase Two of this project.

As a consequence of including all plans in our premiums and benefits analysis, our 2006 and 2007 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 2007 premiums and benefits

[18] This plan sample inclusion rule was adopted for this report and for our report on MA in 2008 (Pope et al., 2010). Our report on MA in 2006 (Pope et al., 2007) excluded all plans with demonstration status in 2006 other than those specified in footnote 16. Thus, the plan sample and results for 2006 contained in our report on MA in 2006 (Pope et al., 2007) differ slightly from the 2006 results contained in this report and in our report on MA in 2008 (Pope et al., 2010).

analysis is limited to a cross-sectional analysis of 2007 and changes from 2006 to 2007. We did not attempt trend analysis of MA premiums and benefits for 2000 to 2007, or even 2005 to 2007.

Even if we had not made the change in enrollment weighting, comparison of 2006 and 2007 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 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 2007). 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 (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 areas of 1 million or more
- Medium urban: counties in metropolitan areas of 250,000 to 1 million
- Small urban: counties in metropolitan areas of less than 250,000
- Rural, urban-adjacent: nonmetropolitan counties adjacent to at least one metropolitan county
- Rural, nonadjacent: nonmetropolitan counties not adjacent to any metropolitan counties

Our regional definition was the four U.S. census regions:

- Northeast
- Midwest
- South
- West

## 2.6 Beneficiary Sample

Our analysis focuses on options available to Medicare beneficiaries. However, since individuals diagnosed with end stage renal disease (ESRD) 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 on 2000 to 2005, we were unable to obtain a consistent month of the year for trend analyses because of data limitations (see Pope et al. [2006] for more details). For 2006 and 2007, we chose to obtain data for July of each year, 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 2007 and July 2006, not an "ever enrolled" in 2007 or in 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 and 2007 and analyzing trends for 2000 to 2007. 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 analyze 2007 and changes from 2006 to 2007.

We discussed in Section 2.4 that 2000 to 2007 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 2007 and of changes from 2006 to 2007.

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 and 2007 with the MIIR,

compared to our imperfect exclusion for 2000 to 2005 with the EDB. For this report, we use the MIIR to analyze 2007 MA enrollment and changes in enrollment from 2006 to 2007.

## 2.9 Data Sources

**CMS Health Plan Management System (HPMS)**—The primary data source used in our analyses was CMS' Health Plan Management System (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) datasets are available for each month and contain information describing the benefit package provided by each plan, including information on premiums, co-payments, coinsurance 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 and July 2007 HPMS/PBP extracts.

**HPMS Plan Enrollment Data Extract**—Because of delays in obtaining the MIIR enrollment data, RTI completed 2006 and 2007 national-level premiums and benefits analyses using plan enrollment weights from the Plan Enrollment Data Extract from 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 (MIIR)**—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 and 2007 enrollment analyses.

**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 (OOP) Cost Estimates—**CMS/Fu Associates simulated average OOP costs for beneficiaries of various ages and health statuses if they were enrolled in each MA plan in 2007 (Fu Associates, 2007). Using Medicare Current Beneficiary Survey data, CMS/Fu developed an average medical services utilization profile for beneficiaries in each age and health status cell. CMS/Fu 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/health status cell sizes reported by Fu (Fu Associates, 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 nonmerges 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.

## SECTION 3
## PLAN AVAILABILITY

### 3.1 Introduction

One goal of 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 BBA and BBRA were implemented) and 2007 (3 years after initial MMA provisions were implemented), focusing on trends in the most recent 2 years. We examined changes in total number of contracts participating in 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 2007

#### 3.2.1 Number of Contracts

First, we looked at 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.[19]

**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 |
|---|---|---|---|---|---|---|---|---|
| Total MA contracts | 264 | 179 | 154 | 178 | 178 | 289 | 408 | 458 |
| Total coordinated care contracts | 263 | 178 | 152 | 175 | 175 | 275 | 387 | 414 |
| HMO[1] | 259 | 173 | 147 | 137 | 132 | 176 | 256 | 293 |
| Local PPO[2] | 1 | 2 | 3 | 35 | 40 | 93 | 120 | 107 |
| Regional PPO | — | — | — | — | — | — | 11 | 14 |
| MSA[3] | — | — | — | — | — | — | — | 3 |
| PFFS | 1 | 1 | 2 | 3 | 3 | 14 | 21 | 41 |

[1] HMO includes HMO POS; 2006 and 2007 also include PSO.

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

[3] Includes MSA demonstration contracts.

NOTES: SNPs incorporated by plan type. 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.

[19] A contract is an agreement between an MA organization and CMS 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 SNPs) (e.g., HMOs, local PPOs).

The sharp increase in the number of contracts that began in 2005 continued into 2007, with the total number of MA contracts rising to 458. The gain in total contracts from 2006 to 2007 did slow to 50, down from about 100 more total contracts per year in 2005 and in 2006. PFFS contracts showed the largest proportional growth in 2007, with an almost doubling (from 21 to 41) of the number of contracts between 2006 and 2007. By July 2007, the number of HMOs continued their trend of adding new contracts each year (37 new in 2007). However, with the MMA moratorium on new local PPOs in 2007, growth in PPOs (seen particularly in 2005 and 2006) ended, with the total number of PPO contracts in MA decreasing in 2007 relative to 2006. In 2007, there were 13 fewer local PPO contracts but 3 additional regional PPOs participating in MA. Three new 2007 contracts represented the first MSA contracts in MA.

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, 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 about 62 percent. By June 2005, the number of MA contracts, exceeded the number of contracts at the beginning of our analysis period, 2000.

HMOs remained the dominant plan type of MA contract, but alternative types have grown in importance since the MMA. In 2000, 259 of the 264 MA contracts, or 98 percent, were HMOs. In 2007, HMOs were 293 of 458 MA contracts, or 64 percent. Local PPOs grew from 1 to 107 contracts from 2000 to 2007 and comprised 23 percent of MA contracts in 2007. This Medicare share for local PPOs is a reduction compared to 2006, when 29 percent of MA contracts were local PPOs. PFFS plans accounted for only a relatively small number of contracts throughout the period (2000-2004) but have also increased substantially since then. By 2007, 9 percent of MA contracts were PFFS. While this is still a relatively small percentage of total MA contracts, PFFS contracts tend to cover large service areas relative to other plan types.

### 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 health care plans, we also analyzed for each year between 2000 and 2007 the percentage of counties in which at least one Medicare contract was available. Our findings are shown in Table 3-2. Table 3-2 maps the contracts to counties served and presents data on the proportion of counties with access by each type of plan.[20] Continuing the trend from the last several years, most plan types were available in more counties in 2007 than in earlier years.

[20] 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 |
|---|---|---|---|---|---|---|---|---|
| Coordinated care plans | | | | | | | | |
| HMO[1] | 25.9% | 20.3% | 19.1% | 17.8% | 18.5% | 29.0% | 34.5% | 40.3% |
| Local PPO[2] | 0.2 | 0.2 | 0.4 | 6.3 | 7.6 | 22.7 | 29.5 | 28.5 |
| Regional PPO | — | — | — | — | — | — | 89.9 | 89.9 |
| Noncoordinated care plans | | | | | | | | |
| MSA[3] | — | — | — | — | — | — | — | 71.3 |
| PFFS | 52.7 | 52.7 | 51.6 | 54.9 | 40.6 | 92.9 | 96.0 | 99.9 |

[1] HMO includes HMO POS; 2006 and 2007 also include PSO.

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

[3] Includes MSA demonstration contracts.

NOTES: SNPs incorporated by plan type. 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.

In 2007, HMO availability continued to increase significantly to include at least one plan in 40.3 percent of counties. This followed 2006, in which HMO availability rose moderately, and beneficiaries had access to HMOs in just over a 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 almost 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 in the percentage of counties with at least one HMO contract, to 29.0 percent.

In 2007, with the moratorium on new plans, local PPO availability was reduced slightly (a reduction in access of 1.0 percent of counties). This reverses the trend of sharply 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. In their first year, regional PPOs accounted for only 11 contracts but were available in almost 90 percent of all counties. Regional PPO access remained unchanged between 2006 and 2007, with

these larger contracts reaching a large proportion of counties despite the relatively few number of contracts.

By 2007, virtually all counties had access to at least one PFFS option, driven by the almost doubling of PFFS contracts between 2006 and 2007. 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.

MSAs, offered for the first time under MA in 2007, were available in 71.3 percent of counties. Like regional PPOs and PFFS options, MSA plans cover this wide service area with very few contracts (three).

### 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 CMS Web site; results for 2005 to 2007 were drawn from the CMS Denominator files.[21]

In 2007, all MA plan types were available to a majority of Medicare beneficiaries. Over 77 percent of Medicare beneficiaries had access to an HMO in 2007—above the 2000 level. Nearly all beneficiaries had access to PFFS and MSA plans. However, access to PPOs decreased slightly in 2007 relative to 2006 with the MMA moratorium on new local PPOs, but a majority of beneficiaries retained access to these options.

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21 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.) In order to facilitate a comparison of 2006 data to 2005, the results for 2005 were recalculated using the Denominator file; as a result, the 2005 results reported here differ from earlier tables reported in Pope et al. (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 |
|---|---|---|---|---|---|---|---|---|
| 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 |
| 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 |
| 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 |
| Regional PPO | — | — | — | — | — | — | 34,426,846 | 35,019,154 |
| 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 |
| MSA[3] | — | — | — | — | — | — | — | 31,119,087 |
| II. Percent | | | | | | | | |
| MA plans | 83.3% | 80.9% | 78.3% | 78.5% | 74.8% | 97.7% | 99.6% | 99.9% |
| HMO[1] | 68.1 | 62.9 | 60.0 | 57.4 | 59.2 | 69.9 | 72.3 | 76.6 |
| Local PPO[2] | 1.5 | 2.1 | 4.1 | 23.0 | 25.1 | 56.0 | 64.5 | 63.5 |
| Regional PPO | — | — | — | — | — | — | 88.5 | 88.4 |
| PFFS | 38.1 | 37.9 | 36.0 | 37.0 | 30.7 | 75.0 | 81.1 | 99.6 |
| MSA[3] | — | — | — | — | — | — | — | 78.6 |

[1] HMO includes HMO POS; 2005 to 2007 also include PSO.

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

[3] Includes MSA demonstration contracts.

NOTES: Medicare beneficiaries by county prior to 2005 were obtained from the CMS Web site; beneficiaries from 2005 through 2007 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 U.S. territories.

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

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 throughout our analysis period. This is because offerings of HMOs and local PPOs have limited service areas and are concentrated in populous urban counties. 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 2007 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. Regional PPOs, like PFFS, covered wide service areas and large numbers of potential Medicare enrollees through relatively few 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 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 the percentage of counties with at least one HMO, local PPO, regional PPO, or PFFS contract by a range of urban/rural categories, from 2000 to 2007. Our results are shown in Table 3-4. Table 3-4 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 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.

From this analysis, a number of interesting trends emerged. From 2006 to 2007, access to HMOs continued to grow across all urbanicity categories, while access to local PPOs leveled off or slightly declined, showing the effects of the 2006-2007 moratorium on new local PPOs. Access to regional PPOs was stable in 2007. Access to PFFS plans, already nearly universal in most areas in 2006, improved in 2007 to 100 percent of large urban counties from 87 percent of such counties in 2006 and remained much more available to beneficiaries residing in rural and small urban counties than either HMO or local PPO options. MSA plans were available in a majority of counties of all urbanicity classifications. The availability of SNPs grew the fastest of any plan category from 2006 to 2007. Nationally, in 2006, SNPs were available in 25.4 percent of counties and only in a majority of large urban counties. This increased markedly to availability in 46.5 percent of counties by 2007, suggesting that SNPs are gaining popularity rapidly. SNPs were available in over one-third of rural counties in 2007 compared to only 16 percent of rural counties in 2006.

## 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 |
|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 3,120 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.6% | 100.0% |
| HMO[1] | — | 25.9% | 20.3% | 19.1% | 17.7% | 18.5% | 29.0% | 30.6 | 36.5 |
| Local PPO[2] | — | 0.2 | 0.2 | 0.4 | 6.3 | 7.6 | 22.7 | 28.5 | 27.3 |
| Regional PPO | — | — | — | — | — | — | — | 89.9 | 89.9 |
| MSA[3] | — | — | — | — | — | — | — | — | 71.3 |
| PFFS | — | 52.7 | 52.7 | 51.6 | 54.9 | 40.6 | 92.9 | 96.0 | 99.9 |
| Special needs plan[4] | — | — | — | — | — | — | — | 25.4 | 46.5 |
| Urban | 1,089 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.4 | 100.0 |
| HMO[1] | — | 51.8 | 44.1 | 39.5 | 36.4 | 38.1 | 52.0 | 55.4 | 61.2 |
| Local PPO[2] | — | 0.5 | 0.6 | 1.0 | 14.6 | 17.4 | 43.5 | 51.1 | 48.4 |
| Regional PPO | — | — | — | — | — | — | — | 90.0 | 90.0 |
| MSA[3] | — | — | — | — | — | — | — | — | 66.7 |
| PFFS | — | 42.9 | 42.9 | 41.3 | 43.4 | 34.9 | 88.0 | 92.0 | 99.8 |
| Special needs plan[4] | — | — | — | — | — | — | — | 43.0 | 62.3 |
| Large urban | 414 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.8 | 100.0 |
| HMO[1] | — | 75.8 | 64.3 | 58.5 | 52.4 | 55.3 | 63.3 | 66.4 | 70.5 |
| Local PPO[2] | — | 1.2 | 1.7 | 2.4 | 22.7 | 27.3 | 57.0 | 65.2 | 60.4 |
| Regional PPO | — | — | — | — | — | — | — | 91.5 | 91.5 |
| MSA[3] | — | — | — | — | — | — | — | — | 58.7 |
| PFFS | — | 33.6 | 33.6 | 31.6 | 29.7 | 25.8 | 81.2 | 86.7 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 55.1 | 69.8 |
| Medium urban | 324 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.7 | 100.0 |
| HMO[1] | — | 49.1 | 44.4 | 37.7 | 37.0 | 39.5 | 58.6 | 63.6 | 71.3 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.3 | 13.9 | 16.4 | 46.3 | 57.7 | 54.9 |
| Regional PPO | — | — | — | — | — | — | — | 88.6 | 88.6 |
| MSA[3] | — | — | — | — | — | — | — | — | 75.6 |
| PFFS | — | 50.3 | 50.3 | 48.5 | 51.5 | 41.7 | 92.0 | 95.7 | 99.7 |
| Special needs plan[4] | — | — | — | — | — | — | — | 48.1 | 66.0 |
| Small urban | 351 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 98.6 | 100.0 |
| HMO[1] | — | 25.9 | 19.9 | 18.8 | 16.8 | 16.5 | 32.5 | 34.8 | 40.7 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 5.7 | 6.6 | 25.1 | 28.5 | 28.2 |
| Regional PPO | — | — | — | — | — | — | — | 89.5 | 89.5 |
| MSA[3] | — | — | — | — | — | — | — | — | 67.8 |
| PFFS | — | 47.0 | 47.0 | 46.2 | 52.1 | 39.3 | 92.3 | 94.9 | 99.7 |
| Special needs plan[4] | — | — | — | — | — | — | — | 23.9 | 49.9 |

(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 |
|---|---|---|---|---|---|---|---|---|---|
| Rural | 2,031 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.6% | 100.0% |
| HMO[1] | — | 12.0% | 7.5% | 8.2% | 7.7% | 8.0% | 16.6% | 17.3 | 23.3 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 1.9 | 2.3 | 11.5 | 16.4 | 16.1 |
| Regional PPO | — | — | — | — | — | — | — | 89.9 | 89.9 |
| MSA[3] | — | — | — | — | — | — | — | — | 73.8 |
| PFFS | — | 57.9 | 57.9 | 57.1 | 61.1 | 43.7 | 95.5 | 98.1 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 16.0 | 38.1 |
| Rural—urban adjacent | 1,061 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.5 | 100.0 |
| HMO[1] | — | 18.9 | 12.0 | 11.0 | 12.1 | 12.6 | 25.1 | 24.9 | 32.7 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 3.6 | 4.3 | 15.1 | 22.1 | 21.6 |
| Regional PPO | — | — | — | — | — | — | — | 90.9 | 90.9 |
| MSA[3] | — | — | — | — | — | — | — | — | 69.4 |
| PFFS | — | 57.0 | 57.0 | 55.8 | 61.1 | 44.3 | 94.9 | 97.4 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 20.1 | 46.4 |
| Rural—not urban adjacent | 970 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.7 | 100.0 |
| HMO[1] | — | 4.3 | 2.7 | 5.1 | 3.0 | 2.9 | 7.4 | 9.0 | 13.1 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 7.5 | 10.1 | 10.0 |
| Regional PPO | — | — | — | — | — | — | — | 88.9 | 88.9 |
| MSA[3] | — | — | — | — | — | — | — | — | 78.7 |
| PFFS | — | 58.9 | 58.9 | 58.6 | 61.0 | 43.1 | 96.1 | 99.0 | 99.9 |
| Special needs plan[4] | — | — | — | — | — | — | — | 11.5 | 29.0 |

[1] HMO includes HMO POS; 2006 and 2007 also include PSO.

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

[3] Includes MSA demonstration contracts.

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

NOTES: 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.

Among open-access plans, the primary differences in availability between urban and rural counties were largely confined to HMOs and local PPOs; the proportion of urban counties in which these plan types were available was nearly twice that of rural counties. This contrasts with regional PPOs, PFFS, and MSAs, which had relatively small differences in availability in urban and rural counties. PFFS plans were available to virtually all counties in 2007, and MSAs (in their first year) appear to also be indifferent to urbanicity in determining their service areas. The type of urban area, however, played a large role in the availability of other plan types. For example, in 2007 more than 70 percent of medium and large urban areas were served by at least

one HMO, while this value in small urban areas was just over 40 percent. In urban adjacent rural areas, this figure was just under 33 percent, and in nonurban adjacent areas 13 percent. Clearly, population density was closely related to the viability of offering an HMO plan. A similar pattern emerged for local PPOs, another type of local provider network-based, coordinated care plan.

At the time the BBA was enacted, MA-type options were generally more widely available to beneficiaries in larger urban areas while 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 as well as the creation of new plan types such as private fee-for-service 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. The PFFS option is available to nearly 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. The HMO option is available to beneficiaries in only 23 percent and 41 percent of rural and small urban counties, respectively. This compares to HMO access to beneficiaries in over 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 2007, SNPs were more common in urban areas (62.3 percent of counties) than rural areas (38.1 percent of counties). While availability of SNPs increased in both urban and rural areas, access in rural counties increased more rapidly in 2007 relative to 2006. 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 HMOs, which remained the dominant plan type through 2007 despite the continued growth of PFFS and new availability of MSAs. A larger proportion of large urban counties had at least one HMO every year between 2002 and 2007 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.

### 3.2.5 Plan Availability by Census Region

To understand 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 |
|---|---|---|---|---|---|---|---|---|---|
| Northeast | 217 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 94.5% | 100.0% |
| HMO[1] | — | 69.1% | 60.4% | 58.1% | 57.1% | 58.1% | 63.1% | 66.4 | 71.0 |
| Local PPO[2] | — | 2.3 | 2.3 | 2.3 | 32.7 | 34.1 | 56.7 | 71.9 | 69.1 |
| Regional PPO | — | — | — | — | — | — | — | 69.1 | 69.1 |
| MSA[3] | — | — | — | — | — | — | — | | 84.8 |
| PFFS | — | 30.9 | 30.9 | 30.9 | 30.9 | 30.9 | 46.1 | 74.7 | 98.6 |
| Special needs plan[4] | — | — | — | — | — | — | — | 60.4 | 70.5 |
| Midwest | 1,056 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 100.0 | 100.0 |
| HMO[1] | — | 17.4 | 16.0 | 16.6 | 14.4 | 14.9 | 27.8 | 30.6 | 35.3 |
| Local PPO[2] | — | 0.0 | 0.2 | 0.4 | 3.7 | 5.1 | 13.1 | 19.6 | 19.6 |
| Regional PPO | — | — | — | — | — | — | — | 100.0 | 100.0 |
| MSA[3] | — | — | — | — | — | — | — | | 65.2 |
| PFFS | — | 49.3 | 49.3 | 49.3 | 57.8 | 48.9 | 100.0 | 100.0 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 23.2 | 33.0 |
| South | 1,425 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 100.0 | 100.0 |
| HMO[1] | — | 24.8 | 16.4 | 13.2 | 11.6 | 12.9 | 23.4 | 24.1 | 31.4 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.1 | 4.6 | 6.0 | 21.0 | 25.5 | 23.6 |
| Regional PPO | — | — | — | — | — | — | — | 100.0 | 100.0 |
| MSA[3] | — | — | — | — | — | — | — | | 70.9 |
| PFFS | — | 58.9 | 58.9 | 52.7 | 53.7 | 33.4 | 98.2 | 98.5 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 23.6 | 57.5 |
| West | 423 | — | — | — | — | — | — | — | — |
| Any open-access plan | — | — | — | — | — | — | — | 99.3 | 100.0 |
| HMO[1] | — | 28.1 | 23.4 | 25.3 | 26.4 | 26.2 | 33.3 | 33.8 | 39.0 |
| Local PPO[2] | — | 0.0 | 0.0 | 0.0 | 5.2 | 5.2 | 34.9 | 38.5 | 37.6 |
| Regional PPO | — | — | — | — | — | — | — | 41.4 | 41.4 |
| MSA[3] | — | — | — | — | — | — | — | | 81.1 |
| PFFS | — | 51.3 | 51.3 | 64.3 | 64.2 | 49.3 | 80.7 | 88.7 | 100.0 |
| Special needs plan[4] | — | — | — | — | — | — | — | 19.1 | 30.7 |

[1] HMO includes HMO POS; 2006 and 2007 also include PSO.

[2] Includes PPO demonstration projects 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 an SNP and not counted as an HMO).

NOTES: 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 had access to at least one plan in 2007, due largely to the existence of PFFS. PFFS plans were available in virtually every county in 2007. In 2006, PFFS plans were less available in the Northeast than in other regions (75 percent of Northeastern counties). But by 2007, PFFS plans were available almost everywhere in the Northeast, similar to their universal presence in other regions.

From 2006 to 2007, HMO availability rose in every region. HMOs were most widely available in the Northeast (over 70 percent of counties in 2007 compared to about one-third 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 was stable or slightly declined in all regions from 2006 to 2007. In 2007, local PPOs were available in a substantially higher proportion of counties in the Northeast than other regions (69 percent versus 20 to 38 percent elsewhere).

MSAs were also widely available, although they were available in a smaller proportion of counties in the Midwest and South than in the Northeast and West. Regional PPO availability was unchanged between 2006 and 2007. 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.[22]

From 2006 to 2007, SNP access more than doubled in the South and the Midwest and rose significantly in the West, all from relatively low 2006 levels. SNPs were already widely available in the Northeast in 2006, but their penetration grew even higher in 2007. In 2007, the Northeast had a higher percentage of counties served by SNPs than other regions (71 percent versus a maximum of 58 percent elsewhere). These results may be partly a consequence of relatively fewer rural counties in the Northeast.

### 3.3 Plan Choices Available to Beneficiaries in 2007

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, 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 2007.

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 2007, with comparisons to 2006. It generally is believed that the broader the set of 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 a single PFFS plan may comprise a greater degree of plan choice than

[22] Regional PPOs were not available in the following five MA regions in 2007: 1 (ME, NH); 2 (CT, MA, RI, VT); 20 (CO, NM); 23 (ID, OR, UT, WA); and 26 (AK).

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 2007 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. In Tables 3-9 and 3-10, 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 3-6 displays the number and percentage of beneficiaries facing each combination of plan choices, as well as the number and percentage of counties in which the particular combinations were offered, in 2007 and 2006. In 2007, 75 percent of all Medicare beneficiaries lived in counties where HMOs, PPOs and PFFS were all offered; these counties represented 39 percent of all counties. At least one PPO and PFFS plan, with no HMO, were available to another 22 percent of beneficiaries (in 56 percent of counties). Less than 2 percent of beneficiaries had access to only one of these three plan types. As of 2007, all Medicare beneficiaries had access to at least one of these three plan types. Put another way, 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 as of 2007, most Medicare beneficiaries had at least some choice among multiple plan types. From 2006 to 2007, the percentage of beneficiaries with access to all three plan types rose from 54 to 75 percent. Primarily this appears to be because PFFS plans were first offered in 2007 in certain large urban areas where previously only HMOs and PPOs were available.

### 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 3-7 examines how access to combinations of plan types varied with county urbanicity in 2006 and 2007. 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.

Very few beneficiaries, particularly in large and medium urban locations, had access to only a single plan type. In urban regions, 86 percent of beneficiaries had access to all three major plan types; over a third of rural beneficiaries had access to all plan types. The lower proportion of rural beneficiaries with access to all three major MA plan types is due primarily to the 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 likely resulted from HMOs being less prevalent in lower population urban areas than in higher population ones and is consistent with findings shown in Table 3-4 that found HMOs to be present in a substantially smaller proportion of small urban areas than medium and large urban areas. While 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. Growth of PPO options under the MMA through the regional PPO program may explain this finding.

**Table 3-6**
**Percentage of beneficiaries and counties with access to MA plan types, 2007 and 2006**

| Plan types | 2007 Beneficiaries | 2007 Counties | 2006 Beneficiaries | 2006 Counties | Change in percentage points, 2006 to 2007, beneficiaries | Change in percentage points, 2006 to 2007, 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 | 1.6 | 4.2 | 1.3 | 4.4 | 0.3 | -0.2 |
| HMO & PPO[2,3] | 0.4 | 0.1 | 17.5 | 2.3 | -17.1 | -2.2 |
| HMO & PFFS[2] | 1.0 | 1.3 | 0.6 | 0.6 | 0.4 | 0.7 |
| PPO & PFFS[3] | 22.1 | 55.4 | 24.9 | 59.5 | -2.9 | -4.5 |
| HMO & PPO & PFFS[2,3] | 75.0 | 38.9 | 54.3 | 31.5 | 20.8 | 7.9 |

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

[2] HMO includes HMO POS and PSO plans.

[3] PPO includes local and regional PPOs.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2006 and July 2007 data.

**Table 3-7**
**Percentage of beneficiaries with access to MA plan types, by urbanicity, 2007 and 2006**

| Urbanicity | No plans[1] | HMO only[2] | PPO only[3] | PFFS only | HMO & PPO[2,3] | HMO & PFFS[2] | PPO & PFFS[3] | HMO & PPO & PFFS[2,3] |
|---|---|---|---|---|---|---|---|---|
| 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 |
| 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 |
| Change in percentage points, 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 |

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

[2] HMO includes HMO P**O**S and PSO plans.

[3] PPO includes local and regional PPOs.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2006 and July 2007 data.

Comparing 2007 with 2006, of particular note is the increased availability of PFFS—and hence of all three plan types—in large urban areas in 2007. The availability of all three plan types also rose in all other urbanicity categories, although not as dramatically as in large urban areas. In rural areas, the increased availability of all three plan types was primarily due to greater penetration of HMOs in rural areas (Table 3-4).

### 3.3.3 Choice Among Plan Types by Census Region

Table 3-8 examines how access to MA plan type varied by census region in 2007. In each region, two-thirds or more of beneficiaries were able to choose among each of the major plan types, and 95 percent were able to choose from two or more plan types. In all regions, the two most prevalent plan type combinations were available to 90 percent or more of beneficiaries and all beneficiaries in each region had access to at least one MA plan in 2007. In the Northeast and West, 85 percent or more of beneficiaries had access to all three plan types. In the Midwest and South, a lower percentage, 66 to 70 percent, had access to all three types because of the lesser availability of HMOs in those regions. From 2006 to 2007, there was a significant increase in the availability of PFFS to beneficiaries residing in the Northeast and in the West.

### 3.3.4 Choice of Multiple Medicare Advantage Contracts

Tables 3-6 to 3-8 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. Another aspect of choice, however, 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 as well as the presence of multiple competing organizations (e.g., insurance companies) offering these options. Tables 3-9 and 3-10 use the number of contracts in a county as an alternative way to evaluate "choice" to beneficiaries in that county in 2007.

Table 3-9 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, substantially larger in 2007 than 2006 in all strata. On average, beneficiaries could choose from 11.9 contracts in 2007, up from 7.7 contracts in 2006. Sixty-five percent of beneficiaries could choose from 10 or more contracts in 2007, versus 27 percent in 2006.

Consistent with the results in 2006, these show that the number of contracts in 2007 was related to county urbanicity, with urban areas as a whole having more total contract options than rural areas. Within urban areas, the number of contracts available to beneficiaries was an increasing function of the size of the urban area, with large urban areas having, on average, roughly 150 percent of the number of contracts of small urban areas. Rural urban-adjacent beneficiaries had roughly one more contract available on average than nonurban-adjacent beneficiaries.

**Table 3-8**
**Percentage of beneficiaries with access to MA plan types, by region, 2007 and 2006**

| Census region | No plans[1] | HMO only[2] | PPO only[3] | PFFS only | HMO & PPO[2,3] | HMO & PFFS[2] | PPO & PFFS[3] | HMO & PPO & PFFS[2,3] |
|---|---|---|---|---|---|---|---|---|
| 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 |
| 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 |

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

[2] HMO includes HMO POS and PSO plans.

[3] PPO includes local and regional PPOs.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2006 and July 2007 data.

**Table 3-9**
**Percentage of beneficiaries with access to MA plan types, by number of contracts and urbanicity, 2007 and 2006**

| Urbanicity | 0 Contracts | 1–3 Contracts | 4–6 Contracts | 7–9 Contracts | 10+ Contracts | Mean # contracts/ county[1] |
|---|---|---|---|---|---|---|
| 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 |
| Change in percentage points, 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 |

[1] Weighted by eligibles in county.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2006 and July 2007 data.

**Table 3-10**
**Percentage of beneficiaries with access to MA contracts, by number of contracts and region, 2007 and 2006**

| Census region | 0 Contracts | 1–3 Contracts | 4–6 Contracts | 7–9 Contracts | 10+ Contracts | Mean # contracts/ county[1] |
|---|---|---|---|---|---|---|
| 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 |
| 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 |

[1] Weighted by eligibles in county.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2006 and July 2007 data.

Most of the distinction between large and medium urban area counties and all other counties was a result of the discrepancy in counties offering seven or more contracts. More than 95 percent of beneficiaries living in large and medium urban areas had access to more than seven contracts (up from 71 and 52 percent, respectively, in 2006), as opposed to roughly 75 percent in small urban counties (19 percent in 2006), 75 percent in urban-adjacent rural counties (16 percent in 2006), and 63 percent in nonurban-adjacent rural counties (8 percent in 2006). For counties with 10 or more contracts, the difference between the urbanicity strata was more pronounced—84 percent of beneficiaries in large urban counties and 78 percent in medium urban counties had access to 10 or more contracts, while only 36 percent of beneficiaries in small urban counties had access to this many contacts. The proportion of urban-adjacent rural beneficiaries with access to 10 or more contracts was not much different from the small urban areas at 32 percent, while nearly 13 percent of residents of nonurban-adjacent rural areas had access to 10 or more contracts.

Table 3-10 stratifies the number of contracts per county by census region. In 2007, in all regions, on average, at least 10 contracts were offered per county (weighted by MA-eligible Medicare beneficiaries residing in each county). The West and the Northeast regions had the meanest contracts per county in 2007, and the Midwest the fewest. In all regions, more than half of beneficiaries had a choice among 10 or more MA contract options. In contrast to 2006, when at least 12 percent of beneficiaries in each region had access to 3 or fewer contract options, in 2007 no region had more than 2 percent of beneficiaries with a similar scarcity of choices.

## 3.4 Special Needs Plans in 2007

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 3-11 identifies the number of contracts offering at least one SNP, and contracts offering only SNPs by plan type in 2007 and 2006. The analysis shows that in 2007 SNPs were offered through both HMO and PPO contracts, including six regional PPOs that offered SNPs. About 88 percent of contracts offering SNPs were HMOs. About 42% of the contracts offering at least one SNP in 2007 specialized in offering SNPs only. A significant number of these contractors were Medicaid-only HMOs that upon passage of the MMA, applied to be SNPs in order to keep their populations served intact. The total number of MA contracts offering SNPs rose from 158 in 2006 to 215 in 2007, with 54 additional HMO and 3 additional regional PPO contracts offering at least one SNP. MSA and PFFS contracts do not offer SNPs.

**Table 3-11**
**Number of contracts offering special needs plans, by plan type, 2007 and 2006**

| Plan type | 2007 Total[1] | 2007 SNP only[2] | 2006 Total[1] | 2006 SNP only[2] | Change, 2006 to 2007, total[1] | Change, 2006 to 2007, SNP only[2] |
|---|---|---|---|---|---|---|
| Total | 215 | 90 | 158 | 67 | 57 | 23 |
| HMO[3] | 190 | 77 | 136 | 58 | 54 | 19 |
| Local PPO | 19 | 10 | 19 | 9 | 0 | 1 |
| Regional PPO | 6 | 3 | 3 | 0 | 3 | 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.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2006 and July 2007 data.

Table 3-12 shows the number of SNPs by plan type and target population in 2007 and 2006. There was a 45 percent growth in the total number of SNPs from 2006 to 2007. Growth occurred in all three types of SNPs—institutional, dual Medicare/Medicaid eligible, and chronic condition. The number of chronic condition SNPs increased from only 10 in 2006 to 57 in 2007. Despite growth in the other two types, dual-eligible SNPs still comprised 70 percent of total SNPs in 2007. The HMO plan type was the most common for all three types of SNPs in 2007, but about 28% of institutional SNPs were local PPOs, and about one-third of chronic condition SNPs were offered through regional PPO contracts. Overall, 65 percent of 2007 SNPs were HMOs targeted at dual-eligible beneficiaries.

**Table 3-12**
**Number of special needs plans, by plan type and target beneficiaries, 2007 and 2006**

| Plan type | Total | Institutional | Dual eligible | Chronic condition |
|---|---|---|---|---|
| 2007 | | | | |
| Total | 381 | 58 | 266 | 57 |
| 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 |
| Change, 2006 to 2007 | | | | |
| 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 |

[1] HMO includes HMO POS and PSO plans.

[2] 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 July 2006 and July 2007 data.

## SECTION 4
## PREMIUMS AND BENEFITS

This section analyzes the premiums and benefits of MA plans in 2007, including changes from 2006. 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 OOP costs of MA plans.[23]

### 4.1 Premiums

With the introduction of Part D in 2006, MA plans offering prescription drug benefits now charge two premiums, for Part C benefits (corresponding to Medicare 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 their plan. The only exceptions are if the beneficiary is enrolled in a PFFS plan not offering Part D or in an MSA plan (MSA plans do not offer Part D), in which case the beneficiary can obtain Part D through a stand-alone 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.

As well as discussing MA premiums in 2007, we consider changes in premiums from 2006 to 2007. 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 both years or from changes in the mix of plans offered in the 2 years. For example, even if the premiums of all plans offered in both years were unchanged, if new, higher-premium plans were first offered in 2007, the average plan premium could rise from 2006 to 2007. 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 2007, if enrollment shifted toward higher-premium plans in 2007, enrollment-weighted premiums could rise. Plan types with relatively few plans offered and/or limited enrollment—such as regional PPOs and institutional and chronic condition 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

[23] For a summary of the MA payment structure and how it relates to plan premiums and benefits, please see Pope et al. (2007, Section 1.3) and MedPAC (2007).

substantial and stable enrollment—such as HMOs—are likely to be dominated by changes in the premiums of beneficiaries who remain in the same plan for both 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 4-1 presents national average enrollment-weighted and unweighted Part C, Part D, and combined Parts C + D 2007 and 2006 monthly premiums and percentage changes by MA plan type. MA total (Parts C + D) monthly premiums by plan type, weighted by enrollment, averaged between $20 and $40 in 2007, with the exception of local PPOs, which were notably more expensive than other plan types, and institutional SNPs which were less expensive. Among open-access (non-SNP) plans, PFFS plans were the least expensive, with HMOs in the middle, and PPOs the most expensive. 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) rose from 2006 to 2007, by 9.0 percent, from $29.67 to $32.35. The average Part C + Part D premium charged by MA plans (the unweighted plan average) was little changed from 2006 to 2007, at between $44 and $45 in both years. The increase in enrollment-weighted total premiums while unweighted total premiums were flat indicates that plans with larger enrollments—which tend to be lower-premium plans—raised their total premiums at a higher than average rate between 2006 and 2007.

Enrollment-weighted total premiums rose for all open-access plan types but by a much larger absolute and percentage amount for PFFS and regional PPO plans than for HMOs and local PPOs. Across all plan types, the enrollment-weighted Part C premium rose significantly while the Part D premium was flat. Part D premium changes varied significantly by plan type. HMO Part D premiums fell, but all other plan types' Part D premiums rose, with PFFS plans' Part D premiums exhibiting an especially large increase. Weighted total SNP premiums rose slightly.

Table 4-2 shows the percentage of enrollees in zero-premium plans by MA plan type in 2007 and 2006. In 2007, almost exactly half (51.4 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 58 percent for PFFS plans to a low of 14 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.

Consistent with the increase in average total MA premiums, the percentage of enrollees in zero total premium plans fell slightly from 2006 to 2007, from 53.8 percent to 51.4 percent of enrollees. The percentage point decline in zero total premium enrollees was largest for PFFS plans (from 65.3 percent to 58.3 percent), consistent with their large percentage rise in average premiums. The percentage of enrollees with a zero Part C premium rose slightly, while a significantly lower percentage of enrollees had a zero Part D premium in 2007 compared to

2006. Among open-enrollment plans, a lower percentage of Part D than Part C enrollees had a zero premium in 2007, whereas the reverse was true in 2006.

**Table 4-1**
**Mean monthly premiums of MA plans, by plan type, 2007 and 2006**

| 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 | | | | | | |
| 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 |
| Change in percentage points, 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 |
| HMO2 | 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 |

[1] For plans offering Part D.

[2] HMO includes HMO POS and PSO plans.

[3] Includes MSA demonstration contracts.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

**Table 4-2**
**Percentage of MA enrollees in zero-premium plans, by plan type, 2007 and 2006**

| Plan type | Parts C + D[1] | Part C | Part D[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 |
| Change in percentage points, 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 |

[1] For plans offering Part D.

[2] HMO includes HMO POS and PSO plans.

[3] Includes MSA demonstration contracts.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

### 4.1.2 Enrollment by Premium Range

Table 4-3 shows the distribution of MA enrollees in open-enrollment plans by Part C, Part D, and Parts C + D premium range in 2007 and 2006. Among open-access plans in 2007, there was a large concentration of enrollment at zero total premium with about 55 percent of enrollees in plans with Part C and D coverage, and about 60 percent of enrollees with Part C–only 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. Over one-fifth (22.3 percent) were paying a monthly total premium of $75 or greater, and 10.5 percent were paying $100 or more each month.

Compared to 2006, there was a mixed pattern of gains and losses in 2007 across the premium categories in percentage of total enrollees. There was a 1.8 percentage point decrease, from 57.1 to 55.4 percent, in the percentage of MA enrollees in plans offering Parts C+D enrolled in zero premium plans, and a 2.6 percentage point increase in the percentage of MA enrollees paying a total premium of $100 or more per month, from 8.0 to 10.5 percent.

Table 4-3 adds to the information from Tables 4-1 and 4-2 by showing that although about half of MA enrollees were in zero-premium plans, and the average premium was modest, some MA enrollees were paying substantial premiums.

### 4.1.3 By Urbanicity and Region

Table 4-4 shows enrollment-weighted 2007 and 2006 average MA premiums by urbanicity. Premiums in different 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 demand for extra benefits, and degree of competition among plans. Urban premiums were lower than rural premiums in 2007, but not by a large amount. The average total (Parts C + D) urban premium was $32.08 compared to $36.85 in rural areas. 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 ($48.16) were the highest of any urban or rural category by a considerable margin. Within rural areas, enrollees in counties adjacent to urban counties paid slightly higher average premiums than enrollees in nonadjacent counties.

From 2006 to 2007, average total premiums rose by the largest percentages in nonurban-adjacent rural areas (18.2 percent) and in large urban areas (13.6 percent). Premium increases were modest in small urban and urban-adjacent rural areas, and average premiums actually fell in medium urban areas. Because premium increases were largest in the lowest-premium areas, there was some compression of differences in average premiums by urbanicity from 2006 to 2007.[24]

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[24] Changes for both Part C and Part D premiums were negative, but positive for total (Part C+D) premiums, for small urban, rural, and rural—urban-adjacent categories. The reason for this apparent anomaly is that the Part C sample of plans includes plans not offering Part D, and Part C-only plans in these areas had significant average premium reductions from 2006 to 2007.

**Table 4-3**
**Percentage of enrollees in MA open-access (non-SNP) plans, by premium range, 2007 and 2006**

| Monthly premium | Parts C + D[1] | Part C | Part D[1] |
|---|---|---|---|
| 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 |
| Change in percentage points, 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 |

[1] For plans offering Part D.

[2] HMO includes HMO POS and PSO plans.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

**Table 4-4**
**Mean monthly premiums of MA plans, by urbanicity, 2007 and 2006**

| Urbanicity | Parts C + D[1] | Part C | Part D[1] |
|---|---|---|---|
| 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 |
| Change in percentage points, 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 |

[1] For plans offering Part D.

[2] HMO includes HMO POS and PSO plans.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

Findings from Table 4-5, percentage of MA enrollees in zero-premium plans by urbanicity, largely mirror those of Table 4-4.

**Table 4-5**
**Percentage of MA enrollees in zero-premium plans, by urbanicity, 2007 and 2006**

| Urbanicity | Parts C + D[1] | Part C | Part D[1] |
|---|---|---|---|
| 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 |
| Change in percentage points, 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 |

[1] For plans offering Part D.

[2] HMO includes HMO POS and PSO plans.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

Table 4-6 shows enrollment-weighted average premiums by census region, and Table 4-7 presents percentage of enrollees in zero-premium plans by region. Regional premium differences were pronounced. Average premiums were highest in the Northeast ($58.51) and lowest in the South ($13.49). Over 7 of 10 Southern MA enrollees paid no total premium, while less than 1 in 4 of Northeast MA enrollees were in zero total premium plans. Variations in the Part C premium, which showed a 5 to 1 range across regions, contributed more to total premium differences than did the 3 to 1 range in the Part D premium (Table 4-6). The Northeast had an unusually low percentage of enrollees in zero-premium MA-PDs, only 24.0 percent, compared to at least 49 percent in the other regions (Table 4-7).

From 2006 to 2007, total premiums rose at the lowest percentage rate in the Northeast (5.8 percent) and the highest rate in the West (14.1 percent). Average Part C premiums rose by at least 10 percent in all regions except the Midwest, where they were virtually unchanged. Average Part D premiums rose in the Midwest and West but declined in the Northeast and the South.

**Table 4-6**
**Mean monthly premiums of MA plans, by region, 2007 and 2006**

| Census region | Parts C + D[1] | Part C | Part D[1] |
|---|---|---|---|
| 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 |
| Change in percentage points, 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 |

[1] For plans offering Part D.

[2] HMO includes HMO POS and PSO plans.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

**Table 4-7**
**Percentage of MA enrollees in zero-premium plans, by region, 2007 and 2006**

| Census region | Parts C + D[1] | Part C | Part D[1] |
|---|---|---|---|
| 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 |
| Change in percentage points, 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 |

[1] For plans offering Part D.

[2] HMO includes HMO POS and PSO plans.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

### 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. In 2007, the Medicare Part B premium was $93.50, and in 2006, it was $88.50.

Table 4-8 shows the percentage of MA enrollees who had a Part B premium reduction in 2007 and in 2006. Overall, 3.4 percent of MA enrollees had their Part B premium reduced in 2007, and the average Part B premium reduction among enrollees with a reduction was $52.71. PFFS and HMO enrollees, and enrollees in urban areas and in the South, were most likely to have their Part B premium reduced. More than 7 percent of Southern enrollees and more than 4 percent of PFFS plan enrollees had their Part B premium reduced.

**Table 4-8**
**Part B premium reduction by MA plan type, urbanicity, and region, 2007 and 2006 (Percentage of enrollees)**

| Plan type/ urbanicity/ region | 2007 With any reduction | 2007 Mean reduction[1] | 2006 With any reduction | 2006 Mean reduction[1] | Change, 2006 to 2007, with any reduction | Change, 2006 to 2007, mean reduction[1] |
|---|---|---|---|---|---|---|
| Total | 3.4% | $52.71 | 3.5% | $35.72 | -0.1% | $16.99 |
| Plan type | | | | | | |
| HMO[2] | 3.5 | 41.51 | 4.0 | 35.32 | -0.6 | 6.20 |
| Local PPO | 1.3 | 56.23 | 1.3 | 87.70 | 0.0 | -31.47 |
| Regional PPO | 0.0 | N/A | 0.0 | N/A | 0.0 | N/A |
| MSA[3] | 0.0 | N/A | N/A | N/A | N/A | N/A |
| PFFS | 4.1 | 84.46 | 1.4 | 25.05 | 2.7 | 59.41 |
| Urbanicity | | | | | | |
| Urban | 3.6 | 53.34 | 3.7 | 36.41 | 0.0 | 16.93 |
| Rural | 1.6 | 41.31 | 1.7 | 20.21 | -0.2 | 21.09 |
| Census region | | | | | | |
| Northeast | 0.6 | 21.12 | 1.2 | 5.16 | -0.6 | 15.96 |
| Midwest | 1.0 | 31.72 | 0.8 | 25.12 | 0.2 | 6.61 |
| South | 7.2 | 65.89 | 5.2 | 57.32 | 1.9 | 8.57 |
| West | 2.6 | 23.34 | 4.7 | 19.51 | -2.1 | 3.83 |

[1] Among enrollees with a reduction.

[2] HMO includes HMO POS and PSO plans.

[3] Includes MSA demonstration contracts.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

The percentage of MA enrollees with a premium reduction rose from 2.7 percent in 2006 to 3.4 percent in 2007. The average amount of the reduction also rose. The biggest increases in percentage of enrollees with a reduction were for PFFS and Southern 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 2007, including changes from 2006.

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 2007 (2006) had a $265 ($250) deductible and 25 percent enrollee cost sharing until the enrollee reached an "initial coverage limit" of $2,400 ($2,250) in total covered drug expenses. There was no coverage (other than discounted prices) in the "coverage" gap from the initial coverage limit to the OOP threshold of $3,850 ($3,600). Catastrophic coverage reimbursed most expenditures above $3,850 ($3,600) in out-of-pocket 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 coinsurance 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 nonpreferred 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 initial coverage limit 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 initial coverage limit, 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 initial coverage limit, Section 4.2.4 on their initial coverage limits, and Section 4.2.5 on their coverage if any in the coverage gap.

### 4.2.1 By Plan Type

Table 4-9 shows type of prescription drug benefit by MA plan type in 2007 and in 2006. About 13 percent of MA enrollees were in plans without a drug benefit in 2007, up from about 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.

Twenty-two percent of MA enrollees were in MA-PDs offering basic coverage in 2007, down from 27 percent in 2006. Most basic coverage continued to be an actuarially equivalent variant rather than defined standard, but actuarially equivalent coverage fell from 20.4 percent in 2006 to 16.9 percent in 2007. Basic coverage—particularly defined standard—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. Enrollees in SNP institutional or chronic condition plans were more likely than enrollees in SNP dual-eligible plans to have enhanced or actuarially equivalent basic coverage. Basic coverage—nearly all actuarially equivalent—was more prevalent than average among local and regional PPO enrollees.

Enhanced coverage was the most common Part D benefit in all plan types except SNPs (MSAs do not offer Part D coverage). A majority of enrollees in each non-SNP plan type had enhanced coverage. Overall, 64.6 percent of MA enrollees enjoyed enhanced coverage in 2007, up from 63 in 2006. Among HMOs, local PPOs, and SNPs, there was an increase in enhanced coverage at the expense of basic coverage. Among regional PPO and PFFS enrollees, the opposite occurred: the percentage with enhanced coverage declined and the percentage with basic coverage rose.

### 4.2.2 By Urbanicity and Region

Table 4-10 shows type of prescription drug benefit by urbanicity. 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. Among enrollees in MA-PDs, the distribution of benefit type did not vary markedly by urbanicity. The percentage of urban MA enrollees with an enhanced Part D benefit grew slightly from 2006 to 2007, while the enhanced percentage among rural enrollees was flat.

**Table 4-9**
**Prescription drug benefits by MA plan type, 2007 and 2006**
**(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 |
|---|---|---|---|---|---|---|
| 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 |
| Change in percentage points, 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 | -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 |

[1] Basic includes defined standard and actuarially actuarially equivalent.

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

[3] HMO includes HMO POS and PSO plans.

[4] Includes MSA demonstration contracts.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

**Table 4-10**
**Prescription drug benefits of MA enrollees by urbanicity, 2007 and 2006**
**(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 |
|---|---|---|---|---|---|---|
| 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 |
| Change in percentage points, 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 |

[1] Basic includes defined standard and actuarially equivalent.

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

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

Table 4-11 shows Part D benefit type by census region. 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. Western and Northeastern enrollees were more likely to have only basic drug coverage. The proportion of MA enrollees with enhanced MA-PD coverage rose substantially from 2006 to 2007 in the Northeast and fell in the South.

**Table 4-11**
**Prescription drug benefits of MA enrollees by region, 2007 and 2006**
**(Percentage of enrollees with Part D benefit type for each region)**

| Census region | Total | None | Basic[1] total | Defined standard | Actuarially equivalent[2] | Enhanced |
|---|---|---|---|---|---|---|
| 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 |
| Change in percentage points, 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 |

[1] Basic includes defined standard and actuarially equivalent.

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

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

### 4.2.3 Cost Sharing Before the Initial Coverage Limit

Table 4-12 shows the cost-sharing structure of MA-PDs before the initial coverage limit, by type of drug benefit. The vast majority (90.3 percent in 2007, up from 85.8 percent in 2006) of MA-PD enrollees paid no deductible. Virtually no enrollees in enhanced alternative plans paid a deductible, and most in actuarially equivalent plans did not. All enrollees in defined standard coverage paid the $265 (2007) deductible, but they were a small minority of MA-PD enrollees.

With the exception of defined standard plans (which used only a 25 percent coinsurance tier), most enrollees are in plans that used both co-payment and coinsurance tiers. From 2006 to 2007, there was a significant increase in the percentage of enrollees in plans with three rather than two co-payment tiers. Also, in 2007 fewer enrollees were in plans without any coinsurance tiers (this percentage fell from 25.7 percent in 2006 to 18.4 percent in 2007). Coinsurance 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 like multiple sclerosis, rheumatoid arthritis, hemophilia, and some cancers. There was also an increase in 2007 in the percentage of enrollees in plans with one rather than two coinsurance tiers.

Table 4-13 presents more detail on the drug tiering design and cost-sharing amounts. It tabulates median (weighted by plan enrollment) co-payments and coinsurance percentages for the most common MA-PD drug tiering designs. Co-payments are for a 30-day drug supply at in-network retail pharmacies. Over 90 percent of MA-PD enrollees were subject to one of the cost-sharing structures reported in Table 4-13.

There was a substantial shift from 2006 to 2007 to the most common cost-sharing structure of three co-payment and one coinsurance tiers. Over half of all MA enrollees were subject to this structure in 2007 versus 27.8 percent in 2006. Correspondingly, there was a decrease in cost-sharing structures involving two co-payment tiers, especially two co-payment and two coinsurance tiers.

Overall, median co-payments were generally slightly increasing or fairly stable between 2006 and 2007. The gap between generic and brand co-payments was widened in the most common cost-sharing structures. The median co-payment for tier 1 (generic) drugs in the most common three co-pay/one coinsurance tier structure actually fell from $5 to $4, perhaps to match Wal-Mart Stores, Inc.'s $4 generic prescription offer. Preferred and nonpreferred brand median co-pays in the most common structure rose from $28 to $29 and from $58 to $60, respectively. Median coinsurance for injectible or specialty drugs in the most common cost-sharing structure rose from 25 percent to 33 percent and in the second most common cost-sharing structure from 25 percent to 30 percent. This may have increased the OOP cost burden on enrollees taking these expensive drugs.

## Table 4-12
## Cost sharing before the initial coverage limit, by type of MA prescription drug plan, 2007 and 2006
## (Percentage of enrollees in each Part D benefit type with specified cost sharing)

| Cost sharing | 2007 Total | 2007 Defined standard | 2007 Actuarially equivalent[1] | 2007 Enhanced | 2006 Total | 2006 Defined standard | 2006 Actuarially equivalent[1] | 2006 Enhanced | 2006 to 2007 Total | 2006 to 2007 Defined standard | 2006 to 2007 Actuarially equivalent[1] | 2006 to 2007 Enhanced |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deductible | | | | | | | | | | | | |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Zero | 90.3 | 0.0 | 84.5 | 99.1 | 85.8 | 0.0 | 71.1 | 99.1 | 4.5 | 0.0 | 13.3 | -0.1 |
| Reduced | 1.4 | 0.0 | 3.8 | 0.9 | 2.3 | 0.0 | 9.5 | 0.2 | -0.9 | 0.0 | -5.7 | 0.7 |
| Defined standard[2] | 8.3 | 100.0 | 11.8 | 0.0 | 11.9 | 100.0 | 19.4 | 0.6 | -3.6 | 0.0 | -7.6 | -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% | 0.0% | 0.0% | 0.0% | 0.0% |
| No cost sharing | 0.7 | 0.0 | 0.0 | 0.9 | 0.8 | 0.0 | 0.0 | 1.1 | -0.1 | 0.0 | 0.0 | -0.1 |
| 25% Co-insurance amount | 6.5 | 100.0 | 2.7 | 0.0 | 7.1 | 100.0 | 0.0 | 0.0 | -0.5 | 0.0 | 2.7 | 0.0 |
| One or more groups of cost sharing | 92.8 | 0.0 | 97.3 | 99.1 | 92.2 | 0.0 | 100.0 | 98.9 | 0.6 | 0.0 | -2.7 | 0.1 |
| # of Co-payment tiers | | | | | | | | | | | | |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| None | 7.7 | 100.0 | 4.4 | 1.2 | 8.9 | 100.0 | 1.2 | 2.2 | -1.2 | 0.0 | 3.1 | -1.1 |
| 1 | 0.4 | 0.0 | 0.6 | 0.3 | 3.6 | 0.0 | 2.3 | 4.3 | -3.2 | 0.0 | -1.7 | -4.0 |
| 2 | 15.1 | 0.0 | 46.3 | 8.1 | 40.4 | 0.0 | 40.0 | 44.6 | -25.3 | 0.0 | 6.3 | -36.5 |
| 3 | 70.8 | 0.0 | 41.9 | 84.0 | 43.5 | 0.0 | 49.2 | 46.1 | 27.3 | 0.0 | -7.2 | 37.9 |
| 4 | 5.4 | 0.0 | 6.8 | 5.5 | 3.0 | 0.0 | 6.4 | 2.2 | 2.5 | 0.0 | 0.3 | 3.4 |
| 5+ | 0.7 | 0.0 | 0.1 | 0.9 | 0.7 | 0.0 | 0.9 | 0.7 | 0.0 | 0.0 | -0.8 | 0.2 |
| # of Co-insurance tiers | | | | | | | | | | | | |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| None | 18.4 | 0.0 | 55.0 | 10.1 | 25.7 | 0.0 | 50.4 | 20.4 | -7.4 | 0.0 | 4.6 | -10.2 |
| 1 | 67.0 | 100.0 | 33.1 | 72.7 | 46.8 | 100.0 | 25.2 | 48.5 | 20.2 | 0.0 | 7.9 | 24.3 |
| 2 | 14.5 | 0.0 | 9.8 | 16.8 | 27.0 | 0.0 | 24.1 | 30.6 | -12.4 | 0.0 | -14.3 | -13.8 |
| 3+ | 0.1 | 0.0 | 2.1 | 0.3 | 0.5 | 0.0 | 0.4 | 0.6 | -0.4 | 0.0 | 1.7 | -0.3 |

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

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

**Table 4-13**
**Common cost-sharing structures in MA prescription drug plans, 2007 and 2006**
**(Median co-payments[1] or coinsurance, 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 |
|---|---|---|---|---|---|---|---|
| 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 |
| 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 |

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

NOTES: Medians are weighted by plan enrollment. This cost sharing is before the initial coverage limit. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

### 4.2.4 Initial Coverage Limit

Table 4-14 characterizes the initial coverage limit in MA-PDs. SNPs are excluded. Eighty six percent of 2007 MA-PD enrollees were in plans with the standard $2,400 initial coverage limit. This represented a substantial increase from the 76 percent of 2006 enrollees in plans with the standard initial coverage limit ($2,250 in 2006). In 2007, about 8 percent of enrollees had a lower than standard, and about 6 percent a higher than standard, initial coverage limit. Both of these percentages declined sharply from 2006.

Among Part D benefit types, all enrollees in defined standard plans and most enrollees in actuarially equivalent and enhanced plans had the standard $2,400 initial coverage limit. Ten percent of MA-PD enrollees in actuarially equivalent plans had a lower initial coverage limit. These enrollees' plans lowered the initial coverage limit to keep the actuarial value of the plan equal to standard coverage while reducing other cost sharing, such as eliminating the deductible. About 8 percent of enhanced plan enrollees had a lower than $2,400 initial coverage limit and 8 percent had a higher limit. A higher initial coverage limit 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.

Differences by MA plan type in proportions of enrollees with the standard initial coverage limit narrowed from 2006 to 2007. A higher proportion of HMO and local PPO enrollees had the standard initial coverage limit in 2007 than in 2006, moving these proportions closer to the PFFS and regional PPO proportions. In 2007, HMOs were the only plan type that enhanced some enrollees' Part D benefits through a higher initial coverage limit, although even in HMOs, the proportion with a higher initial coverage limit fell by almost half from 2006 to 2007.

Urban–rural and regional differences in the proportion of MA-PD enrollees with the standard initial coverage limit also narrowed from 2006 to 2007. A higher proportion of urban enrollees had the standard initial coverage limit in 2007, moving the urban proportion closer to the rural one. Virtually all enrollees with a higher than standard initial coverage limit resided in urban areas. The proportion of Western MA-PD enrollees with a higher than standard initial coverage limit fell precipitously from 2006 to 2007, leaving the South as the region in 2007 with the highest percent of enrollees with an enhanced initial coverage limit. No Northeastern MA-PD enrollees were in plans that raised their initial coverage limit above the standard amount in 2007. From 2006 to 2007, in the South, the proportion of MA-PD enrollees with a lower than standard initial coverage limit fell precipitously; the reasons for this change are not clear.

### 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 4-15 shows that 34 percent of MA-PD enrollees were in plans with some form of gap coverage in 2007.[25] Overwhelmingly, gap coverage was for generic drugs only (25 percent of the 34 percent with gap coverage had it for generics only). The percentage of MA-PD enrollees with some gap coverage rose significantly in 2007, up from 28

[25] 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 4-14**
**Initial coverage limit (ICL) in MA prescription drug plans, by plan and geographic characteristics, 2007 and 2006**
**(Percentage of enrollees)**

| Benefit type/plan type/urbanicity/region | 2007 <$2,400 | 2007 $2,400 | 2007 >$2,400 | 2006 <$2,250 | 2006 $2,250 | 2006 >$2,250 | 2006 to 2007 <ICL[1] | 2006 to 2007 ICL[1] | 2006 to 2007 >ICL[1] |
|---|---|---|---|---|---|---|---|---|---|
| Total, open-enrollment plans | 8.0% | 86.0% | 6.1% | 15.0% | 75.7% | 9.4% | -7.0% | 10.3% | -3.3% |
| Benefit type | | | | | | | | | |
| Defined standard | 0.0 | 100.0 | 0.0 | 0.0 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Actuarially equivalent | 10.0 | 90.1 | 0.0 | 15.7 | 84.0 | 0.3 | -5.8 | 6.1 | -0.3 |
| Enhanced | 8.1 | 83.7 | 8.2 | 16.2 | 70.5 | 13.3 | -8.1 | 13.2 | -5.1 |
| Plan type | | | | | | | | | |
| HMO[1] | 8.1 | 84.0 | 7.9 | 16.5 | 72.6 | 10.9 | -8.3 | 11.4 | -3.1 |
| Local PPO | 11.5 | 88.5 | 0.0 | 12.3 | 83.8 | 3.9 | -0.7 | 4.7 | -3.9 |
| Regional PPO | 1.8 | 98.2 | 0.0 | 1.8 | 98.2 | 0.0 | -3.6 | 3.6 | 0.0 |
| PFFS | 7.2 | 92.8 | 0.0 | 5.4 | 94.6 | 0.0 | 5.4 | -5.4 | 0.0 |
| Urbanicity | | | | | | | | | |
| Urban | 8.2 | 85.2 | 6.6 | 15.5 | 74.5 | 10.0 | -7.3 | 10.7 | -3.4 |
| Rural | 5.6 | 94.3 | 0.1 | 8.1 | 91.6 | 0.3 | -2.5 | 2.7 | -0.3 |
| Region | | | | | | | | | |
| Northeast | 15.8 | 84.2 | 0.0 | 18.4 | 80.2 | 1.4 | -2.6 | 3.9 | -1.4 |
| Midwest | 10.5 | 87.3 | 2.2 | 11.1 | 87.9 | 1.0 | -0.6 | -0.6 | 1.2 |
| South | 1.4 | 88.9 | 9.8 | 13.2 | 75.4 | 11.4 | -11.9 | 13.5 | -1.6 |
| West | 8.0 | 83.6 | 8.4 | 16.0 | 68.0 | 16.1 | -8.0 | 15.7 | -7.7 |

[1] HMO includes HMO POS and PSO plans.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

## Table 4-15
## Gap coverage in MA prescription drug plans, by plan and geographic characteristics, 2007 and 2006
## (Percentage of enrollees)

| Benefit type/plan type/urbanicity/region | 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 | 2006 to 2007, None | 2006 to 2007, All formulary drugs | 2006 to 2007, Generics only | 2006 to 2007, Generics and brand |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total, open-enrollment plans | 66.2% | 3.3% | 24.8% | 5.7% | 72.3% | N/A | 22.4% | 5.3% | -6.1% | N/A | 2.4% | 0.4% |
| Benefit type | | | | | | | | | | | | |
| Defined standard | 100.0 | 0.0 | 0.0 | 0.0 | 100.0 | N/A | 0.0 | 0.0 | 0.0 | N/A | 0.0 | 0.0 |
| Actuarially equivalent | 100.0 | 0.0 | 0.0 | 0.0 | 100.0 | N/A | 0.0 | 0.0 | 0.0 | N/A | 0.0 | 0.0 |
| Enhanced | 57.6 | 4.1 | 31.1 | 7.1 | 62.5 | N/A | 30.4 | 7.2 | -4.8 | N/A | 0.8 | -0.1 |
| Plan type | | | | | | | | | | | | |
| HMO[1] | 60.6 | 4.2 | 28.2 | 7.0 | 68.2 | N/A | 25.5 | 6.3 | -7.6 | N/A | 2.6 | 0.7 |
| Local PPO | 65.6 | 0.8 | 31.9 | 1.7 | 72.6 | N/A | 25.0 | 2.4 | -7.0 | N/A | 7.0 | -0.7 |
| Regional PPO | 74.4 | 1.5 | 24.1 | 0.0 | 96.2 | N/A | 3.8 | 0.0 | -21.8 | N/A | 20.3 | 0.0 |
| PFFS | 92.1 | 0.0 | 6.3 | 1.6 | 100.0 | N/A | 0.0 | 0.0 | -7.9 | N/A | 6.3 | 1.6 |
| Urbanicity | | | | | | | | | | | | |
| Urban | 64.6 | 3.4 | 25.8 | 6.2 | 70.9 | N/A | 23.6 | 5.5 | -6.3 | N/A | 2.2 | 0.7 |
| Rural | 82.7 | 2.0 | 14.8 | 0.5 | 90.6 | N/A | 6.5 | 2.9 | -7.9 | N/A | 8.2 | -2.3 |
| Region | | | | | | | | | | | | |
| Northeast | 57.8 | 0.0 | 40.0 | 2.2 | 79.7 | N/A | 20.3 | 0.0 | -21.9 | N/A | 19.7 | 2.2 |
| Midwest | 74.5 | 0.6 | 24.5 | 0.5 | 91.0 | N/A | 8.1 | 0.9 | -16.5 | N/A | 16.4 | -0.4 |
| South | 60.9 | 4.9 | 24.4 | 9.9 | 64.9 | N/A | 27.8 | 7.3 | -4.1 | N/A | -3.4 | 2.6 |
| West | 73.1 | 5.3 | 15.4 | 6.2 | 66.6 | N/A | 24.8 | 8.6 | 6.5 | N/A | -9.4 | -2.4 |

[1] HMO includes HMO POS and PSO plans.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data, and CMS 2007 and 2006 Landscape files.

percent in 2006. The percentage of MA-PD enrollees with some brand coverage in the gap nearly doubled—from 5.3 percent to 9.0 percent—if one includes the new 2007 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 2007, about 26 percent of regional PPO enrollees, 34 percent of local PPO enrollees, and 39 percent of HMO enrollees had gap coverage. But only about 8 percent of PFFS MA-PD enrollees had gap coverage. About 11 percent of HMO enrollees had some brand gap coverage (again including "all formulary drugs" as some brand coverage), but few enrollees in other plan types had any brand gap coverage. The percentage of enrollees with some gap coverage rose from 2006 to 2007 for all plan types. The increasing proportion of total MA enrollment in PFFS plans—with their very limited gap coverage—limited the overall rise in the percentage of MA enrollees with gap coverage.

Urban MA-PD enrollees were more than twice as likely as rural enrollees to have gap coverage (35 percent versus 17 percent) and were much more likely to have some brand coverage (9.6 percent versus 2.5 percent). In 2007, some gap coverage was most common in the Northeast and South, and least common in the Midwest and West. Generics-only gap coverage was most common in the Northeast, where 40 percent of MA-PD enrollees had it. Some brand gap coverage was most common in the South (15 percent) and West (12 percent). From 2006 to 2007, generics-only gap coverage grew strongly in the Northeast and Midwest at the expense of no gap coverage. In the West, no gap coverage rose at the expense of generics-only gap coverage. In the South, some brand gap coverage grew at the expense of generics-only gap coverage.

## 4.3 Other Benefits and Cost Sharing

This section turns from MA plans' Part D drug benefits to consideration of other benefit and cost-sharing policies of MA plans in 2007 and changes from 2006. 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 4-16 shows the percentage of MA enrollees who enjoyed selected mandatory supplemental benefits by plan type. "Supplemental" means that the benefits supplement the standard Medicare FFS Part A/B benefits. "Mandatory" means that the benefits were included as part of a plan's basic benefit package.[26]

The most common of the supplemental benefits considered is vision coverage (eye exams and glasses), which 79 percent of MA enrollees had in 2007. About two-thirds of MA enrollees had coverage for hearing exams, one-third dental coverage, about one-quarter coverage for podiatry, and 5 percent for chiropractic treatment. The percentages of MA enrollees with these

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

**Table 4-16**
**Selected mandatory supplemental benefits in MA plans, by plan type, 2007 and 2006**
**(Percentage of enrollees with benefit)**

| Benefit | Total | HMO[6] | Local PPO | Regional PPO | MSA[7] | PFFS |
|---|---|---|---|---|---|---|
| 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 |
| Change in percentage points, 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 |

[1] Excludes employer-only and Part B-only plans.

[2] Includes routine hearing tests.

[3] Includes prophylaxis (cleaning).

[4] Includes routine foot care.

[5] Includes routine care.

[6] Includes MSA demonstration contracts.

NOTE: Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

benefits in 2007 did not change much from 2006, with the exception of a slight decline in the proportion of enrollees with vision coverage. Among plan types, HMO and local PPO enrollees were most likely to have vision coverage, PFFS enrollees were most likely to have hearing exam coverage, local and regional PPO enrollees were most likely to have dental and podiatry coverage, and local PPO enrollees were mostly likely to have chiropractic coverage. The proportion of PFFS enrollees with vision and dental benefits rose strongly from 2006 to 2007 but still lagged the provision of those benefits in other non-MSA plan types. 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 IRS rules).

### 4.3.2 Cost Sharing

Table 4-17 shows the percentage of MA enrollees who faced cost sharing of the indicated amounts for selected services in 2007 and in 2006, by plan type.[27] In 2007, as in 2006, most MA enrollees faced co-payments of $5 to $15 for primary care physician visits. But the co-payment distribution shifted upward from 2006 to 2007. For example, 29.0 percent of MA enrollees' co-payments were in the $10.01 to $15 range in 2007 versus 25.1 percent in 2006. In 2007, 10 percent of enrollees had no primary care co-payment, while another 9 percent paid more than $15.

Co-payments for specialist physician visits were higher. The most common amounts in 2007 were in the $25.01 to $35 range, up from the $15.01 to $25 range in 2006. Emergency department co-payments were almost always about $50. More than 85 percent of MA enrollees faced co-payments or coinsurance for hospital services, either acute inpatient admissions, or outpatient care. More than three-quarters were charged co-payments or coinsurance for X-ray and clinical laboratory services. The proportion of MA enrollees charged co-payments or coinsurance for all these services rose slightly from 2006 to 2007.

Cost sharing tended to be higher in PFFS plans than in other MA plan types. 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. But some cost sharing in HMOs rose significantly from 2006 to 2007. For example, the proportion of HMO enrollees with a primary care visit co-payment of more than $25 rose from 0.2 percent in 2006 to 7 percent in 2007, and the proportion with a specialist visit co-payment of $25.01 to $35.00 rose from 16.2 percent to 26.4 percent.

### 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

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[27] MSA plans are excluded from Table 4-17. 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 coinsurance or co-payments between the plan deductible and OOP limit.

## Table 4-17
## Cost sharing for selected services in MA plans by plan type,[1] 2007 and 2006

| Cost sharing | 2007 Total | 2007 HMO | 2007 Local PPO | 2007 Regional PPO | 2007 PFFS | 2008 Total | 2008 HMO | 2008 Local PPO | 2008 Regional PPO | 2008 PFFS | 2006 to 2007 Total | 2006 to 2007 HMO | 2006 to 2007 Local PPO | 2006 to 2007 Regional PPO | 2006 to 2007 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% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| $0 | 9.7 | 13.7 | 0.3 | 0.0 | 0.3 | 10.3 | 12.1 | 4.1 | 0.0 | 3.6 | -0.6 | 1.6 | -3.8 | 0.0 | -3.3 |
| $0.01–$5 | 17.3 | 16.6 | 26.4 | 19.4 | 17.4 | 18.0 | 19.7 | 20.7 | 1.8 | 9.6 | -0.6 | -3.0 | 5.6 | 17.6 | 7.8 |
| $5.01–$10 | 34.6 | 35.6 | 36.3 | 78.9 | 26.3 | 38.6 | 39.5 | 41.1 | 96.2 | 27.3 | -4.0 | -3.9 | -4.8 | -17.4 | -1.0 |
| $10.01–$15 | 29.0 | 22.2 | 25.0 | 0.2 | 54.8 | 25.1 | 19.8 | 21.9 | 1.6 | 58.0 | 3.9 | 2.4 | 3.1 | -1.4 | -3.1 |
| $15.01–$25 | 4.3 | 5.0 | 11.4 | 1.6 | 1.1 | 7.8 | 8.8 | 12.2 | 0.4 | 1.6 | -3.5 | -3.9 | -0.8 | 1.2 | -0.5 |
| More than $25 | 5.0 | 7.0 | 0.7 | 0.0 | 0.1 | 0.2 | 0.2 | 0.0 | 0.0 | 0.0 | 4.8 | 6.8 | 0.7 | 0.0 | 0.1 |
| Co-insurance | 3.5 | 3.7 | 0.2 | 0.8 | 3.6 | 3.5 | 4.2 | 0.2 | 0.0 | 0.2 | 0.0 | -0.5 | 0.0 | 0.8 | 3.4 |
| 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 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| $0 | 2.9 | 4.0 | 0.0 | 0.0 | 0.3 | 3.4 | 3.5 | 1.5 | 0.0 | 3.6 | -0.5 | 0.4 | -1.5 | 0.0 | -3.3 |
| $0.01–$5 | 2.6 | 2.5 | 14.7 | 0.0 | 0.3 | 2.9 | 2.9 | 12.5 | 0.9 | 0.0 | -0.3 | -0.4 | 2.2 | -0.9 | 0.3 |
| $5.01–$10 | 14.8 | 15.2 | 16.2 | 28.6 | 11.4 | 17.4 | 18.6 | 12.3 | 21.7 | 11.4 | -2.6 | -3.4 | 4.0 | 7.0 | 0.0 |
| $10.01–$15 | 12.4 | 11.7 | 23.8 | 0.0 | 13.2 | 12.2 | 12.4 | 19.4 | 0.8 | 9.6 | 0.2 | -0.7 | 4.4 | -0.8 | 3.7 |
| $15.01–$25 | 31.9 | 38.0 | 22.7 | 44.4 | 12.5 | 39.4 | 45.2 | 27.5 | 36.1 | 11.0 | -7.5 | -7.2 | -4.7 | 8.3 | 1.6 |
| $25.01–$35 | 33.6 | 26.4 | 17.3 | 26.9 | 62.2 | 23.9 | 16.2 | 26.9 | 40.4 | 64.5 | 9.8 | 10.2 | -9.6 | -13.5 | -2.3 |
| $35.01–$50 | 1.9 | 2.2 | 5.4 | 0.0 | 0.1 | 0.9 | 1.1 | 0.1 | 0.0 | 0.0 | 1.0 | 1.1 | 5.3 | 0.0 | 0.1 |
| Co-insurance | 4.6 | 5.4 | 0.2 | 0.8 | 3.6 | 4.2 | 5.2 | 0.2 | 0.0 | 0.2 | 0.4 | 0.2 | 0.0 | 0.8 | 3.4 |
| 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 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| $0 | 0.9 | 1.1 | 0.1 | 0.0 | 0.0 | 1.2 | 1.4 | 0.1 | 0.0 | 0.0 | -0.3 | -0.3 | 0.0 | 0.0 | 0.0 |
| $0.01–$20 | 0.1 | 0.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 |
| $20.01–$40 | 3.8 | 0.9 | 0.0 | 0.0 | 22.0 | 5.0 | 4.7 | 11.8 | 3.9 | 3.7 | -1.2 | -3.8 | -11.8 | -3.9 | 18.3 |
| $40.01–$50 | 95.2 | 97.8 | 99.9 | 100.0 | 77.9 | 93.8 | 93.9 | 88.2 | 96.1 | 96.3 | 1.4 | 3.9 | 11.7 | 3.9 | -18.4 |
| Any cost sharing (either co-payment or co-insurance)[3] | | | | | | | | | | | | | | | |
| Acute hospital admission | 88.1 | 86.0 | 83.8 | 99.3 | 94.9 | 86.4 | 84.5 | 85.9 | 99.0 | 97.5 | 1.6 | 1.6 | -2.1 | 0.4 | -2.6 |
| Hospital outpatient | 87.5 | 86.0 | 66.8 | 95.7 | 97.1 | 86.6 | 85.2 | 70.4 | 97.0 | 100.0 | 0.9 | 0.8 | -3.6 | -1.3 | -2.9 |
| X-ray services | 78.9 | 74.7 | 58.9 | 79.3 | 98.6 | 74.6 | 70.6 | 66.2 | 97.0 | 100.0 | 4.3 | 4.1 | -7.3 | -17.7 | -1.4 |
| Laboratory services | 78.3 | 74.3 | 57.2 | 96.2 | 95.5 | 76.9 | 74.2 | 62.3 | 97.0 | 96.8 | 1.4 | 0.1 | -5.1 | -0.9 | -1.4 |

[1] Excludes MSA plans.

[2] Sums to 100.0% across co-payment categories. Some plans also had coinsurance for certain services.

[3] Does not include any applicable deductibles.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

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.[28] Tables 4-18 and 4-19 provide analysis of MA plans' and enrollees' OOP cost maximums in 2007 and 2006. Nearly half (45 percent) of MA enrollees had an OOP maximum in 2007, up from 41 percent in 2006 (Table 4-18). About 21 percent in 2007 had a maximum that applied to all covered services, up from 15 percent in 2006.

**Table 4-18**
**Out of pocket (OOP) maximums in MA plans, 2007 versus 2006**
**(Percentage of enrollees)**

| OOP maximum characteristic | 2007 | 2006 | Change in percentage points, 2006 to 2007 |
|---|---|---|---|
| Has OOP maximum | 45.1% | 41.4% | 3.7% |
| OOP maximum applies to[1] | — | — | — |
| All covered services | 20.5 | 14.8 | 5.7 |
| Some covered services excluded | 23.9 | 26.6 | -2.7 |
| Inpatient hospital acute included | 23.5 | 25.1 | -1.6 |
| Inpatient hospital acute excluded | 0.4 | 1.5 | -1.1 |
| OOP maximum amount | — | — | — |
| $1–$1,000 | 4.0 | 2.7 | 1.4 |
| $1,001–$2,000 | 2.9 | 7.7 | -4.8 |
| $2,001–$3,000 | 12.6 | 15.7 | -3.0 |
| $3,001–$4,000 | 13.4 | 5.0 | 8.4 |
| $4,001–$5,000 | 11.3 | 10.4 | 0.9 |
| $5,001+ | 0.2 | 0.1 | 0.1 |

NOTES: In-network OOP maximum. Deductible of MSA nondemonstration plans is considered to be their OOP maximum. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories. All 2007 regional PPO enrollees are imputed to have an OOP maximum; some regional PPO plans did not report an OOP maximum in the 2007 HPMS data. Regional PPO enrollees in plans not reporting an OOP maximum are excluded from the 2007 distribution of enrollees by covered services and by maximum amount.

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

[28] 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 noncovered benefits, such as long-term care, and, for network-based plans, are for services received in network.

**Table 4-19**
**Out-of-pocket (OOP) maximums in MA plans, by plan type, urbanicity, and region, 2007 and 2006**

| Plan type/ urbanicity/region | % Enrollees with OOP maximum, 2007 | Median[1] OOP maximum, 2007 | % Enrollees with OOP maximum, 2006 | Median[1] OOP maximum, 2006 | % Change, 2006 to 2007 | Change, Median[1], 2006 to 2007 |
|---|---|---|---|---|---|---|
| Total | 45.1% | $3,100 | 41.4% | $3,000 | 3.7% | $100 |
| Plan type | | | | | | |
| HMO[2] | 32.8 | 3,100 | 33.1 | 3,000 | -0.3 | 100 |
| Local PPO | 52.7 | 1,000 | 54.1 | 1,500 | -1.4 | -500 |
| Regional PPO[3] | 100.0 | 3,000 | 100.0 | 3,000 | 0.0 | 0 |
| MSA[4] | 100.0 | 2,500 | N/A | N/A | N/A | N/A |
| PFFS | 77.2 | 5,000 | 80.1 | 5,000 | -2.8 | 0 |
| Urbanicity | | | | | | |
| Urban | 42.5 | 3,100 | 39.6 | 3,000 | 3.0 | 100 |
| Rural | 65.3 | 3,200 | 60.9 | 5,000 | 4.4 | -1,800 |
| Region | | | | | | |
| Northeast | 20.3 | 3,000 | 13.0 | 2,960 | 7.3 | 40 |
| Midwest | 65.4 | 3,100 | 68.6 | 3,500 | -3.2 | -400 |
| South | 52.1 | 3,100 | 46.2 | 3,000 | 5.9 | 100 |
| West | 44.8 | 4,000 | 44.8 | 3,000 | 0.0 | 1,000 |

[1] Enrollment-weighted plan median among plans with OOP maximum. In-network OOP maximum.

[2] HMO includes HMO POS and PSO plans.

[3] All regional PPO enrollees are imputed to have a 2007 OOP maximum; some regional PPO plans did not report an OOP maximum in the 2007 HPMS data. Regional PPO enrollees in plans not reporting a maximum are excluded from the calculation of median 2007 OOP maximums.

[4] Includes MSA demonstration contracts. Deductible of MSA nondemonstration plans is considered to be their OOP maximum.

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

SOURCE: RTI analysis of CMS Health Plan Management System July 2007/2006 data.

About one-quarter had a maximum that did not apply to all covered services, but that included hospital inpatient acute care, the largest medical expense category. Less than 1 percent of enrollees in 2007 had a maximum that did not include hospital inpatient acute services.

The most common OOP maximum in 2007 was in the $3,001 to $4,000 range, up from $2,001 to $3,000 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 (Table 4-19).

OOP maximums were least common in HMOs—only one-third of HMO enrollees had one in 2007 (Table 4-19). All regional PPO and MSA enrollees and most PFFS enrollees (77 percent) had an OOP maximum[29], as did about half of local PPO enrollees. Of enrollees with an OOP maximum, local PPO enrollees had the lowest (in-network) 2007 median OOP maximum of only $1,000 (down $500 from 2006). Enrollees in MSA plans had a median OOP maximum of $2,500. HMO and regional PPO enrollees had median OOP maximums of about $3,000. PFFS plan enrollees had the highest median OOP maximum of $5,000.

Urban enrollees were less likely to have OOP cost maximums than rural enrollees, but when they existed urban maximums were typically slightly lower, with the urban–rural gap narrowing substantially from 2006 to 2007. The higher likelihood of OOP maximums for rural enrollees may be because of the larger concentration of rural enrollees in PFFS plans and, conversely, the lower likelihood of OOP maximums for urban enrollees may stem from their smaller concentration in PFFS plans. Regionally, about two-thirds of Midwestern enrollees had OOP cost maximums in 2007, but only one-fifth of Northeastern enrollees did. About half of Southern and Western enrollees were in plans with a maximum. When a maximum existed in 2007, the median was $3,000 or $3,100 in the Northeast, Midwest, and South, but $4,000 in the West, a $1,000 increase from 2006.

## 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 health care. This section analyzes simulated 2007 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 for 2007. 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.

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[29] Nondemonstration 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.

### 4.4.1 By Plan Type

Table 4-20 shows simulated 2007 OOP costs, total and by major component, for MA enrollees by plan type and health status. Across all MA enrollees, OOP costs were simulated to be $303 per month, or $3,640 per year. About 30 percent of total OOP cost was the Medicare Part B premium, $91.46 per month in 2007 before any plan Part B premium reduction. Another 11 percent, or $33 per month, comprised the plan Part C and Part D premiums, for a total of 41 percent accounted for by insurance premiums. About 31 percent more of the total—$95 per month or $1,140 per year—represented outpatient drug expenses, even with prescription drug coverage through Medicare Parts D and B. The remaining 28 percent of OOP costs, or $84 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 4-20 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. To be sure, 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 4-20 shows that simulated OOP costs are about 80 percent greater, $426 versus $237 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 57 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 coinsurance, and the coverage gap. The remaining 43 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), average for HMOs, and below average for PFFS plans and for chronic condition/institutional SNPs.[30] The differences among the open-access plan types are not dramatic. Local PPOs' average OOP costs are about 14 percent greater than the PFFS plan average. Differences in plan type OOP costs arise in large part because of differences in Part C ("plan") premiums. Local PPOs have the highest average premiums, and PFFS plans and SNPs the lowest. The ranking of the plan types by average OOP costs is the same for enrollees in excellent and in poor health as it is for all health statuses, except that regional PPOs are simulated to be slightly more expensive than local PPOs for enrollees in poor health.

[30] 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 wraparound coverage.

**Table 4-20**
**Simulated monthly out-of-pocket costs, by plan type, 2007**

| Plan type | 2007 Health status, any | 2007 Health status, excellent | 2007 Health status, poor |
|---|---|---|---|
| All[1,4] | | | |
| Total | $303.33 | $237.32 | $425.91 |
| Part B premium | 91.46 | 91.46 | 91.46 |
| Part C premium | 22.57 | 22.57 | 22.57 |
| Part D premium | 10.61 | 10.61 | 10.61 |
| Outpatient Rx | 95.21 | 51.56 | 159.95 |
| Inpatient | 25.12 | 7.83 | 64.37 |
| Dental | 25.31 | 33.30 | 19.35 |
| All other | 33.04 | 19.98 | 57.59 |
| HMO[2,3] | | | |
| Total | $304.45 | $237.94 | $427.24 |
| Part B premium | 91.96 | 91.96 | 91.96 |
| Part C premium | 23.92 | 23.92 | 23.92 |
| Part D premium | 9.33 | 9.33 | 9.33 |
| Outpatient Rx | 8.74 | 53.44 | 165.87 |
| Inpatient | 24.51 | 7.66 | 62.79 |
| Dental | 4.97 | 32.84 | 19.12 |
| All other | 31.02 | 18.78 | 54.26 |
| Local PPO[2] | | | |
| Total | $337.87 | $276.36 | $454.18 |
| Part B premium | 92.59 | 92.59 | 92.59 |
| Part C premium | 50.50 | 50.50 | 50.50 |
| Part D premium | 26.08 | 26.08 | 26.08 |
| Outpatient Rx | 90.01 | 48.91 | 151.14 |
| Inpatient | 22.77 | 7.04 | 58.98 |
| Dental | 25.04 | 32.86 | 19.33 |
| All other | 30.89 | 18.38 | 55.55 |
| Regional PPO[2] | | | |
| Total | $317.02 | $242.44 | $460.10 |
| Part B premium | 93.50 | 93.50 | 93.50 |
| Part C premium | 22.50 | 22.50 | 22.50 |
| Part D premium | 13.65 | 13.65 | 13.65 |
| Outpatient Rx | 91.93 | 49.78 | 154.34 |
| Inpatient | 35.95 | 12.22 | 90.53 |
| Dental | 22.79 | 29.78 | 18.03 |
| All other | 36.70 | 21.01 | 67.54 |

(continued)

**Table 4-20 (continued)**
**Simulated monthly out-of-pocket costs, by plan type, 2007**

| Plan type | 2007 Health status, any | 2007 Health status, excellent | 2007 Health status, poor |
|---|---|---|---|
| PFFS[2] | | | |
| Total | $296.73 | $229.83 | $423.05 |
| Part B premium | 87.57 | 87.57 | 87.57 |
| Part C premium | 13.41 | 13.41 | 13.41 |
| Part D premium | 10.56 | 10.56 | 10.56 |
| Outpatient Rx | 80.89 | 43.76 | 136.39 |
| Inpatient | 28.53 | $8.87 | 72.70 |
| Dental | 27.55 | 36.32 | 20.77 |
| All other | 48.23 | 29.34 | 81.65 |
| SNP[4] | | | |
| Total | $265.90 | $208.88 | $371.34 |
| Part B premium | 93.47 | 93.47 | 93.47 |
| Part C premium | 2.39 | 2.39 | 2.39 |
| Part D premium | 11.64 | 11.64 | 11.64 |
| Outpatient Rx | 94.06 | 51.31 | 156.82 |
| Inpatient | 21.03 | 5.93 | 55.40 |
| Dental | 25.20 | 33.18 | 19.26 |
| All other | 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 long-term care costs. Weighted by plan enrollment. Excludes employer-only and Part B-only plans. Excludes Puerto Rico and U.S. territories.

SOURCE: RTI analysis of CMS 2007 OOP cost data July 2007 data.

### 4.4.2 By Urbanicity and Region

As shown in Table 4-21, simulated average monthly MA enrollee OOP costs are similar in urban and rural areas (3 percent greater in rural areas for any health status). Differences are larger across regions, as shown in Table 4-22. Average OOP costs are 12 percent below the national average in the South and 7 percent above average in the Northeast for any health status. This translates into a monthly OOP cost difference of $56, or $676 per year. The Northeast/South difference is mostly due to higher plan Part C and Part D premiums in the Northeast than in the South. Average OOP costs in the West are almost as high as in the Northeast. Western premiums are lower, but drug, inpatient, and other cost sharing is greater than in the Northeast. Midwestern MA enrollee simulated costs are lower than in the Northeast or West, but still slightly above the national average. Western MA enrollees in poor health face the highest simulated OOP costs, followed by Northeastern and Midwestern enrollees (virtually tied), with Southern enrollees lowest. Western costs are high particularly because of high simulated OOP drug costs, indicating a less generous average Part D benefit in the West for enrollees in poor health.

**Table 4-21**
**Simulated monthly out-of-pocket costs, by urbanicity, 2007**

| Urbanicity | 2007 Health status, any | 2007 Health status, excellent | 2007 Health status, poor |
|---|---|---|---|
| Urban | | | |
| Total | $302.58 | $236.48 | $425.18 |
| Part B premium | 91.33 | 91.33 | 91.33 |
| Part C premium | 22.51 | 22.51 | 22.51 |
| Part D premium | 10.30 | 10.30 | 10.30 |
| Outpatient Rx | 95.83 | 51.90 | 160.97 |
| Inpatient | 25.15 | 7.85 | 64.39 |
| Dental | 25.12 | 33.04 | 19.23 |
| All other | 32.34 | 19.55 | 56.45 |
| Rural | | | |
| Total | $311.33 | $246.24 | $433.67 |
| Part B premium | 92.85 | 92.85 | 92.85 |
| Part C premium | 23.22 | 23.22 | 23.22 |
| Part D premium | 13.91 | 13.91 | 13.91 |
| Outpatient Rx | 88.62 | 47.97 | 149.08 |
| Inpatient | 24.82 | 7.64 | 64.20 |
| Dental | 27.37 | 36.09 | 20.65 |
| All other | 40.54 | 24.57 | 69.77 |

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

SOURCE: RTI analysis of CMS 2007 OOP cost data July 2007 data.

**Table 4-22**
**Simulated monthly out-of-pocket costs, by census region, 2007**

| Region | 2007 Health status, any | 2007 Health status, excellent | 2007 Health status, poor |
|---|---|---|---|
| Northeast | | | |
| Total | $325.13 | $263.66 | $437.94 |
| Part B premium | 93.48 | 93.48 | 93.48 |
| Part C premium | 42.90 | 42.90 | 42.90 |
| Part D premium | 20.57 | 20.57 | 20.57 |
| Outpatient Rx | 94.52 | 51.36 | 158.57 |
| Inpatient | 19.07 | 5.76 | 49.99 |
| Dental | 23.08 | 30.21 | 18.13 |
| All other | 31.52 | 19.38 | 54.31 |
| Midwest | | | |
| Total | $312.49 | $244.62 | $440.92 |
| Part B premium | 93.50 | 93.50 | 93.50 |
| Part C premium | 19.64 | 19.64 | 19.64 |
| Part D premium | 13.70 | 13.70 | 13.70 |
| Outpatient Rx | 89.26 | 48.29 | 150.29 |
| Inpatient | 29.16 | 9.21 | 74.26 |
| Dental | 27.57 | 36.36 | 20.76 |
| All other | 39.65 | 23.92 | 68.76 |
| South | | | |
| Total | $270.89 | $207.13 | $390.40 |
| Part B premium | 87.96 | 87.96 | 87.96 |
| Part C premium | 6.90 | 6.90 | 6.90 |
| Part D premium | 6.17 | 6.17 | 6.17 |
| Outpatient Rx | 89.19 | 48.20 | 150.07 |
| Inpatient | 25.43 | 7.72 | 65.86 |
| Dental | 23.96 | 31.47 | 18.49 |
| All other | 31.29 | 18.72 | 54.96 |
| West | | | |
| Total | $318.66 | $248.31 | $447.79 |
| Part B premium | 92.80 | 92.80 | 92.80 |
| Part C premium | 27.34 | 27.34 | 27.34 |
| Part D premium | 7.36 | 7.36 | 7.36 |
| Outpatient Rx | 104.84 | 56.80 | 175.86 |
| Inpatient | 26.69 | 8.59 | 67.15 |
| Dental | 27.04 | 35.68 | 20.34 |
| All other | 32.59 | 19.73 | 56.93 |

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

SOURCE: RTI analysis of CMS 2007 OOP cost data July 2007 data.

## SECTION 5
## ENROLLMENT

In this section, we present results from our descriptive analysis of MA enrollment during 2006 to 2007. We present a detailed analysis of MA enrollment in 2007, as well as analysis of changes from 2006 to 2007. Our analysis sample for monitoring MA enrollment consisted of two point-in-time samples, specifically, all beneficiaries enrolled on July 1, 2006, and all beneficiaries enrolled on July 1, 2007, as indicated in the MIIR. Our analysis sample was beneficiaries enrolled in an MA plan (HMO[31], local PPO, regional PPO, PFFS, MSA), excluding employer-only plan enrollment,[32] Part B-only plan enrollment, and enrollment in Puerto Rico and U.S. territories.

### 5.1 Overall and by Plan Type

Table 5-1 (a and b) shows MA enrollment overall and by plan type. 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. Although HMOs were still the dominant plan type in MA, together PFFS and PPOs (local and regional) had about 30 percent of MA enrollment, which was about 10 percentage points higher than in 2006. Compared to the HMO increase in enrollment of 5.0 percent from 2006 to 2007, the local PPO increase was 27 percent, the PFFS increase was 87 percent, and the regional PPO increase was 124.2 percent. MSA plans had an enrollment of 2,260 beneficiaries in 2007.

The magnitude of recent increases in MA enrollment is clearly shown in Table 5-1 (a and b). From 2006 to 2007 there has been an increase in MA enrollment of 1,080,277, with 668,676 of this increase for PFFS plans. Several factors might explain these increases in MA enrollment. One likely key factor is higher MA payments and, in particular, payments to plans operating in areas where MA benchmarks are based on urban or rural “floor” rates. The creation of floor rates, originally established in the BBA and subsequently expanded to include urban floors, helped make MA plan options more widely available to Medicare beneficiaries, by allowing plans in areas that previously had little or no MA availability to offer lower premiums or additional benefits to enrollees. In addition to premiums and benefits, greater availability of plans in all areas—including plan types offering less restrictive access to providers—likely enhanced MA enrollment in 2007.

MA enrollment by beneficiary characteristics is presented in Table 5-2 (a and b). For 2007, the youngest elderly group (aged 65 to 74) made up the highest percentage of MA enrollment (45.3 percent), with the aged 75 to 84 group having 31.9 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). At 26.6 percent, the percentage change in enrollment from 2006 to was highest

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31 Includes HMO POS and PSO plans.

32 As mentioned in Section 2, 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 MA enrollment (CMS, 2008).

**Table 5-1a**
**MA[1] enrollment by plan type, 2007 and 2006[2]**

| Plan type | Enrollment | % of total enrollment | % of total eligibles[3] |
|---|---|---|---|
| 2007 | | | |
| Total Medicare Advantage | 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 Medicare Advantage | 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] | — | — | — |

**Table 5-1b**
**Change in MA[1] enrollment by plan type, 2007 and 2006[2]**

| Plan type | Change in enrollment | Enrollment | Change in % points, % of total enrollment | Change in % points, % of total eligibles[3] |
|---|---|---|---|---|
| Change 2006 to 2007 | | | | |
| Total Medicare Advantage | 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 | — | — | — |

[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.

## Table 5-2a
## MA[1] enrollment by beneficiary characteristics, 2007 and 2006[2]

| Beneficiary characteristics | Enrollment[3] | % of total enrollment | % of total eligibles[4] | % of subpopulation eligibles[4] |
|---|---|---|---|---|
| 2007 | | | | |
| Total Medicare Advantage | 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 Medicare Advantage | 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 |

## Table 5-2b
## Change in MA[1] enrollment by beneficiary characteristics, 2007 and 2006[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 2006 to 2007 | | | | |
| Total Medicare Advantage | 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 |

[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, and July 1, 2007.

[3] Includes MSA demonstration contracts.

[4] MA eligibles defined as Medicare beneficiaries with Part A and Part B.

NOTE: Eligibles calculated using Medicare denominator file.

SOURCE: RTI analysis of 2006–2007 Management Information Integrated Repository.

for Medicare beneficiaries eligible by disability (under age 65), compared to any other age group. Beneficiaries dually eligible for Medicare and Medicaid accounted for 16.2 percent of MA enrollees but had a lower take-up rate for MA than non-Medicaid enrollees. However, the percentage change in enrollment from 2006 to 2007 was higher than average for Medicaid enrollees (30.6 percent).[33]

## 5.2 By Urbanicity and Census Region

As shown in Table 5-3 (a and b), among 2007 MA enrollees, 88.7 percent resided in urban areas and 11.3 percent in rural areas. At 19.5 percent, the percentage of beneficiaries residing in urban areas that take up MA was much higher than for rural beneficiaries (8.9 percent). However, the percentage increase in rural enrollment from 2006 to 2007 was 55.9 percent, compared to only 15.4 percent for urban enrollment. The increase in rural enrollment is certainly correlated with the increase in PFFS and regional PPO enrollment. In addition, as a percentage of total MA enrollment, rural enrollment increased by 2.7 percentage points, with urban enrollment falling by 2.7 percentage points.

Table 5-4 (a and b) shows that in 2007, the South and West each had the highest number of MA enrollees among census regions, with 2.2 million and 2.0 million, respectively. However, the take-up rate for Medicare beneficiaries residing in the West census region was about one and a half times that of the South census region (25.5 versus 14.8 percent). The Midwest and South census regions had the highest percentage changes in enrollment from 2006 to 2007, with the Midwest census region growing by 31.0 percent, and the South census region by 27.0 percent. Like the increase for rural areas, the increase for the Midwest and South census regions is related to the increase in PFFS and regional PPO enrollment.

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 2007, only 4.6 percent (column percentage in Table 5-5a) resided in rural areas. This can be contrasted with 32.9 percent of PFFS enrollees residing in rural areas. However, 67.1 percent of PFFS enrollment was in urban areas, with most of the urban PFFS enrollment in medium and small urban areas. Interestingly, the percentage of MA enrollees in large urban areas decreased by close to 5 percentage points (column percentage in Table 5-5b), showing that the distribution of MA enrollees has had some shift from urban to rural.

With PFFS accounting for 61.5 percent of rural enrollment in 2007 (row percentage in Table 5-6a), clearly PFFS raised MA enrollment in rural areas. In addition, PFFS accounted for 54.1 percent of small urban enrollment. The distribution of MA enrollment is changing. From 2006 to 2007, the percentage of rural enrollment in PFFS plans increased by 8.3 percentage points (row percentage in Table 5-6b), and the percentage for HMOs decreased by 10.2 percentage points. Similarly, the percentage of small urban enrollment in PFFS plans increased by 10.2 percentage points, compared with a 12.3 percentage point decrease for HMOs. The

33 "This increase may be linked to the high percentage increase in SNP enrollment between 2006 and 2007. See Section 5.3."

## Table 5-3a
## MA[1] enrollment by urbanicity, 2007 and 2006[2]

| Urbanicity | Enrollment[3] | % of total enrollment | % of total eligibles[4] | % of subpopulation eligibles[4] |
|---|---|---|---|---|
| 2007 | | | | |
| Total Medicare Advantage | 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 Medicare Advantage | 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 |

## Table 5-3b
## Change in MA[1] enrollment by urbanicity, 2007 and 2006[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 2006 to 2007 | | | | |
| Total Medicare Advantage | 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 |

[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, and July 1, 2007.

[3] Includes MSA demonstration contracts.

[4] MA eligibles defined as Medicare beneficiaries with Part A and Part B. Eligibles calculated using 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 2006–2007 Management Information Integrated Repository.

**Table 5-4a**
**MA[1] enrollment by census region, 2007 and 2006[2]**

| Census region | Enrollment[3] | % of total enrollment | % of total eligibles[4] | % of subpopulation eligibles[4] |
|---|---|---|---|---|
| 2007 | | | | |
| Total Medicare Advantage | 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 Medicare Advantage | 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 |

**Table 5-4b**
**Change in MA[1] enrollment by census region, 2007 and 2006[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 2006 to 2007 | | | | |
| Total Medicare Advantage | 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 |

[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, and July 1, 2007.

[3] Includes MSA demonstration contracts.

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

SOURCE: RTI analysis of 2006–2007 Management Information Integrated Repository.

## Table 5-5a
## MA[1] enrollment, plan type by urbanicity,[2] column percentages, 2007 and 2006[3]

| Urbanicity | Total | HMO[4] | Local PPO | Regional PPO | PFFS | MSA[5] |
|---|---|---|---|---|---|---|
| 2007 | | | | | | |
| Total Medicare Advantage | 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 Medicare Advantage | 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 | — |

## Table 5-5b
## Change in MA[1] enrollment, plan type by urbanicity,[2] column percentages, 2007 and 2006[3]

| Urbanicity | Total | HMO[4] | Local PPO | Regional PPO | PFFS | MSA[5] |
|---|---|---|---|---|---|---|
| Change in percentage points, 2006 to 2007 | | | | | | |
| Total Medicare Advantage | — | — | — | — | — | — |
| 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 | — |

[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 and July 1, 2007.

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

[5] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2007 Management Information Integrated Repository.

## Table 5-6a
## MA[1] enrollment, plan type by urbanicity,[2] row percentages, 2007 and 2006[3]

| Urbanicity | Total | HMO[4] | Local PPO | Regional PPO | PFFS | MSA[5] |
|---|---|---|---|---|---|---|
| 2007 | | | | | | |
| Total Medicare Advantage | 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 Medicare Advantage | 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 | — |

## Table 5-6b
## Change in MA[1] enrollment, plan type by urbanicity,[2] row percentages, 2007 and 2006[3]

| Urbanicity | Total | HMO[4] | Local PPO | Regional PPO | PFFS | MSA[5] |
|---|---|---|---|---|---|---|
| Change in percentage points, 2006 to 2007 | | | | | | |
| Total Medicare Advantage | — | -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 | — |

[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 and July 1, 2007.

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

[5] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2007 Management Information Integrated Repository.

Conference Report for the MMA of 2003 cites the decline in plan participation and indicates 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." The MMA Conference Report also refers 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 2007, they drew 21.6 percent of their total enrollment from rural areas (column percentage in Table 5-5a), five times that of HMOs, but only two-thirds the percentage of PFFS. Regional PPOs accounted for 5.5 percent of total rural MA enrollment (row percentage in Table 5-6a). Over half of rural MA enrollees were in PFFS plans, with most of the rest in HMOs. In contrast, 76.2 percent of urban MA enrollees were in HMOs, with only 16.0 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. Close to 60 percent of regional PPO enrollment in 2007 was in the South (59.2 percent—column percentage in Table 5-7a), and 44.1 percent of PFFS enrollment was in the South. Regional PPOs and PFFS plans each captured less than 10 percent of MA enrollment in the Northeast. Interestingly, the percentage of regional PPO enrollment in the Midwest increased by 5.8 percentage points from 2006 to 2007 and dropped by 6.3 percentage points in the West (see the column percentages in Table 5-7b). Among the MA enrollees residing in the Northeast census region, over 8 out of 10 enrollees were in an HMO (84.3 percent—row percentage in Table 5-8a). The West region was also dominated by HMOs, with 82.9 percent of Western enrollees. This substantially differs from the Midwest and South census regions, where a higher proportion of MA enrollees chose PFFS plans. For example, among Midwestern MA enrollees, 44.2 percent were in a PFFS plan, with 47.1 percent in an HMO. Given that the MA take-up rate for Midwesterners was relatively low (11.9 percent in Table 5-4a), PFFS plans appeared to be an important MA option in the Midwest.

## 5.3 By Special Needs Plans (SNPs) and Part D

Table 5-9 (a, b, and c) provides SNP enrollment by MA plan type. Among MA enrollees in 2007, 746,408 (11 percent) were enrolled in a SNP, which was a 53 percent increase over 2006. Among SNP enrollees, 70.7 percent were enrolled in a dual-eligible SNP, with 9.9 percent enrolled in a chronic condition SNP, and 19.4 percent enrolled in an institutional SNP. Enrollment in chronic condition SNPs did change substantially from 2006 to 2007, from 1,490 in 2006 to 74,039 in 2007. Most SNP enrollees (651,650 out of 746,408) were in HMOs. The majority of HMO SNP enrollees were in dual-eligible SNPs (78.0 percent). Interestingly, regional PPOs had the highest percentage of their enrollment in SNPs (25.3 percent), with a relatively strong chronic condition SNP presence. Local PPOs also had a high percentage of their enrollment in SNPs (13.2 percent), with a relatively strong institutional presence. SNPs can only be offered as a coordinated care plan; a SNP cannot be offered through the PFFS or MSA models.

**Table 5-7a**
**MA[1] enrollment, plan type by census regions, column percentages, 2007 and 2006[2]**

| Census region | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA[4] |
|---|---|---|---|---|---|---|
| 2007 | | | | | | |
| Total Medicare Advantage | 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 Medicare Advantage | 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 | — |

**Table 5-7b**
**Change in MA[1] enrollment, plan type by census regions, column percentages, 2007 and 2006[2]**

| Census region | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA[4] |
|---|---|---|---|---|---|---|
| Change in percentage points, 2006 to 2007 | | | | | | |
| Total Medicare Advantage | — | — | — | — | — | — |
| 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 | — |

[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, and July 1, 2007.

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

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2007 Management Information Integrated Repository.

**Table 5-8a**
**MA[1] enrollment, plan type by census regions, row percentages, 2007 and 2006[2]**

| Census region | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA[4] |
|---|---|---|---|---|---|---|
| 2007 | | | | | | |
| Total Medicare Advantage | 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 Medicare Advantage | 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 | — |

**Table 5-8b**
**Change in MA[1] enrollment, plan type by census regions, row percentages, 2007 and 2006[2]**

| Census region | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA[4] |
|---|---|---|---|---|---|---|
| Change in percentage points, 2006 to 2007 | | | | | | |
| Total Medicare Advantage | — | -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 | — |

[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, and July 1, 2007.

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

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2007 Management Information Integrated Repository.

## Table 5-9a
## MA[1] Special Needs Plan enrollment, by plan type, 2007 and 2006[2]

| SNP enrollment | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA |
|---|---|---|---|---|---|---|
| 2007 | | | | | | |
| Total Medicare Advantage | 6,793,883 | 4,813,240 | 347,670 | 193,713 | 1,437,000 | 2,260 |
| SNP | 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 |
| SNP % of total Medicare Advantage | 11.0% | 13.5% | 13.2% | 25.3% | 0.0% | 0.0% |
| 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 Medicare Advantage | 89.0 | 86.5 | 86.8 | 74.7 | 100.0 | 100.0 |
| 2006 | | | | | | |
| Total Medicare Advantage | 5,713,606 | 4,585,076 | 273,797 | 86,409 | 768,324 | — |
| SNP | 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 | — |
| SNP % of total Medicare Advantage | 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 Medicare Advantage | 91.4 | 90.0 | 91.0 | 96.1 | 100.0 | — |

## Table 5-9b
## Change in MA[1] Special Needs Plan enrollment, by plan type, 2007 and 2006[2]

| SNP enrollment | % Change total | % Change HMO[3] | % Change local PPO | % Change regional PPO | % Change PFFS | % Change MSA |
|---|---|---|---|---|---|---|
| Change 2006 to 2007 | | | | | | |
| Total Medicare Advantage | 18.9% | 5.0% | 27.0% | 124.2% | 87.0% | — |
| SNP | 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 5-9c**
**Change in MA[1] Special Needs Plan enrollment, by plan type, 2007 and 2006[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 |
|---|---|---|---|---|---|---|
| SNP % of total Medicare Advantage | 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 Medicare Advantage | -2.4 | -3.5 | -4.2 | -21.4 | — | — |

[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, and July 1, 2007.

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

SOURCE: RTI analysis of 2006–2007 Management Information Integrated Repository.

Finally, Table 5-10 (a, b, and c) lists Part D enrollment statistics for MA enrollees. At 93.0 percent, the majority of MA enrollees (6.3 million) were enrolled in the Medicare Part D drug program. The Part D take-up rate for each plan type (except for MSA) was approximately 90 percent, with PFFS 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 an MA-PD (92.8 percent), although 7.2 percent were enrolled in a stand-alone 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 2007. PFFS plans are not required to offer Part D, and, if they do not, their enrollees are allowed under Part D program rules to enroll in a stand-alone drug plan. About 36 percent of PFFS enrollees with Part D coverage were enrolled in stand-alone drug plans.

## Table 5-10a
## Part D enrollment in MA,[1] by plan type, 2007 and 2006[2]

| Part D enrollment | Total | HMO[3] | Local PPO | Regional PPO | PFFS | MSA |
|---|---|---|---|---|---|---|
| 2007 | | | | | | |
| Total Medicare Advantage | 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 |
| 2006 | | | | | | |
| Total Medicare Advantage | 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 | — |

## Table 5-10b
## Change in Part D enrollment in MA,[1] by plan type, 2007 and 2006[2]

| Part D enrollment | % Change Total | % Change HMO[3] | % Change Local PPO | % Change Regional PPO | % Change PFFS | % Change MSA |
|---|---|---|---|---|---|---|
| Change 2006 to 2007 | | | | | | |
| Total Medicare Advantage | 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 5-10c
## Change in Part D enrollment in MA,[1] by plan type, 2007 and 2006[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 |
|---|---|---|---|---|---|---|
| % 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 | — |

[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, and July 1, 2007.

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

[4] Includes MSA demonstration contracts.

SOURCE: RTI analysis of 2006–2007 Management Information Integrated Repository.

## SECTION 6
## MEDICARE ADVANTAGE ORGANIZATION PERSPECTIVES[34]

To supplement the quantitative analyses presented in Sections 3 through 5, we conducted discussions with selected Medicare Advantage Organizations (MAOs) to obtain their feedback on recent changes in the MA program. Topics for discussion included

- Reasons why MAOs chose to offer or not offer specific MA plan types, and MAOs' comments on the different plan types
- Reactions to the new bidding and risk adjustment payment procedures
- Recent trends in premiums and benefits
- Factors affecting MA enrollment, including the implementation of the Medicare Part D drug benefit

A total of nine discussions were conducted between February and April 2008. The discussions were held by telephone conference call and were guided by a list of topics that were provided to organizations in advance. Potential participant MAOs were identified by RTI in consultation with CMS. Our goal was not to achieve a representative sample of organizations. Rather, we identified a convenience sample that included national and locally based organizations, organizations that served different geographic areas of the country, as well as organizations with extensive to limited MA plan offerings. Potential organizations identified by RTI and approved by CMS were contacted, and, if they agreed to participate in the discussion, logistics were scheduled. Most discussions lasted about an hour. The MAOs participating in these discussions are listed in Table 6-1.

**Table 6-1**
**Medicare Advantage Organizations participating in discussions**

| Medicare Advantage Organization | Location of plans offered |
|---|---|
| University of Pittsburgh Health Plan | Western Pennsylvania |
| Order of St. Francis | Central Illinois |
| Cigna | Arizona (with some National) |
| Group Health Inc. (GHI) | New York City |
| Blue Cross Blue Shield of Minnesota | Minnesota and Northern Plains |
| Aetna | National |
| Kaiser Permanente | West Coast and other selected areas |
| Humana | National |
| United Health Group | National |

SOURCE: RTI International.

[34] The opinions expressed in this section are those of the MAOs that we held discussions with. They do not necessarily represent the views of RTI or of CMS.

## 6.1 Medicare Advantage Product Offerings

Factors cited by MAOs as influencing their decisions to offer specific MA options in local market areas varied across MAOs, but included

- Perceived beneficiary or employer demand for the product
- Competitive positioning versus offerings from other MAOs
- Strength of the MAO's local provider network
- Provider network or system receptivity to the product
- Operational feasibility
- Protecting or enhancing MAO market share
- Popularity of the product type in the local employer-based market
- Medicare payment levels relative to the MAO's local medical costs. Area medical costs were determined, in part, by the MAO's methods of contracting with providers in an area

We now turn to summaries of MAOs' specific comments on each of the major MA plan types.

### 6.1.1 Health Maintenance Organizations (HMOs)

Most organizations continued to view the HMO as a core MA option. HMOs were initially the only option available under Medicare and they remain the "bread and butter" product for most organizations offering MA products. Several organizations are committed to local, network-based, coordinated care plans and see them as the best vehicle to drive quality and efficiency improvements. HMOs continue to appeal to "value-driven" beneficiaries who are willing to accept restrictions on provider choice in return for a lower premium, especially if the HMO provider network is extensive or covers their current providers. The HMO product is the one that can get to the lowest price point (particularly zero-premium plans, which are very appealing to beneficiaries, and this is important to the Medicare market. Several organizations continue to expand the geographic reach of their HMO offerings. HMOs continue to be dominant in some urban Western markets, where there is long experience with and provider and beneficiary acceptance of HMOs and little interest in other plan types. HMO products, while mature and stable, are not among the faster-growing MA plan types.

### 6.1.2 Preferred Provider Organizations (PPOs)

According to one MAO, PPOs are less popular in Medicare than in employer-based insurance because employers often eliminate the indemnity insurance option or require employees to pay the higher costs of the indemnity insurance if they choose it. Employers offer PPOs as an option with greater freedom of provider choice than HMOs, but that are more cost-effective for the employer than indemnity plans. In Medicare, beneficiaries can still choose the

indemnity option—original Medicare—and many do, often combine with supplemental insurance.

A second MAO pointed out that another reason PPOs are relatively less popular in Medicare is that beneficiaries turning age 65 and moving to a limited income prefer the lower premium of the HMO if their doctor is in the HMO's network. Cost is a bigger factor in the elderly's decision making than for the employed, which means the elderly have a stronger relative preference for the HMO. HMOs are better able to control medical costs, and hence keep their premiums low, than PPOs.

Local PPOs

Despite the continued emphasis on HMOs, local PPOs were also described as an important Medicare option for the long term. They appeal to beneficiaries who travel or who want greater freedom of provider choice. MAOs acknowledged that local PPO enrollment has not risen rapidly so far, but they expected it to build steadily over time as more beneficiaries familiar with PPOs from their employer insurance age in to Medicare. High PPO premiums have been an impediment to their growth. Price-conscious beneficiaries often prefer lower-premium HMOs, particularly if their providers are in the HMO's network. Beneficiaries desiring greater provider choice may prefer original Medicare plus a supplement even if they are costlier. A few advantages of PPOs compared to traditional FFS plus a supplement pointed out by one discussant were lower in-network costs, coordination of providers, and the integration of the drug plan with medical benefits.

PPOs were offered for a combination of reasons. First, for many organizations, offering a local Medicare PPO had little marginal cost. Most organizations had already contracted with physician networks through their HMO or commercial PPO and were therefore able to build on these for local PPOs. Some of the organizations we spoke with offered local PPOs when they first became available as demonstration plans, particularly in service areas where the PPOs had been successful in the commercial market. Second, some MAOs offered local PPOs in hopes of attracting MA members from the FFS population who wanted the additional benefits offered by managed care but were reluctant to enroll in an HMO because HMOs use more limited networks. In general, local and regional West Coast organizations, many of whom continued to rely heavily on the HMO model, were less likely to offer PPOs.

Regional PPOs

Interest in the regional PPO option was somewhat limited. Organizations offering the regional PPO were unsure of its long-term viability, although some employers have expressed interest because they can cover retirees across large regions with a consistent plan structure. Of particular concern is the regional PPO requirement to offer the same premium and benefits across an MA region.

MAOs pointed out that the regional PPO Medicare payment benchmark is weighted by Medicare eligibles in different counties across the region, not by the number of enrollees a plan projects it will attract in each county. Local plan benchmarks, conversely, are based on projected enrollment in each county. Bids for both regional and local plans are weighted based on projected plan enrollment. Citing potential distortions that may result when different methods for

weighting bids and benchmarks are used, at least some MAOs would prefer enrollment rather than eligible weighting of the regional PPO benchmark.

The regional PPO requirement for a region-wide provider network drew mixed reviews. Some national organizations had no problem with this. But locally based organizations, in general, were unwilling to contract provider networks outside of their local market area, which generally did not extend to the entire state-based region. One organization had established provider networks in certain parts of a region, especially urban areas, but found it to be a significant effort to contract with providers in rural or other areas where it currently did not have a presence.

### 6.1.3 Private Fee-for-Service (PFFS) Plans

A few of the MAOs we spoke with have offered the PFFS option for several years. Others are just entering the PFFS market, believing that offering PFFS was necessary to compete given the recent enrollment growth in this type of plan. These MAOs have little experience with PFFS at this time. The remaining MAOs we talked to have chosen not to offer PFFS plans.

MAOs varied in the rationales they reported for offering PFFS plans, although the ability to offer a consistent product over a wide—sometimes national—service area without provider networking issues was commonly cited as a positive feature of the PFFS model. PFFS brings broad access and competition to the market, along with benefits it adds to traditional Medicare FFS. The ease of offering widely available PFFS plans was particularly important for national MAOs who needed to offer Medicare products to large national employers. Based on our interviews, MAOs believed PFFS plans appeal to two groups: (1) beneficiaries seeking a zero- or low-premium product with wide provider choice that also has more comprehensive coverage than original Medicare, particularly in areas where other MA options are limited, such as in many rural or small city areas; and/or (2) employers seeking a product able to cover beneficiaries nationwide with a uniform plan design and low administrative costs. One MAO reported that PFFS plans were particularly attractive to beneficiaries who had Medicare only (no supplement), because PFFS was so similar to original Medicare but offered extra benefits. Another reported that PFFS is primarily drawing enrollees from traditional FFS plus a supplement, not from MA coordinated care plans.

PFFS allows MAOs to offer plans in areas where they do not have established provider networks and to enter new markets with relative ease. Developing an adequate provider network can be particularly difficult in areas where a small number of providers have substantial market power—for example, areas with only one or two hospitals or dominant physician groups in key specialties. So far, MAOs reported that most providers are accepting PFFS terms and treating PFFS-enrolled beneficiaries, albeit with considerable provider education on the part of the MAO.

Providers are generally willing to participate with PFFS for the Medicare FFS payment rates. In the non-PFFS plans, several MAOs reported that providers had to be paid more than FFS to participate in network-based MA products (HMOs, PPOs) because of provider market power (especially in rural areas) or because of the extra requirements of network-based products, such as reporting quality-of-care indicators. Potentially, these lower costs in PFFS may make it possible for them to locate and attract beneficiaries in areas with significant provider market

power, such as rural areas. However, an advantage of network-based plans, which is not always fully appreciated by beneficiaries, is that they guarantee enrollees access to network providers. Non-network PFFS does not guarantee access to any particular providers.

While some MAOs we spoke with did not design their Medicare PFFS products to include significant care management activities, several large MAOs reported that they apply the same medical management to PFFS enrollees as to other MA (HMO or PPO) members (except for precertification of admissions and concurrent review, and provider network-based aspects). Citing use of disease management programs in their PFFS plans, one MAO considers their PFFS plans to be managed care products.

Another more locally based MAO voiced concern about the PFFS model for Medicare because of the lack of care management found in most PFFS products and potential difficulties in obtaining services without guaranteed access to a specific plan network. Others raised concerns about the PFFS model's lack of medical management for enrollees. One national MAO we spoke with expected PFFS plans to eventually include provider networks as the model evolved. While some MAOs thought including a PFFS option would be important for future growth, others saw it as contrary to their care management structure.

### 6.1.4 Special Needs Plans (SNPs)

Of the plans we interviewed, most plans offered at least one type of SNP, and this plan option was offered by both locally based and national MAOs. However, some of the locally based MAOs with the most limited service areas did not offer SNPs because they did not believe their markets were large enough to support a specialized enrollment product. Among the MAOs we talked to, SNPs targeted toward dual eligibles were most prevalent, although chronic condition SNPs are beginning to be offered more widely. Several MAOs' SNPs were originally offered in part to take advantage of the 2006 opportunity for "passive enrollment" (auto assignment) of dual-eligible enrollees in preexisting Medicare and Medicaid plans into Medicare SNPs. Several MAOs said that their SNPs allowed them to offer zero premiums and low co-pays to dual eligibles, which was critical for this population.

MAOs generally approved of the SNP model. Medicare and Medicaid benefits can be coordinated through dual-eligible SNPs, which is simpler for both beneficiaries and providers (e.g., providers only have to bill one plan instead of separate Medicare and Medicaid plans). SNPs allow medical management to be tailored to the unique needs of enrollees, especially those with multiple chronic conditions. In assessing the SNP option for enrollees with a specific medical condition, one MAO observed that medical management can be more focused and achieve a better result than a general program in an open-enrollment plan. Several MAOs offered in their chronic condition SNPs better gap coverage of drugs commonly used by the SNP population (e.g., diabetic supplies) in exchange for higher co-payments for other drugs. Their SNPs also offer specialists tailored to the chronic condition and disease-specific care management. Chronic condition SNPs are offered for such conditions as diabetes, osteo-arthritis, and Alzheimer's disease. According to one MAO, chronic condition SNPs are about developing the right product with the right medical management. Another MAO pointed out that marketing the chronic care SNP is a very labor-intensive, expensive endeavor. A small number of MAOs did question whether such a specialized products was necessary, and suggested the needs of

beneficiaries eligible for SNPs could be met in plans that served a broad cross-section of beneficiaries.

### 6.1.5 Medical Savings Account (MSA) Plans

None of the organizations we spoke with offered MSAs in either 2007 or 2008. But many had evaluated it and would not rule out offering it in the future. Some found MSAs to be an interesting concept and liked the idea of involving the member more in the financial management of their care. Some cited impediments to the introduction and growth of MSAs. MSAs are a new, complex product that is difficult to explain to beneficiaries and requires a lot of beneficiary education. MSAs are not intuitive to beneficiaries. They take a lot of financial acumen on the part of beneficiaries to understand and make the decision to join. Completing beneficiary education to the point of enrolling the new member in the 6-week open-enrollment period in October to December is challenging. This option also has high start-up and operational costs, which are difficult to justify given the low expected demand for the product among Medicare beneficiaries. MAOs told us that Medicare MSAs require substantial investments in the financial mechanism for setting up individual bank accounts where medical service costs could be deducted. Essentially, MAOs did not believe this infrastructure investment would pay off, although there was some willingness among MAOs to develop MSAs in the future if they sensed growing demand for the option among future Medicare beneficiaries. A number of MAOs decided not to offer a Medicare MSA until there was greater demand in their commercial markets for these products. One locally based MAO noted that its markets were too small to offer an MSA product given the high fixed costs. Another MAO told us that they might consider Medicare MSAs if there were more preretirees potentially rolling over funds from HSAs. The general feeling from even those MAOs most interested in potentially offering an MSA was that it is the type of product that beneficiaries must initially become familiar with in the commercial market (presumably in the form of employer or private HSAs).

## 6.2 Competitive Bidding Process

Most organizations we interviewed were reasonably satisfied with the new competitive bidding system implemented for MA, noting its incentives to generate rebates to fund benefits for enrollees. As one MAO noted: “Through competitive bidding there is a greater urgency to offer the best product to attract every potential member.” Rebates generated through the bidding process are typically used to reduce plan cost sharing, enhance Part A/B benefits, or buy down the plan Part D premium.

Several organizations noted the difference between the bidding methods for Part D and Part C. On the Part D side, plans are uncertain about payment, premiums, and whether they will bid low enough to qualify for auto-enrollment of dual eligibles. This uncertainty has led to aggressive bidding by some PDP sponsors and PDP premiums, and Medicare subsidies have been lower than expected. Conversely, on the Part C side, plans are bidding against a known benchmark so there is little uncertainty—MAOs know when they are bidding what their premium will be and what their payment will be. Thus, Part C bidding is less aggressive and competitive. While most agreed that the competitive bidding process enhanced competition in the MA program, others indicated that the process created a significant new administrative burden and added complexity while not improving efficiency.

## 6.3 Risk Adjustment

MAOs felt that the implementation of health (diagnosis) based risk adjustment was an improvement over previous demographics-only risk adjustment. For example, risk adjustment made SNPs that target beneficiaries with high-cost conditions viable and reduced risk selection concerns in offering high and low option plan variants. Several MAOs felt that with their care management expertise, under risk adjustment they might earn better margins on sicker than healthier enrollees. MAOs reported that risk adjustment made payment fairer, especially to plans that enroll sicker beneficiaries, and reduced incentives for risk selection in MA enrollment. Risk adjustment has also provided the financial support and data/patient identification infrastructure for disease management and outreach programs for the chronically ill or high-risk enrollees. However, some plans did not feel that risk adjustment has had a big impact on the types of beneficiaries MA plans enroll, noting that virtually all beneficiaries can enroll in MA plans, or that prior to risk adjustment they had not selected "for the best risk."

Plans noted a few concerns about the current risk adjustment methodology, including the inability of organizations to add diagnoses for new enrollees switching plans for the current payment year. Similarly, a major issue with SNP payments cited by one MAO was the lag between collection of diagnoses and when the risk-adjusted payment is made. Now, plans must wait 18 to 24 months to be paid accurately for new enrollees who are sicker than predicted by the new enrollee demographic risk adjustment model because plans are paid on their prior year's diagnoses. It takes a year for new Medicare enrollees to accumulate a diagnostic profile that can be used in risk-adjusting their payments.

MAOs noted that risk adjustment has put a focus on submitting complete and accurate diagnosis data; failure to submit complete data puts entities at a competitive disadvantage. Use of more complete data has resulted in higher risk scores. Referring to a proposal in the February 2008 45-day notice that could have reduced payments for some plans based on their higher risk scores, several MAOs stressed that CMS should focus on plans that are reporting inaccurate data rather than those that report complete data. One MAO addressed timing issues, believing the risk adjustment model should be recalibrated less frequently.

## 6.4 Trends in Premiums, Benefits, and Cost Sharing

The MAOs we spoke with generally described their premiums, benefits, and cost sharing as stable since 2006, although some had seen an upward or downward trend. Several MAOs noted that aggressive competition from zero-premium PFFS plans (and from SNPs according to one MAO) had forced other plans to keep premiums down and benefits up. However, a few organizations noted that medical care costs increased faster than Medicare payments to MA plans. Some MAOs also expressed concern over policy discussions that would cut payment rates in the future.

## 6.5 Medicare Advantage Enrollment

MAOs we spoke with reported being reasonably satisfied with enrollments in their MA products, with the exception of regional PPOs. One general concern of several MAOs was the short time frame for the Medicare open-enrollment period, which includes the

November/December holidays. These MAOs believe that seniors would prefer a period longer than 45 days to evaluate health plan options.

### 6.5.1 Impact of Part D

We asked MAOs how the implementation of Medicare Part D had impacted MA enrollment. One possibility was that, prior to 2006, MA plans were purchased by some Medicare beneficiaries as a way to gain access to drug benefits; under this logic, the introduction of stand-alone Part D plans in 2006 would lower the incentives for Medicare beneficiaries to enroll in MA plans. An alternative theory suggests that the marketing of private drug plans in Medicare for Part D could have a positive spillover effect for MA plans as beneficiaries became more aware of options for receiving their Part A/B benefits from MA plans.

The majority of MAOs we spoke with were unsure of the Part D impact, did not feel that Part D had much impact, or thought there was a positive but limited impact. "Most beneficiaries are not willing to make a major change in their medical care coverage just because of Part D" was one response. However, several MAOs reported that the availability of better or more affordable drug benefits through MA plans had increased MA enrollment.

### 6.5.2 Other Factors

Rather than Part D per se, several MAOs felt that the biggest driver of MA growth has been the geographic expansion of affordable plan offerings into new areas. PFFS, for example, has been a large driver. Pre-MMA, integrated Part C and prescription drug benefits at a low cost (low or zero premium, low cost sharing) were generally more widely available in large metropolitan areas. Post-MMA, this package is available virtually everywhere.

The Medicare market has different "segments." Some beneficiaries prefer original Medicare plus a supplement. They want to pay only a premium, with minimal cost sharing. They want very predictable health care costs and choice of provider. "Value" shoppers, on the other hand, are more willing to "pay as they go" (i.e., pay cost sharing for specific services used). They are more interested in paying low or no monthly premiums and are willing to accept restrictions on provider choice to get that. The "special needs" segment has particular health care needs to be met. Beneficiaries differ in how much care management they want.

Generally, it is easier to grow MA enrollment where there are already MA choices. MA enrollment is highest in areas that have traditionally had high managed care penetration, like the West Coast and Minnesota. People who are seeing managed care for the first time while entering Medicare are unlikely to take it because they have never had the option before. In markets that have managed care penetration already, beneficiaries are used to this option and making a choice among plans. It is possible for new entrants to enter these markets and take enrollment from existing plans. It is much more difficult to enter markets with little managed care penetration where beneficiaries are not used to making a choice. One MAO, however, reported that it can be difficult to enter "saturated" managed care markets like California. Providers would not offer discounts to new plans because the new plans had no patient volume to offer to providers.

A number of MAOs projected that significant increases in MA enrollment would only emerge when the population more familiar and comfortable with managed care products (like

HMOs and PPOs) ages into Medicare. One MAO expressed concern that seniors are already overwhelmed with the amount of information available on Medicare plans, adding that the problem was compounded with the introduction of Part D. The complexity can result in confusion for beneficiaries, and confusion about benefits and costs of MA versus traditional FFS with Medigap can mean that some beneficiaries do not make the choice best suited to their needs. MAOs noted that it is often difficult to market MA options to beneficiaries who have other supplemental coverage. Other MAO pointed out that, while MA plans must charge the same premium to all enrollees, Medigap plans can age-rate their premiums. In addition, brokers often find that selling Medigap plans is very profitable and MAOs do not have enough margins to pay brokers comparably.

## 6.6 Care Management Strategies

We received varied responses from MAOs about the current status of care management efforts in MA. Most MAOs saw care management as a key value added by MA and a critical part of their strategy to improve quality and efficiency. One national MAO thinks that multiple approaches to care management are necessary to improve quality and efficiency. A network-based coordinated care model is one component. Benefit design (e.g., lower co-pays) should incent enrollees to use primary care and use preventive screenings. Physicians should be encouraged to follow evidence-based practice patterns. Medication management, management of chronic diseases, prevention, and end-of-life care are all important.

## 6.7 Payment Levels and the Value of Medicare Advantage

One MAO maintained that the "alleged MA overpayment relative to traditional FFS," especially in rural areas, is not really overpayment. According to this MAO, there is underservice in traditional Medicare in rural areas. Beneficiaries in rural areas with traditional Medicare only cannot afford services because of the cost sharing. MA provides better access with lower cost sharing; hence, its utilization is higher than under traditional FFS. One of the main advantages of PFFS is allowing an MA product in a rural setting where MA is normally not available. The generally lower cost sharing available in a PFFS (relative to traditional FFS) encourages poor people who are unlikely to seek services to seek services. This is because, generally, Medicare's 20 percent cost sharing is expensive and may prevent rural patients from getting services such as knee or hip replacements.

Another MAO pointed out that the figures that compare MA payments to FFS do not take into account the extra benefits MA plans offer. One MAO offers plans in areas where payment rates are at the rural or MSA floor. Without the payment floors, they would not be able to operate plans in these areas. In these markets, it is a "given" that providers will be paid 100 percent of Medicare (or more), so the floor rates allow them to offer the full benefits that make their product appealing. Before the floor, it would not have been possible to offer benefits like theirs in this marketplace.

Many MAOs thought that the care management services they provided, especially to chronically ill beneficiaries, were a major value added of MA plans. The integration of Part C and Part D benefits enhanced their ability to manage care, as opposed to the alternative of separate traditional Medicare, supplemental insurance, and stand-alone Part D products. While some MAOs felt that costs could be significantly reduced through care management, others

justified their care management programs more on improving quality of care and outcomes. One MAO did not foresee a lot of cost savings in the near term from their delivery model. But savings would occur in the long term as medical practice patterns are influenced, including in the FFS sector.

# SECTION 7
# CONCLUSIONS

The 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 FFS program as well as MA. New plan types have been introduced or encouraged in MA, including local and regional PPOs, PFFS, SNPs, and MSAs. MA payment rates have been substantially enhanced in many areas since the spring 2004 implementation of the MMA-mandated MA payment methodology changes. The continuing impact of these changes was experienced in 2007. Changes in 2007 were not as radical as in 2006, but such major innovations as Part D and regional PPOs that were introduced in 2006 were still quite new in 2007.

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, and enrollment.

## 7.1 Plan Availability

MA plan availability—already good in 2006—improved even further in 2007. Two noteworthy improvements in availability in 2007 were the universal availability of PFFS plans and the greater availability of SNPs—both outside of large urban areas and with different target populations. Access to at least one PFFS plan improved in 2007 to nearly all counties. Particularly important was that in 2007 a PFFS plan was offered in 100 percent of large urban counties compared to 87 percent of such counties in 2006. This raised the percentage of Medicare beneficiaries with access to a PFFS plan to nearly 100 percent, from 81 percent in 2006. Also, the expansion of PFFS plans in large urban areas was the primary reason that the percentage of beneficiaries with access to all three major plan types—HMOs, PPOs (local or regional), and PFFS—rose from 54 to 75 percent from 2006 to 2007.

The availability of SNPs almost doubled from 25 percent of counties in 2006 to 47 percent in 2007. SNPs were available in 38 percent of rural counties in 2007 compared to only 16 percent in 2006, and were available in 50 percent of small urban counties in 2007 versus 24 percent in 2006. Although SNPs targeted at dual Medicare/Medicaid eligibles continued to be the most common type in 2007, comprising 70 of all SNPs, the number of chronic condition SNPs rose from 10 in 2006 to 57 in 2007.

In other developments, MSAs were offered for the first time in 2007 by 2 regular and 1 demonstration contract. MSAs were available in 71 percent of counties to 79 percent of beneficiaries nationally, including broadly across urban and rural areas and different regions. 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 may only be temporary because new local PPO plans are allowed again in 2008.

In terms of sheer number of plan sponsors to choose from, 65 percent of Medicare beneficiaries had access to 10 or more MA contracts in 2007, a significant increase over 27 percent in 2006. In rural areas, the percentage of beneficiaries with access to 7 or more contracts

rose to 71 percent in 2007 from 13 percent in 2006, and the rural percentage that had 3 or fewer MA contracts to choose from fell from 46 percent in 2006 to less than 2 percent in 2007.

## 7.2 Premiums and Benefits

MA average premiums remained relatively modest in 2007, but rose faster than the rate of general inflation. Many beneficiaries continued to be enrolled in zero premium plans, but some enrollees paid substantial premiums. Among MA plans offering both Parts C and D, the average enrollment-weighted total monthly premium rose by 9 percent from 2006 to 2007. However, this increase was only $2.68, from $29.67 in 2006 to $32.35 in 2007. Half (51.4 percent) of MA enrollees continued to receive their Part C and Part D benefits at zero premium in 2007, only a slight decline from 2006 (53.8 percent). The percentage of MA enrollees paying more than $100 per month in total premiums rose slightly, from 8 percent in 2006 to 11 percent in 2007.

Among plan types, PFFS plan average total premiums rose quite rapidly, by 57 percent, from $14.80 in 2006 to $23.20 in 2007. HMO total premiums rose much more modestly, by 8 percent, from $30.65 in 2006 to $33.11 in 2007. Thus, some of the price advantage of PFFS plans over HMOs eroded between 2006 and 2007.

The Part D benefits offered by MA prescription drug plans were stable to slightly improved in 2007. A slightly higher percentage of enrollees had an enhanced benefit in 2007 than in 2006 (65 versus 63 percent). Moreover, typical (median) drug co-payments were fairly stable between 2006 and 2007. In the most common 3 copayment/1 coinsurance tier structure, the median co-payment for tier 1 (generics) fell from $5 to $4; for tier 2 (preferred brand) rose from $28 to $29; and for tier 3 (non-preferred brand) rose from $58 to $60.[35] However, median co-insurance for the expensive specialty drug tier rose from 25 to 33 percent, and a higher percentage of MA-PD enrollees were subject to coinsurance tiers in 2007, 82 percent versus 74 percent in 2006.

More MA-PD enrollees enjoyed gap coverage in 2007: 34 percent of (non-SNP) enrollees, up from 28 percent in 2006. Overwhelmingly, gap coverage continued to be for generic drugs only (25 percent of the 34 percent with gap coverage had it for generics only). But the percentage of enrollees with some brand gap coverage nearly doubled 2006 to 2007—from 5 to 9 percent.

The percentages of MA enrollees with supplemental coverage for vision care, hearing exams, dental care, podiatry, and chiropractic care benefits in 2007 did not change much from 2006, with the exception of a slight decline in the proportion of enrollees with vision coverage. The proportion of PFFS plan enrollees with vision and dental benefits rose strongly from 2006 to 2007, but still lagged the provision of these benefits in HMOs and PPOs.

Physician visit co-payments remained modest in MA plans in 2007, but increased. In 2007, as in 2006, most MA enrollees faced co-payments of $5 to $15 for primary care physician visits. But the primary care co-payment distribution shifted upwards from 2006 to 2007. The

[35] Copayments are for a 30-day drug supply at in-network retail pharmacies.

most common specialist physician visit co-payment amounts in 2007 were in the $25.01 to $35 range, up from the $15.01 to $25 range in 2006.

A slightly higher proportion of MA enrollees had protection from catastrophic medical expenses in 2007. 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 out of pocket maximum was $3,100 in 2007, up $100 from $3,000 in 2006.

Across all MA enrollees, 2007 average OOP costs were simulated to be $303 per month. About 30 percent of total OOP cost was the Medicare Part B premium, 11 percent was comprised of the plan Part C and Part D premiums, 31 percent represented outpatient drug expenses (even with prescription drug coverage through Medicare Parts D and B), and 28 percent was payments for inpatient (8 percent), dental (8 percent), and all other services (11 percent). Simulated OOP costs are 80 percent greater, $426 versus $237 per month, for MA enrollees in poor health compared to enrollees in excellent health. The largest contributor to higher OOP costs with poor health is increased outpatient prescription drug expenses, accounting for 57 percent of the total increase.

## 7.3 Enrollment[36]

MA enrollment continued to increase significantly in 2007. MA enrollment in 2007 was 6.8 million, rising 19 percent from 2006 to 2007. Nearly all the increase in 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. The MA penetration of the total eligible Medicare population was 17.2 percent in 2007, up 2.5 percentage points from 2006.

Plan types that are relatively new to MA captured a significant share of MA enrollment in 2007. Although HMOs were still the dominant plan type in MA, together PFFS and PPOs (local and regional) had about 30 percent of 2007 MA enrollment, which was about 10 percentage points 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.

MA enrollment retained its bias towards urban areas in 2007, but the rate of enrollment growth was much stronger in rural areas. Among 2007 MA enrollees, 89 percent resided in urban areas, and 11 percent in rural areas. At 20 versus 9 percent, the MA penetration rate was double for urban compared to rural beneficiaries. However, the percentage increase in rural enrollment from 2006 to 2007 was 56 percent, compared to only 15 percent for urban enrollment.

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36 Our analysis of MA enrollment, as was true of our analyses of MA plan availability and premiums and benefits, focused on open-access MA plans and special needs plans, not all Medicare private health plans. We excluded employer-specific, some demonstration (see Section 2 for details), cost, PACE, and other non-MA Medicare private health plans, as well as plans located in Puerto Rico and the U.S. Territories. Other sources that include some or all of the plans we excluded will show larger MA enrollment.

MA enrollment growth in 2007 was strongest in the Midwest and South, regions that historically have had lower MA penetration. In 2007, the MA penetration rate was 26 percent in the West, 19 percent in the Northeast, 15 percent in the South, and 12 percent in the Midwest. However, the Midwest and South had the highest percentage growth in MA enrollment from 2006 to 2007, with the Midwest growing by 31 percent and the South by 27 percent. This compares to 13 percent MA growth in the Northeast and 10 percent in the West.

The popularity of MA plan types differed across urban and rural areas, and across regions. Only 5 percent of MA HMO enrollees and 9 percent of local PPO enrollees resided in rural areas in 2007. This contrasted with 33 percent of PFFS enrollees, 32 percent of MSA enrollees, and 22 percent of regional PPO enrollees. In 2007, HMOs accounted for 76 percent of urban MA enrollment and PFFS plans 16 percent. In contrast, PFFS plans accounted for 62 percent of rural MA enrollment and HMOs 29 percent. PPOs accounted for less than 10 percent of MA enrollment in both urban and rural areas, and 2007 MSA enrollment was negligible.

Regional PPO and initial MSA enrollment was heavily concentrated in the South in 2007 (59 and 65 percent, respectively). Over three-quarters of PFFS enrollment was in the South or Midwest (44 and 34 percent, respectively). In 2007, MA enrollment in the Northeast and West was dominated by HMOs, comprising more than 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 44 and 29 percent of enrollment, respectively).

SNPs grew in popularity in 2007. Among MA enrollees in 2007, 746,408 (11 percent) were enrolled in a SNP, which was a 53 percent increase over 2006. Among SNP enrollees, 71 percent were enrolled in a dual-eligible SNP, with 10 percent in a chronic condition SNP, and 19 percent in an institutional SNP. Enrollment in chronic condition SNPs rose substantially from 1,490 in 2006 to 74,039 in 2007.

Most SNP enrollees (651,650 out of 746,408, or 87 percent) were in HMOs. The majority of HMO SNP enrollees were in dual-eligible SNPs (78 percent). Regional PPOs had the highest percentage of their enrollment in SNPs (25 percent), with a relatively strong chronic condition SNP proportion. Local PPOs also had a high percentage of their enrollment in SNPs (13 percent), with a relatively strong institutional SNP proportion.

At 93 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 rate for each plan type (except for MSA at 77 percent) was approximately 90 percent, with PFFS enrollees slightly less likely to have Part D coverage than enrollees in other non-MSA plan types. Almost 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. However, the percentage of MA enrollees in Part D that were enrolled in a stand-alone drug plan increased by 3.7 percentage points between 2006 and 2007. About 36 percent of PFFS enrollees with Part D coverage were enrolled in stand-alone drug plans.

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Pope, G.C., Greenwald, Kautter, J., Healy, D., and Siegel, S.Y.: Medicare Advantage Plan Availability, Premiums and Benefits, and Beneficiary Enrollment in 2008. Report submitted to Centers for Medicare & Medicaid Services, Contract No. 500-00-0024, T.O. #17. Waltham, MA. RTI International, 2010.

## COMPUTER OUTPUT LIST

Section 3 Tables

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

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request1_oct23.log
2006 H:\project\07964\017 FAMA\pgm\ykaganova\Programs\new_request4_no06630_2006_march14.log

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

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request8_dec17.log
2006 H:\project\07964\017 FAMA\pgm\ykaganova\Programs\new_request4_no06630_2006_april04.log

**Table 3-3—Number and percent of Medicare beneficiaries with access to MA plans**

Computer Output:
2007 fama\pgm\ykaganova\Programs\hpms_july2007\additional_8_HMO_counties.xls
2006 fama\pgm\ykaganova\Programs\hpms_july2007\additional_8_HMO_counties.xls

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

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request8_dec17.log
2006 H:\project\07964\017 FAMA\pgm\ykaganova\Programs\new_request4_no06630_2006_snp_feb20.log

**Table 3-5—Percent of counties with at least one MA contract, by plan type and region**

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request8_dec17.log
2006 H:\project\07964\017 FAMA\pgm\ykaganova\Programs\new_request4_no06630_2006_snp_feb20.log

**Table 3-6—Percentage of beneficiaries and counties with access to MA plans**

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request9_dec18.log
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_request4_no06630_2006_nt_march14.log

**Table 3-7—Percentage of beneficiaries and counties with access to MA plans, by urbanicity**

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request9_dec18.log
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_request4_no06630_2006_nt_march14.log

**Table 3-8—Percentage of beneficiaries and counties with access to MA plans, by region**

Computer Output:
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2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_request4_no06630_2006_nt_march14.log

**Table 3-9—Percentage of MA contracts , by number of contracts and urbanicity**

Computer Output:
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2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_request4_no06630_2006_nt_march14.log

**Table 3-10—Percentage of MA contracts , by number of contracts and region**

Computer Output:
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request9_dec18.log
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**Table 3-11—Number of special needs contracts by plan type and target beneficiaries**

Computer Output:
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**Table 3-12—Number of special needs plans, by plan type and target beneficiaries, 2008-2006**

Computer Output:
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## Section 4 Tables

**Table 4-1—Mean monthly premiums of MA plans, by plan type**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_bd_request3_april4_check.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request1_oct23.log

**Table 4-2—Percent of MA enrollees in zero premium plans, by plan type**

Computer Output:
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2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request1_oct23.log

**Table 4-3—Percent of enrollees in MA plans, by premium range**

Computer Output:
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**Table 4-4—Mean monthly premiums of MA plans, by urbanicity**

Computer Output:
2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\jk_enrollment_request2_check.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log

**Table 4-5—Percent of MA enrollees in zero premium plans, by urbanicity**

Computer Output:
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**Table 4-6—Mean monthly premiums of MA plans, by region**

Computer Output:
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2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log

**Table 4-7—Percent of MA enrollees in zero premium plans, by region**

Computer Output:
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2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log

**Table 4-8—Part B premium reduction, by MA plan type, urbanicity and region, percent of enrollees**

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2006 H:\project\07964\017 fama\pgm\ykaganova\Programs\new_gp_request_april30a.log
2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log

**Table 4-9—Prescription drug benefits, by MA plan type, percent of enrollees**

Computer Output:
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2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request3_oct30.log

**Table 4-10—Prescription drug benefits of MA enrollees, by urbanicity, percent of enrollees**

Computer Output:
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2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log

**Table 4-11—Prescription drug benefits of MA enrollees by region, percent of enrollees**

Computer Output:
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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:
H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request4_oct30.log

**Table 4-14—Initial coverage limit in MA prescription drug plans, by plan and geographic characteristics**

Computer Output:
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**Table 4-15—Gap coverage in MA prescription drug plans, by plan and geographic characteristics**

Computer Output:
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**Table 4-16—Selected mandatory supplemental benefits in MA plans, percent of enrollees with benefit**

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**Table 4-17—Cost sharing for selected MA plans**

Computer Output:
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2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_request2_oct29.log

**Table 4-18—Out of pocket (OOP) maximums in Medicare Advantage plans, percent of enrollees**

Computer Output:
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2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.log

**Table 4-19—Out of pocket maximums in MA plans, by plan type, urbanicity and region**

Computer Output:
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2007 H:\project\07964\017 fama\pgm\ykaganova\Programs\hpms_july2007\new_jk_request1_feb07.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

**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

**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

Section 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
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**Table 5-2—Medicare Advantage by beneficiary characteristics, 2008-2006**

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**Table 5-3—Medicare Advantage Enrollment by Urbanicity, 2008- 2006**

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**Table 5-4—Medicare Advantage Enrollment by Census Region, 2008-2006**

Computer Output:
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**Table 5-5—Medicare Advantage enrollment, plan type by urbanicity, column percentages, 2008-2006**

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**Table 5-6—Medicare Advantage enrollment, plan type by urbanicity, row percentages, 2008-2006**

Computer Output:
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**Table 5-7—Medicare Advantage enrollment, plan type by urbanicity and census region, column percentages, 2008-2006**

Computer Output:
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**Table 5-8—Medicare Advantage enrollment, plan type by urbanicity and census region, row percentages, 2008-2006**

Computer Output:
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**Table 5-9—Special Needs Plan Enrollment, by Plan Type, 2006-2008**

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**Table 5-10—Part D Enrollment in Medicare Advantage by Plan Type, 2006-2008**

Computer Output:
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