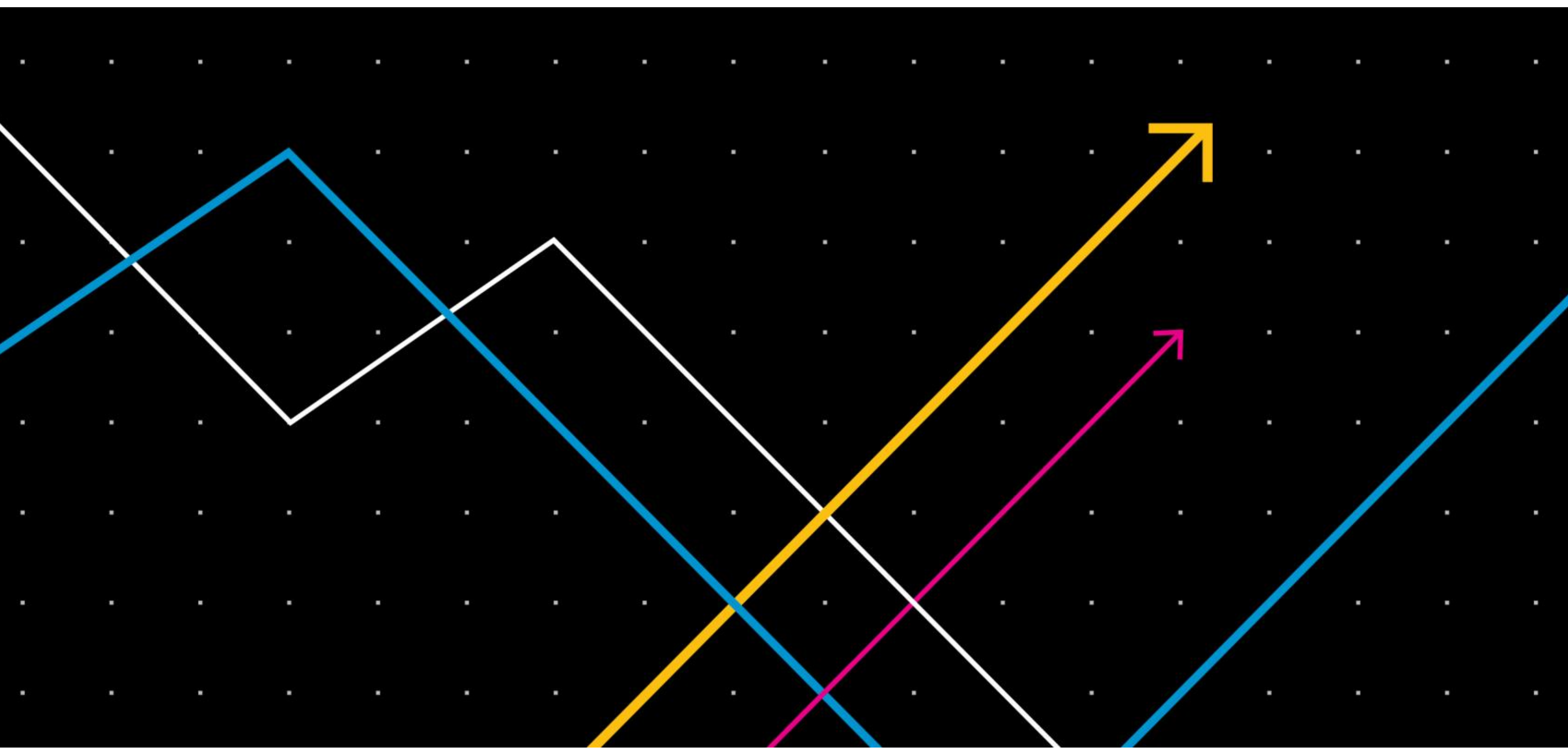

RESEARCH REPORT

Why Did Medicare Advantage Enrollment Grow As Payment Pressure Increased?

Examining the Role of Market and Demographic Changes

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Why Did Medicare Advantage Enrollment Grow As Payment Pressure Increased?

Examining the Role of Market and Demographic Changes

Introduction and Background

Medicare Advantage (MA), also known as Medicare Part C, gives Medicare beneficiaries an option to receive their Parts A and B benefits through private health insurance plans as an alternative to traditional Medicare. MA has been attractive to many Medicare beneficiaries in part because of several enhancements plans typically make to the Part A and B benefit packages. For example, depending on MA plans' bids, they receive rebates that they must use to offer supplemental benefits such as dental, vision, and hearing coverage at no extra cost, or other benefit enhancements such as yearly limits on out-of-pocket spending and low or $0 premiums beyond that required for Part B.[1] Most Medicare Advantage plans also include integrated Part D prescription drug coverage. In addition, MA plans must also have an out-of-pocket maximum, which is not available in traditional Medicare without supplemental coverage.

Overall, MA is often a cheaper, one-stop-shopping alternative compared to a comprehensive traditional Medicare package that includes Part A, Part B, Part D, and MediGap (Berenson 2004). However, though beneficiaries enrolled in the traditional Medicare program enjoy access to almost any health care provider, MA plan enrollees are generally limited in their choice of provider and may need a referral to see a specialist or prior authorization to obtain a particular procedure or service.[2]

Many policymakers believe including private health insurance plans in Medicare has the potential to improve quality, increase beneficiaries' choices, and reduce government spending, among other policy objectives (Berenson and Dowd 2009). But, the federal government has struggled to control MA costs, and in 2009, average payments to MA plans peaked at 114 percent of spending on traditional Medicare (MedPAC 2009a). These overpayments to private plans were partially attributed to the bidding and benchmark process, established in the Medicare Modernization Act of 2003 to stabilize declining plan participation and benefit generosity of private plans in Medicare (Berenson and Dowd 2009; Patel and Guterman 2017; Zarabozo and Harrison 2009).

The Affordable Care Act (ACA), enacted in 2010, introduced several changes to the MA payment rate calculation to better align Medicare spending on private plan enrollees with average spending per traditional enrollee. Under the ACA, the Centers for Medicare & Medicaid Services (CMS) sets county-level benchmarks at four levels based on estimated per capita spending in traditional Medicare, where the quartile of counties with the highest per capita traditional Medicare spending is assigned a benchmark of 95 percent of traditional Medicare cost, and the lowest-spending quartile is assigned a benchmark of 115 percent of traditional Medicare costs (Biles et al. 2012). The ACA also lowered the rebate amounts from 75 percent to 50–70 percent of the difference between the benchmark and a plan's bid, depending on the plan's quality ratings, and allowed plans with four-star quality ratings and above to receive both higher benchmarks and rebate percentages (Hayes 2015). Changes introduced under the ACA succeeded in lowering the payments MA plans from an average of 114 percent of traditional Medicare spending per beneficiary in 2009 to an average of 101 percent in 2018 (MedPAC 2009b, 2017).

The CMS Office of the Actuary and the Congressional Budget Office expected ACA payment changes to reduce enrollment in MA plans by making private plans less attractive to both insurers, through reduced payments, and beneficiaries, through expected cuts to supplemental benefits and increased cost sharing (Foster 2010; Nicholas 2014).[3] Despite those expectations, MA plan enrollment has nearly doubled since ACA implementation, increasing from 10.5 million in 2009 to 18.5 million in 2017 (MedPAC 2018a). Today, one-third of Medicare beneficiaries are enrolled in private plans, a share that the Congressional Budget Office estimates will increase to 42 percent by 2028.[4]

Research shows that MA programs' significant growth in recent years has likely been aided by several factors that also helped plans withstand payment cuts (Guterman, Skopec, and Zuckerman 2018; L&M Policy Research 2016; MedPAC 2009b, 2017, 2018b; Skopec, Zuckerman, and Aarons, forthcoming; Song and Pelech 2018). First, quality bonus payments to MA plans may have alleviated the impact of payment rate cuts. For example, the ACA established bonus payments only for plans that achieve a four-star or higher quality rating, but between 2012 and 2014, CMS conducted a three-year demonstration project that extended bonuses to plans with three- or three-and-a-half-star ratings. An independent evaluation did not find evidence that the demonstration improved MA performance on clinical measures relative to other health insurance sectors (L&M Policy Research 2016). Plan consolidation has also allowed some plans to obtain larger quality bonuses than they would have otherwise received (MedPAC 2018b).

Second, the ACA phased in payment cuts over several years, giving plans time to adjust by controlling costs. On average, MA plans reduced their bids from 102 percent of traditional Medicare

spending per beneficiary in 2009 to 90 percent in 2018 (Guterman, Skopec, and Zuckerman 2018; MedPAC 2009b, 2017). Contrary to initial fears, MA plans lowered their bids without reducing supplemental benefits or increasing premiums and cost sharing, resulting in relatively stable enrollee access and affordability since ACA implementation (Skopec, Zuckerman, and Aarons, forthcoming; Song and Pelech 2018).

Third, rebate reductions under the ACA have been modest; nationally, rebates declined from an average of 12 percent of traditional Medicare spending per beneficiary in 2009 to 10 percent in 2017 (MedPAC 2009b, 2017). Average rebate amounts per beneficiary have grown since ACA implementation, from $83 per beneficiary per month in 2011 to $95 in 2018 (MedPAC 2017, 2018b).

Finally, MA plans' payments are risk adjusted to account for variation in enrollee risk across MA plans and between MA plans and traditional Medicare. Over time, risk scores for MA plans have increased because MA plans more completely code relevant patient diagnoses than traditional Medicare (Kronick 2017). This results in increased risk adjustment payments to MA plans, which could have offset payment cuts, helping preserve revenue (Guterman, Skopec, and Zuckerman 2018; Kronick 2017). While the ACA included an adjustment to risk scores to partially correct for this problem, that adjustment is insufficient to fully recapture excess risk adjustment payments to MA plans (MedPAC 2018b).

These findings alone do not fully explain MA's rapid growth, however. Stable rebates and premiums would be expected to yield stable MA enrollment or modest growth, not rapidly double the size of the program. This report disaggregates MA enrollment growth by plan type and geography to better understand variation in the growth of Medicare private plans and explores county-level market and demographic changes associated with increased MA penetration.

Data and Methods

Our data cover 2009 and 2017 and were collected from publicly available sources provided by CMS and compiled at the state and county levels. CMS files include county-level information on MA penetration and benchmarks, plan- and county-level information on enrollment, contract-level data on star ratings, and both MA and prescription drug plan premiums.[5] Though aggregate enrollment data are available for 2018, the other data needed for this study were only available through 2017 when we conducted the analysis. We supplemented the state- and county-level Medicare information for 2009 and 2017 with

data from the American Community Survey one-year estimates for the corresponding years, which provide the demographic characteristics for counties with populations of at least 65,000.[6]

We used these data for descriptive and multivariate analyses. For the descriptive analyses, we calculated changes in MA penetration and enrollment by plan type across states and regions between 2009 and 2017. Our analysis excluded Programs of All-Inclusive Care for the Elderly and demonstration plans, including dual-eligible demonstrations. Our analysis included plans reimbursed on the basis of their costs that do not take financial risk. Though these plans are not technically part of the MA program, CMS includes them in estimates of the share of the elderly enrolled in private plans, and they are an important component of the Medicare program in some states.[7] Table 1 shows the plan types included in our analyses.

TABLE 1
Medicare Advantage Plan Types

Plan type	Description
Health maintenance organization (HMO)	These plans generally have a network of providers and require enrollees to choose a primary care doctor. Referrals from that primary care doctor are generally required to see specialists. Includes local and regional HMO plans but excludes all employer and special needs plans.
Preferred provider organization (PPO)	These plans generally have a network of providers but do not require enrollees to choose a primary care doctor, and often do not require a referral from a primary care doctor to see specialists. Includes local and regional MA PPO plans but excludes all employer and special needs plans.
Private fee-for-service (PFFS) plans	These plans generally have open networks and no specialist referral requirements. Their availability significantly decreased between 2009 and 2017. Excludes all employer PFFS plans.
Cost plans	These are not MA plans but are administered by private health insurers and included in CMS's estimates of Medicare private plan enrollment. Unlike MA plans, which require both Parts A and B enrollment, cost plans are available to beneficiaries who are only enrolled in Part A, such as those who maintain employer coverage. Cost plans are also available for enrollment or disenrollment all year. Beneficiaries can also receive out-of-network care with Parts A and B standard coverage.
Special needs plans (SNP)	These plans are available only to Medicare beneficiaries who are dually eligible for Medicare and Medicaid (D-SNP), who have certain chronic conditions like diabetes (C-SNP), or who are institutionalized (I-SNP). They can be HMO or PPO plan types.
Employer group health plans (EGHP)	These plans are sponsored by employers or unions and made available to retirees. They can be HMO, PPO, or PFFS plan types.

Notes: CMS = Centers for Medicare & Medicaid Services. MA = Medicare Advantage.

To explain the variation in MA penetration growth across counties between 2009 and 2017, we estimated multivariate first differences models as a function of county-level MA market and demographic changes over the period. The dependent variable for each model was the change in MA penetration. In these models, we only included HMO, PPO, PFFS, cost, and special needs plans when

calculating MA penetration changes. We excluded changes in employer group health plan penetration because employers, rather than beneficiaries, make decisions about retiree coverage. However, we included cost plans because they greatly affect overall private Medicare plan selection in some states.

We used two samples for the multivariate models:

- Sample 1, used in Model 1, includes changes in market characteristics for 2,833 counties.
- Sample 2, used for Model 2, includes changes in demographic data and market characteristics and is limited to 790 counties with populations of 65,000 or greater because of the restrictions of the American Community Survey one-year estimates.

Both models include the following market characteristics for each county: (1) changes in access to a $0 premium plan, (2) changes in access to a four- or four-and-a-half-star plan, (3) changes in access to a five-star plan, (4) changes in monthly Part D premiums, and (5) changes in monthly MA benchmarks. The second model also includes the following demographic characteristics for each county: (1) changes in the share of the population that is elderly (ages 65 and older), (2) changes in the share of the elderly population ages 65 to 69, (3) changes in the share of the elderly population with income below the census poverty line, and (4) changes in the share of the elderly population reporting a disability.

Findings

Descriptive Analyses of Medicare Advantage Enrollment Growth

Between 2009 and 2017, MA enrollment in HMO, PPO, PFFS, SNP, employer, and cost plans grew from 10.2 million to 18.5 million beneficiaries. As shown in table 2, nearly all plan types grew between 2009 and 2017, and, except for PFFS and PPO plans, the share of MA enrollees in each plan type remained relatively stable. A substantial share of the growth in PPO plan enrollment seems related to beneficiaries switching from PFFS to PPO plans, because many PFFS plans were discontinued over this period because of a policy change requiring MA plans to form networks (Pelech 2017). In both 2009 and 2017, HMOs were the dominant plan type in MA, covering nearly half of beneficiaries, but PPOs, employer plans, and SNPs also grew significantly over this period.[8]

Between 2009 and 2017, HMO plan growth accounted for half of the growth in MA, and PPO plans accounted for 29.1 percent of all MA growth (figure 1). However, employer plan growth accounted for 21.7 percent of MA growth over this period, meaning MA growth was not driven exclusively by beneficiary and insurer choices but also by employer choices. Similarly, 11.9 percent of

MA enrollment growth was attributable to SNP plans, which cover beneficiaries dually eligible for Medicare and Medicaid, those with chronic conditions, and those living in institutions (Better Medicare Alliance 2017). This increase in SNP enrollment may reflect, in part, that managed care is increasing among elderly Medicaid beneficiaries (CBO 2018), perhaps making managed care offered through SNPs more familiar to this population. In addition, the share of Medicare beneficiaries also eligible for Medicaid has increased (MedPAC and MACPAC 2018), increasing the potential market size for SNPs.

TABLE 2

Changes in Medicare Advantage Enrollment by Plan Type, 2009–17

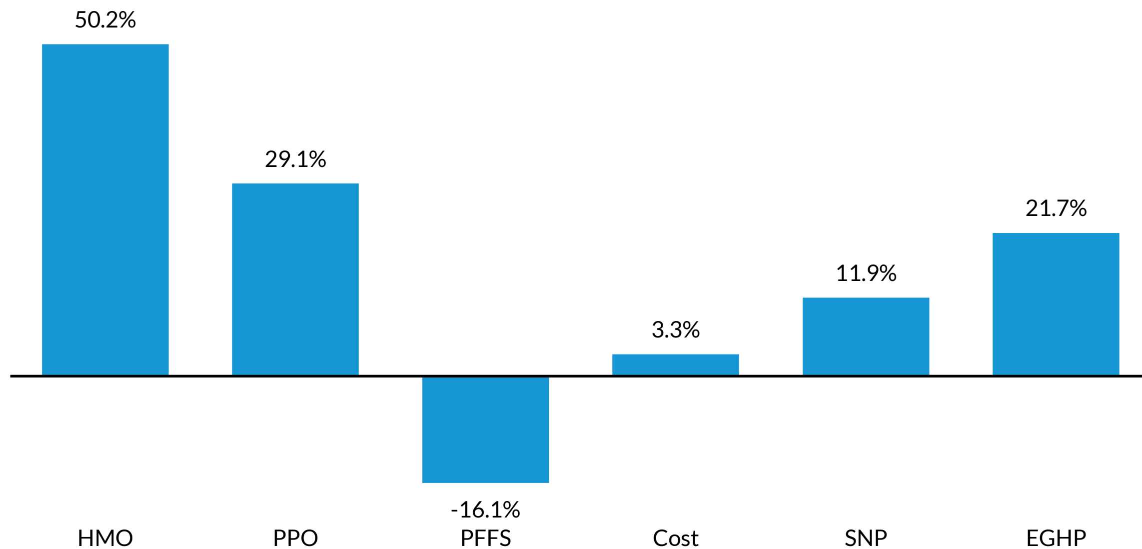
	2009		2017	
Plan type	**Millions enrolled**	**Share of MA enrollees**	**Millions enrolled**	**Share of MA enrollees**
HMO	4.5	44.2	8.7	46.9
PPO	1.0	9.4	3.4	18.2
PFFS	1.5	14.9	0.2	1.0
Cost	0.3	2.8	0.6	3.0
SNP	1.0	10.2	2.0	10.9
EGHP	1.9	18.5	3.7	19.9
Total	**10.2**	**100.0**	**18.5**	**100.0**

Source: 2009 and 2017 Centers for Medicare & Medicaid Services enrollment files.

Notes: HMO = health maintenance organization. PPO = preferred provider organization. PFFS = private fee-for-service. SNP = special needs plan. EGHP = employer group health plans.

FIGURE 1

Share of 2009–17 Medicare Advantage Enrollment Growth Attributable to Each Plan Type

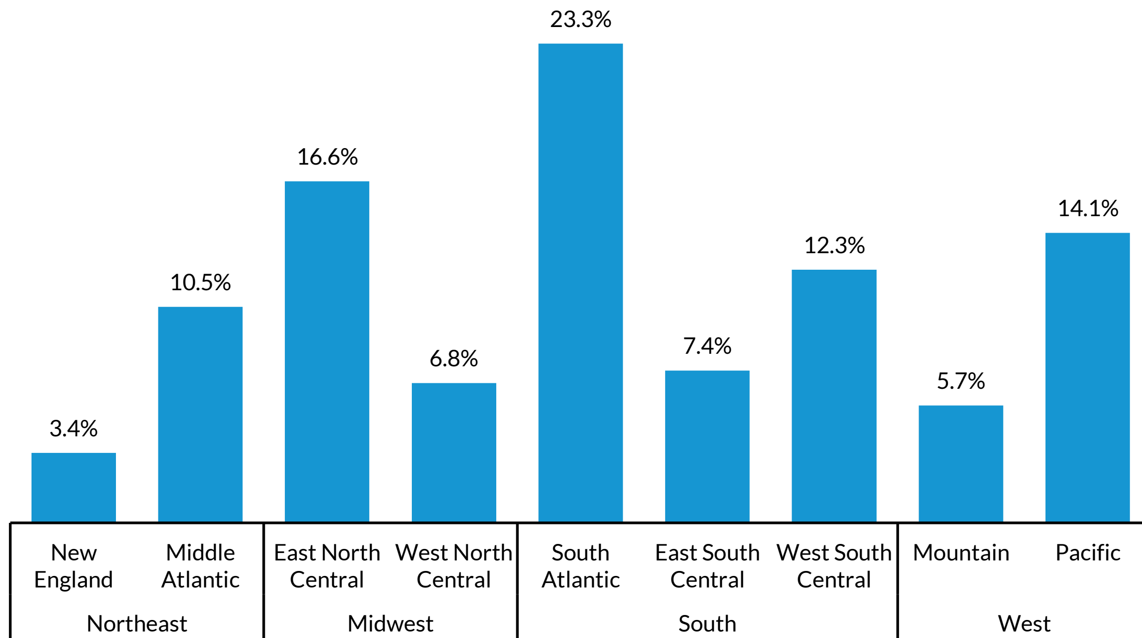


Source: 2009 and 2017 Centers for Medicare & Medicaid Services enrollment files.
Notes: HMO = health maintenance organization. PPO = preferred provider organization. PFFS = private fee-for-service. SNP = special needs program. EGHP = employer group health plan.

MA enrollment grew unevenly across regions (figure 2 and table 3).[9] The South Atlantic region accounted for 23.3 percent of all MA growth between 2009 and 2017, and penetration in that region grew 12.3 percentage points, faster than the national average of 10.2 percentage points (table 3). Penetration grew fastest in the East South Central region, at 13.8 percentage points, but it accounted for only 7.4 percent of MA enrollment growth because of its smaller size. MA was least popular in New England, which accounted for only 3.4 percent of MA growth and had the lowest 2017 penetration rate at 22.7 percent.

FIGURE 2

Share of 2009–17 Medicare Advantage Enrollment Growth Attributable to Each Region



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Source: 2009 and 2017 Centers for Medicare & Medicaid Services enrollment files.

Note: Table A.1 lists the states in each region.

TABLE 3

Changes in Medicare Advantage Penetration between 2009 and 2017 by Census Region

Region	2009 (%)	2017 (%)	Percentage-point growth
New England	16.3	22.7	6.4
Middle Atlantic	28.7	36.5	7.8
East North Central	19.7	30.8	11.0
West North Central	19.0	30.9	11.9
South Atlantic	18.8	31.1	12.3
East South Central	17.1	30.9	13.8
West South Central	17.6	30.2	12.6
Mountain	30.0	34.3	4.3
Pacific	33.2	38.5	5.3
Total	**23.3**	**33.5**	**10.2**

Source: 2009 and 2017 Centers for Medicare & Medicaid Services Medicare Advantage penetration files.
Note: Table A.1 lists the states in each region.

In addition to variation in overall MA growth, we also found regional variation in growth by plan types (table 4). PPO plans, employer plans, and SNPs fueled growth in the South Atlantic, but HMO plans in the region grew slower than average. East South Central had the highest growth in PPO plans nationally, from 2.8 percent of Medicare beneficiaries in 2009 to 9.2 percent in 2017. In contrast, in the East North Central region, employer plans grew substantially, from enrolling 5.4 percent of Medicare beneficiaries in 2009 to 9.7 percent in 2017. This region generally includes the “rust belt” states, and growth in employer plans may partially reflect large employers’ attempts to reduce the costs of their retirement packages.[10] For example, table A.2 shows that 16.6 percent of all Medicare beneficiaries in Michigan had an employer plan in 2017, compared with a national average of 6.5 percent.

The West North Central region, in which MA penetration grew 11.9 percentage points between 2009 and 2017, is unique. Most of the growth in this region occurred in cost plans, which grew from 2.6 percent of Medicare beneficiaries in 2009 to 10.5 percent in 2017 (table 4). Cost plans are not technically part of the MA program, making this region sometimes appear to have low MA penetration if these plans are excluded from analyses, despite high overall private plan penetration. Cost plan growth is prominent in Minnesota and South Dakota, which had 36.6 percent and 15.4 percent of their Medicare populations enrolled in a cost plan in 2017, respectively, far greater than the national average of 1.0 percent (table A.2).

TABLE 4

Medicare Advantage Penetration for Selected Plan Types by Region, 2009 and 2017

	Overall			HMO		PPO		Cost		SNP		EGHP	
Region	**2009 (%)**	**2017 (%)**	**Percentage - point change**	**2009 (%)**	**2017 (%)**	**2009 (%)**	**2017 (%)**	**2009 (%)**	**2017 (%)**	**2009 (%)**	**2017 (%)**	**2009 (%)**	**2017 (%)**
New England	16.3	22.7	6.4	9.6	13.9	0.4	2.8	0.0	0.0	1.6	2.6	3.1	3.1
Middle Atlantic	28.7	36.5	7.8	14.3	15.6	2.7	6.6	0.3	0.0	3.2	5.2	6.8	8.6
East North Central	19.7	30.8	11.0	5.4	11.8	2.1	7.3	0.7	0.6	0.6	1.0	5.4	9.7
West North Central	19.0	30.9	11.9	5.2	9.9	2.1	4.7	2.6	10.5	1.7	1.8	2.4	3.6
South Atlantic	18.8	31.1	12.3	8.1	12.4	2.0	8.0	0.4	0.4	2.2	4.8	1.9	5.2
East South Central	17.1	30.9	13.8	6.2	10.9	2.8	9.2	0.2	0.0	2.5	4.4	2.0	6.3
West South Central	17.6	30.2	12.6	9.1	14.8	1.4	5.4	0.6	0.5	2.2	4.1	1.6	4.7
Mountain	30.0	34.3	4.3	15.3	21.9	2.8	4.1	0.9	0.5	3.0	3.9	3.9	3.7
Pacific	33.2	38.5	5.3	16.5	24.7	2.4	2.4	0.6	0.0	3.7	3.2	7.9	8.1
US average	**23.3**	**33.5**	**10.2**	**10.1**	**15.3**	**2.1**	**5.9**	**0.6**	**1.0**	**2.3**	**3.6**	**4.2**	**6.5**

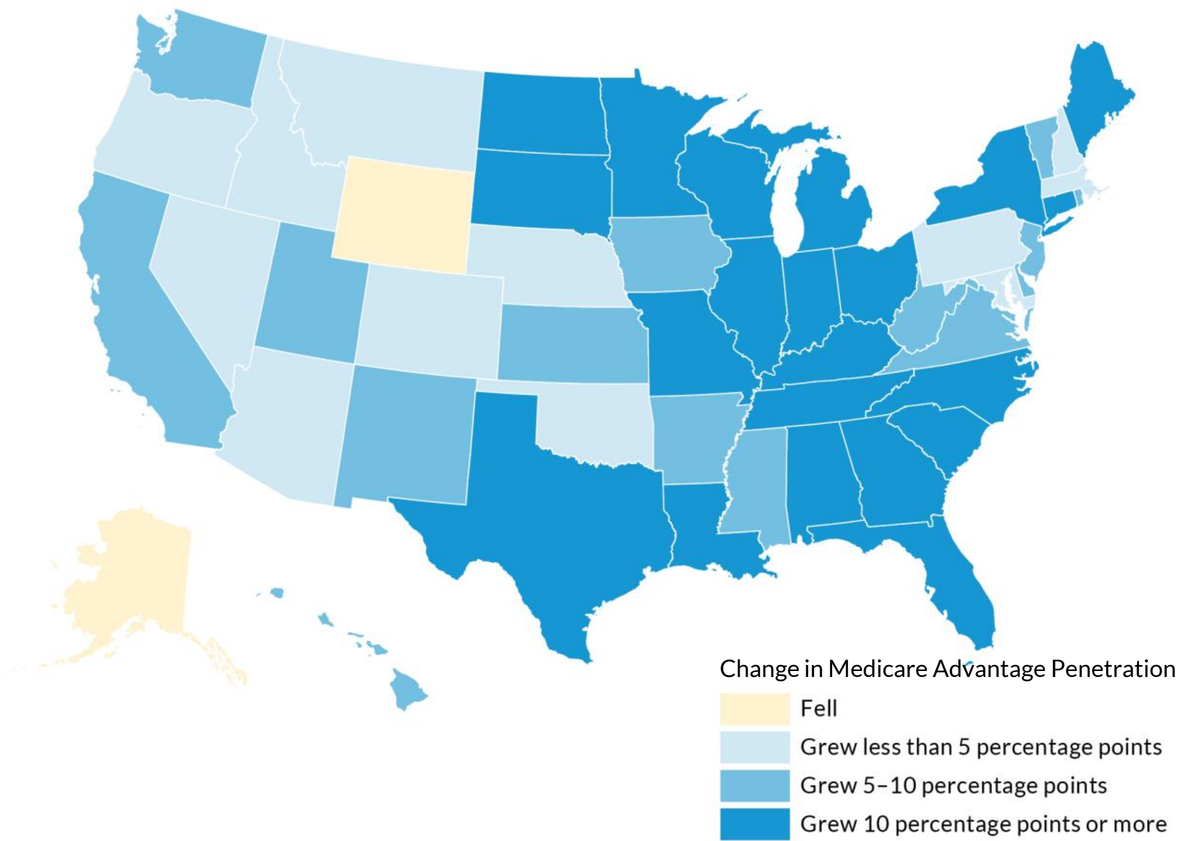
Source: 2009 and 2017 Centers for Medicare & Medicaid Services enrollment files.

Notes: HMO = health maintenance organization. PPO = preferred provider organization. SNP = special needs plan. EGHP = employer group health plan.

Between 2009 and 2017, MA penetration growth varied widely across states (figure 3). MA penetration grew by 10 percentage points or more in 21 states, many of which were in the Midwest and South. Penetration grew only modestly, by less than 5 percentage points, in 13 states, largely concentrated in the West. Finally, penetration fell in only two states, Alaska and Wyoming, between 2009 and 2017.

FIGURE 3

Change in Medicare Advantage Penetration by State, 2009–17



Source: 2009 and 2017 Centers for Medicare & Medicaid Services Medicare Advantage penetration files.
Note: For point estimates, see table A.2.

Plans selected by MA enrollees also varied across states (table A.2). For example, as noted above, Minnesota had the highest MA penetration in 2017 (57.0 percent), driven by enrollment in cost plans, which accounted for 36.6 percent of all Medicare beneficiaries in Minnesota, far above the national average of 1.0 percent. Hawaii had the second-highest MA penetration in 2017 (45.5 percent) and the highest share of Medicare beneficiaries enrolled in a PPO (17.4 percent, compared with a national average of 5.9 percent). Rhode Island also had high MA penetration in 2017 (42.5 percent), and the

highest share of Medicare beneficiaries enrolled in an HMO (31.7 percent, compared with a national average of 15.3 percent). Arizona had above average MA penetration (38.5 percent) and the highest share of Medicare beneficiaries enrolled in SNP nationally in 2017 (8.2 percent, compared with a national average of 3.6 percent). Finally, Michigan had above average MA penetration (36.4 percent) and the highest share of Medicare beneficiaries enrolled in employer plans in the country (16.6 percent compared with a national average of 6.5 percent), perhaps reflecting the high prevalence of union retirees in the state.

What Explains Differences in MA Enrollment Growth across Counties?

Turning to the county-level analysis, as shown in tables 5 and 6, Model 1 explored how changes in MA market characteristics affected MA penetration for 2,833 counties. Access to a $0 premium plan was significantly associated of MA penetration growth, explaining 22.6 percent of the average MA penetration change (derived from tables 5 and 6).[11] Counties that always had access to a $0 premium plan saw MA penetration increases 3.04 percentage points larger than those counties that never had access to a $0 premium plan, and counties gaining access to a $0 premium plan saw MA penetration increases 1.49 percentage points larger than those counties that never had access to a $0 premium plan (table 6). Star ratings were also significantly associated with MA penetration growth, explaining 18.4 percent of the average MA penetration change (derived from tables 5 and 6).[12] Counties gaining a five-star plan had MA penetration growth 7.31 percentage points larger than those counties that never had a five-star plan.[13] Gaining or maintaining access to a four- or four-and-a-half-star plan was also associated with an increase in MA penetration relative to never having access to a four- or four-and-a-half-star plan (1.8 and 2.7 percentage points, respectively). Counterintuitively, increases in Part D premiums and monthly benchmarks were associated with slightly lower MA penetration growth (a -0.2 percentage-point per dollar increase in monthly Part D premiums and -0.01 percentage-point per dollar increase in monthly benchmarks). This may suggest that counties where MA is more popular largely saw benchmark decreases, and that popular MA markets may also have more Part D competition and therefore lower Part D premium growth.

Model 2 incorporated demographic characteristics and included 790 large counties. The counties in this model had a 7.45 percentage point increase in MA penetration over the 2009 to 2017 period on average (table 5). Among demographic characteristics, only the change in the share of the elderly below poverty was significantly associated with MA penetration and had a negative coefficient (-.15 percentage points), suggesting that poverty rate growth was associated with lower MA penetration growth. Though poverty fell an average of 0.2 percentage points between 2009 and 2017 in the 790

counties included in Model 2 (table 5), poverty rates grew in 380 of the 790 counties included in our sample, and these counties tended to have slower MA penetration growth (data not shown).

Model 2, based on fewer counties, showed similar results for MA market characteristics compared to Model 1, though the magnitude of coefficients varied for some measures. For example, gaining access to a four- or four-and-a half star plan was associated with a 2.3 percentage-point increase in penetration in Model 2 relative to never having access to a four- or four-and-a-half-star plan, compared with 1.8 percentage points in Model 1. The largest coefficient change was for gaining access to a five-star plan, which was associated with a 1.7 percentage-point increase in penetration in Model 2 relative to never having a five-star plan, but a 7.3 percentage-point increase in penetration in Model 1. These differences in coefficients across our models may reflect that the 790 counties included in Model 2 were more likely to gain or maintain access to four- or four-and-a-half-star plans than the 2,833 counties included in Model 1 (86 percent of counties in Model 2, compared to 64 percent in Model 1) (Table 5), making the introduction of five-star plans less important.

Finally, in both models, the constant was large and significant, so much of the change in MA penetration was unexplained by the variables included in the models. For example, in Model 1, the constant was 4.63, meaning 4.63 percentage points of the average 7.18 percentage point change in MA penetration was unexplained by the model (64.5 percent). Similarly, in Model 2, the constant was 4.75, meaning 4.75 percentage points of the 7.45 percentage point average change in MA penetration in those 790 counties was not explained by the model (63.8 percent).

TABLE 5

Average Changes in MA Market Characteristics and Demographic Characteristics across Counties, 2009 to 2017

For HMO, PPO, PFFS, SNP, and cost plans only

	Model 1: Market characteristics only	Model 2: Market and demographic characteristics
Average percentage point change in MA penetration	**7.18**	**7.45**
Market characteristics		
Share of counties gaining a $0 premium plan	0.04	0.04
Share of counties losing a $0 premium plan	0.40	0.23
Share of counties that always had a $0 premium plan	0.51	0.71
Share of counties that never had a $0 premium plan (reference group for regression analyses)	0.05	0.02
Share of counties gaining a four- or four-and-a-half-star plan	0.46	0.56
Share of counties losing a four- or four-and-a-half-star plan	0.02	0.02
Share of counties that always had a four- or four-and-a-half-star plan	0.18	0.30
Share of counties that never had a four- or four-and-a-half-star plan (reference group for regression analyses)	0.34	0.12
Share of counties gaining a five-star plan	0.06	0.08
Share of counties that never had a five-star plan (reference group for regression analyses	0.94	0.92
Change in monthly Part D premium	$3.21	$5.16
Change in monthly benchmark without bonuses	$26.76	-$4.65
Demographic characteristics		
Percentage-point change in share of:		
Population that is elderly (ages 65 and over)		3.00
Elderly population ages 65–69		3.13
Elderly population below poverty		-0.19
Elderly population with a disability		-2.48

Sources: Market characteristics derived from Centers for Medicare & Medicaid Services enrollment and penetration files, Medicare Advantage and prescription drug plan landscape files, and rate calculation files for 2009 and 2017. Demographic characteristics are from the American Community Survey one-year files for 2009 and 2017 and are only available for counties with populations larger than 65,000.

Notes: HMO = health maintenance organization. PPO = preferred provider organization. PFFS = private fee-for-service. SNP = special needs plan.

TABLE 6

First Differences Regression Model Results for Percentage-Point Change in Medicare Advantage Penetration

For HMO, PPO, PFFS, SNP, and cost plans only

	Model 1: Market characteristics only	Model 2: Market and demographic characteristics
Market characteristics		
Gained a $0 premium plan	1.49*	-2.15
Lost a $0 premium plan	0.12	-0.52
Always had a $0 premium plan	3.04***	3.09**
Gained a four- or four-and-a-half-star plan	1.82***	2.30***
Lost a four- or four-and-a-half-star plan	-2.16**	-0.75
Always had a four- or four-and-a-half-star plan	2.67***	2.06***
Gained a five-star plan	7.31***	1.71**
Change in monthly Part D premium	-0.20***	-0.20***
Change in monthly benchmark without bonuses	-0.01***	0.00
Demographic characteristics		
Percentage-point change in share of:		
Population that is elderly (ages 65 and over)		-0.04
Elderly population ages 65–69		-0.07
Elderly population below poverty		-0.15**
Elderly population with a disability		0.00
Constant	**4.63*** **	**4.75*** **
Sample size	**2,833**	**790**
R^2	**0.180**	**0.159**

Sources: Market characteristics derived from Centers for Medicare & Medicaid Services enrollment and penetration files, Medicare Advantage and prescription drug plan landscape files, and rate calculation files for 2009 and 2017. Demographic characteristics are from the American Community Survey one-year files for 2009 and 2017 and are only available for counties with populations larger than 65,000.

Notes: HMO = health maintenance organization. PPO = preferred provider organization. PFFS = private fee-for-service. SNP = special needs plan. The dependent variable is the percentage-point change in Medicare Advantage penetration.

Discussion

ACA cuts to MA payments, including reduced rebates, were expected to make MA less attractive to beneficiaries and reduce MA enrollment. However, MA enrollment grew substantially during ACA implementation. Research suggests that this was, in part, because MA plans could lower their bids to preserve rebates (Guterman, Skopec, and Zuckerman 2018). In addition, the ACA included a six-year phase-in period for the counties with the largest payment cuts, so reductions in benchmarks were gradual (Sinaiko and Zeckhauser 2015). Finally, CMS policies like the quality bonus demonstration also softened payment cuts. Taken together, these factors help explain why rebates only fell from 12 percent of traditional Medicare spending to 10 percent between 2009 and 2017. Also, increasing risk

adjustment payments through more complete diagnosis coding in MA plans may have offset payment cuts, helping preserve revenue (Guterman, Skopec, and Zuckerman 2018).

Though these explanations partly explain MA growth, they suggest stable or modest growth in MA enrollment, not the doubling in MA enrollment that occurred. Our descriptive analyses showed that MA growth was not evenly distributed across regions or by plan types, suggesting no single, national explanation for MA enrollment growth. For example, evidence suggests that sponsoring an MA plan for retirees saves employers money relative to other retiree health coverage options.[14] Employer plans were associated with one-fifth of MA growth between 2009 and 2017, suggesting that employer choice, not just beneficiary choice, is an important factor in MA growth.

Our multivariate analyses found that county-level MA penetration growth was related to access to $0 premium and four- or five-star plans, implying that beneficiaries choose MA more frequently where MA plans are more generous or higher quality. MA plans with a four-star rating or higher have higher benchmarks to bid against and a higher rebate percentage to pass on to beneficiaries through extra benefits, and five-star plans can offer year-round open enrollment. Research shows that $0 premiums and extra benefits feature prominently in MA plan advertising (Cai et al. 2008), suggesting that plans see generosity as a major selling point. Though not a causal analysis, our findings imply that MA is particularly popular where it offers a benefit package that compares favorably with the premiums and benefits of traditional Medicare with supplemental coverage. We found no relationship between MA penetration growth and the age distribution of beneficiaries, making it unlikely that growth is driven primarily by the influx of younger beneficiaries, who may be more comfortable with managed care, as suggested in prior studies (Sinaiko and Zuckhauser 2015).

Our multivariate models only explained about a third of the increase in MA penetration, however, suggesting other factors may contribute to MA's increasing popularity but are difficult to quantify. As MA grows, more beneficiaries have friends or family enrolled in MA, and most MA enrollees report positive experiences with the program, suggesting that word of mouth may drive some enrollment.[15] Similarly, some health systems now sponsor MA plans and may encourage seniors who use those providers to enroll (Jacobson et al. 2014). The MA benefit structure also includes an out-of-pocket maximum and nearly always includes integrated Part D coverage, making the benefit package simpler to manage than a combination of traditional Medicare, Part D, and supplemental coverage. Also, though many MediGap plans provide more generous cost-sharing protection than MA plans,[16] the coverage is generally far more expensive to purchase than an MA plan.[17]

Finally, the MA market is profitable for insurers,[18] and insurers advertise directly to seniors to attract enrollees. MA plans also work with insurance brokers to sell both MA and MediGap plans. Qualitative research has shown that brokers are an important source of information for seniors when choosing a plan (Jacobson et al. 2014), but it is currently unclear whether brokers have financial or other incentives to recommend MA enrollment over traditional Medicare with supplemental coverage.

Appendix

TABLE A.1

States in Each Census Region

Region	States
New England	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic	New Jersey, New York, Pennsylvania
East North Central	Illinois, Indiana, Michigan, Ohio, Wisconsin
West North Central	Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
South Atlantic	Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East South Central	Alabama, Kentucky, Mississippi, Tennessee
West South Central	Arkansas, Louisiana, Oklahoma, Texas
Mountain	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific	Alaska, California, Hawaii, Oregon, Washington

TABLE A.2

Medicare Advantage Penetration for Selected Plan Types by State, 2009 and 2017

State	Overall 2009 (%)	Overall 2017 (%)	Overall Percentage-point change	HMO 2009 (%)	HMO 2017 (%)	PPO 2009 (%)	PPO 2017 (%)	Cost 2009 (%)	Cost 2017 (%)	SNP 2009 (%)	SNP 2017 (%)	EGHP 2009 (%)	EGHP 2017 (%)
Alabama	21.3	36.3	15.0	7.8	10.9	5.4	9.2	0.1	0.0	3.2	5.1	2.2	10.4
Alaska	1.1	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	1.1
Arizona	36.9	38.5	1.7	20.8	24.7	2.1	1.4	0.0	0.0	7.1	8.2	4.6	4.1
Arkansas	13.5	21.9	8.4	1.7	7.8	1.1	4.7	0.1	0.0	1.5	4.6	0.5	1.3
California	34.8	41.8	7.0	19.0	27.2	0.8	0.1	0.2	0.0	4.5	3.1	8.9	9.2
Colorado	33.4	37.3	3.8	15.7	24.6	0.5	1.6	3.7	2.2	2.1	1.6	6.8	6.0
Connecticut	16.2	28.0	11.8	11.4	20.4	0.2	1.1	0.0	0.0	1.7	3.8	2.6	2.5
Delaware	4.7	11.1	6.4	0.5	4.4	0.4	1.3	0.0	0.0	1.0	1.2	1.0	4.2
District of Columbia	10.6	15.4	4.8	1.0	1.2	0.1	0.4	2.6	3.6	2.2	6.1	3.8	4.0
Florida	28.7	42.5	13.8	19.1	21.7	3.4	9.4	0.1	0.0	3.5	7.9	1.6	3.4
Georgia	14.8	34.9	20.1	1.7	8.1	1.9	10.2	0.0	0.0	2.3	6.6	1.6	9.1
Hawaii	38.4	45.5	7.2	5.0	8.7	4.1	17.4	16.6	0.0	1.3	8.2	9.6	10.9
Idaho	27.3	31.7	4.4	9.0	17.6	3.4	11.7	0.6	0.0	0.8	0.7	1.5	1.1
Illinois	9.9	24.1	14.3	3.6	8.4	1.6	2.8	0.4	0.1	0.6	0.7	1.2	9.1
Indiana	14.7	26.6	11.8	0.5	6.8	3.7	13.0	0.8	0.0	0.2	0.5	1.8	5.5
Iowa	12.6	18.0	5.4	1.7	5.6	1.2	6.7	1.4	1.6	0.4	0.0	1.1	3.5
Kansas	10.4	15.7	5.3	2.3	5.6	2.7	6.2	0.5	0.0	0.4	0.2	0.7	2.1
Kentucky	15.0	28.7	13.7	1.3	5.2	3.8	10.1	0.7	0.0	1.3	1.1	3.8	11.1
Louisiana	22.3	33.2	10.9	15.7	22.1	0.4	3.0	0.0	0.0	0.7	4.7	1.5	2.9
Maine	9.6	27.8	18.2	2.0	15.4	0.5	5.1	0.0	0.0	0.7	1.2	3.6	4.7
Maryland	7.5	11.1	3.6	1.6	1.9	0.4	0.9	1.3	2.9	1.4	1.4	1.8	3.9
Massachusetts	19.1	22.5	3.4	10.4	10.4	0.6	3.7	0.0	0.0	1.9	3.4	3.6	3.3
Michigan	24.3	36.4	12.0	3.2	8.7	0.7	7.7	0.0	0.0	0.2	0.7	11.4	16.6
Minnesota	36.6	57.0	20.4	7.0	8.0	2.0	3.1	9.1	36.6	4.9	4.1	4.6	4.7
Mississippi	9.2	16.7	7.4	1.3	5.7	0.9	6.6	0.0	0.0	1.1	2.8	0.2	0.8
Missouri	19.8	31.8	12.0	8.8	18.5	3.0	5.7	0.1	0.0	1.3	2.3	3.0	4.6
Montana	16.8	20.6	3.8	0.0	1.6	1.7	16.9	0.0	0.0	0.0	0.1	0.4	0.8
Nebraska	11.6	13.1	1.5	3.2	7.6	0.7	1.5	0.7	0.0	0.2	0.0	1.5	1.9
Nevada	30.8	35.4	4.6	25.1	27.7	1.6	3.0	0.1	0.0	0.1	2.2	2.1	2.2
New Hampshire	6.0	10.3	4.3	0.0	5.4	0.0	0.9	0.0	0.0	0.0	0.1	1.5	2.8
New Jersey	11.9	21.3	9.4	7.8	8.5	0.6	3.4	0.0	0.0	0.4	1.6	2.8	7.7
New Mexico	24.3	33.6	9.3	13.8	15.9	2.7	6.5	0.1	0.0	0.7	4.6	3.0	5.7
New York	28.7	38.7	10.0	14.5	16.3	2.4	6.8	0.3	0.0	3.5	7.2	6.1	7.2

State	Overall			HMO		PPO		Cost		SNP		EGHP	
	2009 (%)	2017 (%)	Percentage-point change	2009 (%)	2017 (%)	2009 (%)	2017 (%)	2009 (%)	2017 (%)	2009 (%)	2017 (%)	2009 (%)	2017 (%)
North Carolina	17.3	32.0	14.7	4.3	12.0	0.9	9.8	0.0	0.0	2.1	1.3	1.6	8.2
North Dakota	7.7	18.2	10.5	0.0	0.0	0.0	1.2	1.0	15.7	0.0	0.0	0.2	0.3
Ohio	26.8	39.0	12.2	11.0	17.9	2.4	7.0	0.9	0.0	0.8	1.0	8.0	9.1
Oklahoma	14.4	18.1	3.7	8.2	10.6	1.4	4.4	0.0	0.0	0.2	0.0	6.7	2.1
Oregon	41.7	44.8	3.1	13.3	21.1	13.3	13.2	0.1	0.0	3.2	3.4	7.0	6.7
Pennsylvania	38.2	41.1	2.9	17.8	18.8	4.4	8.1	0.3	0.0	4.5	4.8	10.1	11.0
Rhode Island	36.3	42.5	6.2	27.1	31.7	0.4	0.7	0.0	0.0	3.8	1.2	3.7	3.1
South Carolina	14.7	25.6	10.9	0.8	6.0	1.5	8.9	0.0	0.0	2.3	6.9	0.6	2.2
South Dakota	7.2	21.1	13.9	0.0	0.1	0.7	4.0	0.0	15.4	0.0	0.0	0.2	0.5
Tennessee	22.1	36.7	14.6	10.9	17.2	0.9	9.8	0.1	0.0	3.5	6.9	1.3	2.3
Texas	18.2	34.9	16.7	9.1	15.1	1.7	6.3	0.9	0.7	3.1	4.7	0.7	6.1
Utah	30.6	35.6	5.0	5.2	26.5	13.1	5.1	0.6	0.0	1.9	2.2	4.0	1.4
Vermont	3.7	8.9	5.2	0.0	1.5	0.2	4.4	0.0	0.0	0.0	0.0	0.8	1.4
Virginia	13.7	19.6	5.9	0.7	6.6	1.0	4.4	0.9	1.0	0.1	0.4	1.2	3.0
Washington	23.8	30.6	6.9	9.9	20.7	2.8	3.3	0.0	0.0	0.8	2.5	4.0	3.9
West Virginia	23.1	29.6	6.6	1.2	2.2	2.6	8.1	3.3	0.0	0.0	0.2	10.3	13.5
Wisconsin	26.8	39.8	13.1	6.6	17.4	2.7	9.5	1.8	4.7	1.2	2.6	2.0	4.3
Wyoming	5.8	3.8	-2.0	0.1	0.2	0.0	0.0	1.0	0.0	0.0	0.0	0.9	1.4
United States	**23.3**	**33.5**	**10.2**	**10.1**	**15.3**	**2.1**	**5.9**	**0.6**	**1.0**	**2.3**	**3.6**	**4.2**	**6.5**

Source: 2009 and 2017 Centers for Medicare & Medicaid Services enrollment files.

Notes: HMO = health maintenance organization. PPO = preferred provider organization. SNP = special needs plan. EGHP = employer group health plan.

Notes

[1] "Medicare and You: The Official US Government Medicare Handbook," the Centers for Medicare & Medicaid Services, accessed February 20, 2019, https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf. Medicare beneficiaries can also choose a private Medicare cost plan, which is administered by a private insurance company but has no enrollment and disenrollment restrictions, is available to beneficiaries who only have Part B coverage, and allows enrollees to retain traditional Medicare coverage for out-of-network benefits.

[2] "Medicare and You: The Official US Government Medicare Handbook," the Centers for Medicare & Medicaid Services.

[3] "Comparison of Projected Enrollment in Medicare Advantage Plans and Subsidies for Extra Benefits Not Covered by Medicare under Current Law and under Reconciliation Legislation Combined with H.R. 3590 As Passed by the Senate," Congressional Budget Office, accessed February 20, 2019, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/macomparisons.pdf.

[4] "Medicare – Congressional Budget Office's January 2017 Baseline." Congressional Budget Office, accessed March 20, 2019, https://www.cbo.gov/sites/default/files/recurringdata/51302-2017-01-medicare.pdf.

[5] For more on MA penetration and plan- and county-level enrollment, see "Medicare Advantage/Part D Contract and Enrollment Data," the Centers for Medicare & Medicaid Services, accessed February 20, 2019, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html. For more on MA benchmarks, see "Ratebooks and Supporting Data," the Centers for Medicare & Medicaid Services, accessed February 20, 2019, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. For more on contract-level data on star ratings, see "Part C and D Performance Data," the Centers for Medicare & Medicaid Services, accessed November 27, 2018, https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html. For more on both MA and prescription drug plan premiums, see "2018 Medicare Advantage and Part D Prescription Drug Program Landscape," the Centers for Medicare & Medicaid Services, accessed February 20, 2019, https://www.cms.gov/newsroom/fact-sheets/2018-medicare-advantage-and-part-d-prescription-drug-program-landscape.

[6] "American Community Survey," United States Census Bureau, accessed February 20, 2019, https://factfinder.census.gov/faces/nav/jsf/pages/programs.xhtml?program=acs.

[7] For example, see "Medicare Enrollment Dashboard," the Centers for Medicare & Medicaid Services, accessed March 4, 2019, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html.

[8] SNPs and employer plans can be either PPO or HMO. To avoid doublecounting, we present SNPs and employer plans separately.

[9] Table A.1 lists states included in each region.

[10] Large employers are more likely to offer MA plans than small employers (Claxton et al. 2018). And MA plans save employers money; see "The Future of Medicare Advantage Employer Group Waiver Plan Market," Aetna, accessed February 20, 2019, https://news.aetna.com/wp-content/uploads/2018/02/20170129-Aetna_EGWP_FINAL.pdf.

[11] This estimate is calculated by multiplying the regression coefficients in table 6 for gaining or maintaining a $0 premium plan by the respective share of counties in each of those groups from table 5, then adding the two estimates together. This gives an estimate of the percentage point change in MA penetration explained by

having access to a $0 premium plan. We then divided by the average percentage point change in MA penetration to estimate the share of MA penetration change explained by access to $0 premium plans.

[12] See methods described in note 11.

[13] No counties had five-star plans in 2009.

[14] "The Future of Medicare Advantage Employer Group Waiver Plan Market," Aetna.

[15] "2015 Medicare Current Beneficiary Survey Chartbook and Slides," the Centers for Medicare & Medicaid Services, accessed March 4, 2019, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2015Chartbook.html. Also, the Kaiser Family Foundation notes that beneficiaries account for friend recommendations when selecting plans (Jacobson et al. 2014).

[16] For example, the most popular MediGap plans are Plans C and F, which both cover Part A deductibles; coinsurance; hospital costs in full, including hospital stays up to 365 days beyond that covered by Medicare benefits; and Part B coinsurance, copayments, and deductibles in full. See Tamera Jackson, "Medicare Supplement Plan F," Medicare.com, September 16, 2018, https://medicare.com/medicare-supplement/medicare-supplement-plan-f/. MA plans, in contrast, often have coinsurance and copays for Medicare-covered services; see Danielle Kunkle Roberts, "The Hidden Costs in Medicare Advantage Plans," *Forbes*, July 25, 2017, https://www.forbes.com/sites/forbesfinancecouncil/2017/07/25/the-hidden-costs-in-medicare-advantage-plans/#c375550429af.

[17] Danielle Kunkle Roberts, "The Hidden Costs in Medicare Advantage Plans."

[18] John Gorman, "Takeaways from the Gorman Health Group 2018 Client Forum," Gorman Health Group (blog), May 2, 2018, https://www.gormanhealthgroup.com/blog/takeaways-from-the-gorman-health-group-2018-client-forum/.

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