RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

Brief No. 2020-5 **MAY 2020** http://www.public-health.uiowa.edu/rupri/

Access to Medicare Part D Plans: A Comparison of Metropolitan and Nonmetropolitan Areas

Mochamad Nataliansyah, MD, MPH; Abiodun Salako, PhD; Fred Ullrich, BA; and Keith Mueller, PhD

Purpose

This policy brief updates previous publications by the University of Minnesota Rural Health Research Center[1] (from 2011 data to 2017 data) and extends the RUPRI Center for Rural Health Policy Analysis reporting of rural activity in the Medicare Part D program. Earlier RUPRI reports focused on enrollment differences between urban (metropolitan) and rural (nonmetropolitan) counties. This policy brief focuses on the types of plans offered by county classification—metropolitan, micropolitan, and noncore (no urban cluster of at least 10,000 persons). Comparisons are made across county type and between Part D plan types (i.e. stand-alone plans and those offered as part of Medicare Advantage [MA] plans) as there are important differences in the manner in which these plans are offered and in premiums and benefits.

Key Findings

- In 2017, the average number of MA plans per county that included prescription drug benefits (MA-PD plans) was lower in noncore counties than in either micropolitan or metropolitan counties (6.4, 8.1, and 12.7, respectively), consistent with the patterns seen in the 2011 study.
- Choices of plans with $0 deductibles were slightly more limited for beneficiaries in noncore counties possibly because of the lower number of available MA-PD plans.
- Beneficiaries in noncore counties had access to multiple stand-alone prescription drug plans (PDPs), and in most noncore counties (80.7 percent) at least 2 MA-PD plans were available.
- In 2017, 10.6 percent of noncore counties had no MA-PD plans available, and 8.7 percent had only one plan offered.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created the Medicare Part D outpatient prescription drug program.[2] Since January 2006, this program has enabled Medicare beneficiaries to add prescription drug coverage to their Medicare coverage.[2] Medicare beneficiaries can obtain Part D coverage by enrolling in either a stand-alone PDP or an MA-PD plan.[3]

RHRC
Rural Health Research & Policy Centers
Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org

This policy brief was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement/grant #U1C RH20419. The information, conclusions and opinions expressed in this policy brief are those of the authors and no endorsement by FORHP, HRSA, HHS is intended or should be inferred.

rupri
RURAL POLICY RESEARCH INSTITUTE

RUPRI Center for Rural Health Policy Analysis,
University of Iowa College of Public Health,
Department of Health Management and Policy
145 Riverside Dr., Iowa City, IA 52242-2007
(319) 384-3830
http://www.public-health.uiowa.edu/rupri
E-mail: cph-rupri-inquiries@uiowa.edu

PDP and MA-PD plans may offer basic drug coverage or coverage providing supplemental benefits. Several options are defined:

- standard coverage (coverage subject to a deductible[4], a coinsurance limit [initial coverage limit], and an out-of-pocket threshold)
- actuarially equivalent standard coverage (where certain substitutions to the defined standard coverage are allowed)
- basic alternative coverage (combines features such as a lower deductible and changes to cost-sharing and the initial coverage limit but coverage is still actuarially equivalent to the defined standard coverage).[5]
- Supplemental benefit plans—also referred to as enhanced benefit plans—offer additional benefits (e.g., additional coverage in the coverage gap or additional tiers of covered drugs) that increase their actuarial value above that of basic coverage plans.[5]

A previous RUPRI Center analysis examined differences between metropolitan and nonmetropolitan areas in access-related characteristics of their PDP and MA-PD plans in the first year of Medicare Part D.[6] The results of that analysis showed that fewer Part D plans were offered in nonmetropolitan areas than in metropolitan areas and that plans offered in nonmetropolitan areas were less affordable (higher premiums and deductibles) and less likely to offer gap coverage. However, the results showed little to no variation in access to PDPs between metropolitan and nonmetropolitan areas. Subsequent RUPRI analysis of 2011 plan and enrollment data yielded similar results: the average monthly MA-PD premium was higher for nonmetropolitan beneficiaries than metropolitan ($52.38 compared to $38.23), and nonmetropolitan enrollment was more heavily in PDPs than MA-PD plans (47.6% of all nonmetropolitan beneficiaries enrolled in PDPs, and 11.5% in MA-PD plans).[7] The University of Minnesota Rural Health Research Center, also using 2011 data, assessed differences in Part D plans offered to metropolitan and nonmetropolitan beneficiaries. Their findings are directly replicated in this brief, using 2017 data. They found that there was little variation in metropolitan-nonmetropolitan characteristics of PDPs; that the average number of MA-PD plans was significantly higher in metropolitan counties; and that among all MA-PD plans, those in metropolitan areas had the lowest costs to beneficiaries.[1] This brief updates the University of Minnesota analysis by reexamining differences in affordability and availability of PDP and MA-PD plans by metropolitan status.

Methods

Data on PDP and MA-PD plan characteristics were obtained from the Centers for Medicare & Medicaid Services' (CMS') 2018 MA and PDP Landscape Source Files.[8] The files contain data on basic characteristics of approved Part D plans as of September 5, 2017, including premiums, deductibles, benchmark plan status, and county availability. The analysis in this brief is limited to PDPs and the following MA-PD plan types: health maintenance organization, health maintenance organization point of service, local preferred provider organization, regional preferred provider organization, private fee-for-service, and 1876 cost (a plan offered under section 1876 of the Social Security Act).[9] National Programs of All-Inclusive Care for the Elderly (PACE) plans (plans for the frail elderly who require nursing home level of care), Medicare-Medicaid plans, and Special Need plans were excluded.[a] [10,11]

We conducted a county-level descriptive analysis of Part D plans presenting national estimates as well as estimates for metropolitan and two categories of nonmetropolitan counties. Metropolitan

[a] A limited number of Medicare beneficiaries obtain their prescription drug coverage from PACE and Medicare-Medicaid plans.[3] These plans are similar to MA-PD plans in that they are prepaid contracts for Medicare beneficiaries but are not MA-PD plans.[3]

counties are those that contain at least one urbanized area with a population of 50,000 or more, and adjacent counties with a high degree of social or economic integration with the metropolitan county. Micropolitan counties contain urban clusters with 10,000-50,000 residents and adjacent counties with a high degree of social or economic integration with the micropolitan county. Counties without an urban cluster of at least 10,000 and without a high degree of integration with core metropolitan or micropolitan counties are categorized noncore.[12] We report national averages for each type of county. In assessing PDPs, we expected minimal differences across types of counties since the plans must offer the same design throughout the region in which they operate. At the time of this analysis, there are 39 regions (5 territories plus 34 regions that include the 50 states and the District of Columbia), ranging from single-state regions to a region that includes 7 states.[13] Differences in national averages across county types are possible, driven by the preponderance of county types in regions with different PDP characteristics (e.g., region 25—IA, MN, MT, NE, ND, SD, WY—with a preponderance of noncore counties, vs. region 5—DC, DE, MD—almost entirely metropolitan). Conversely, we expected to see differences across counties within MA-PD plans, since the MA program allows plan areas to be defined by combinations of counties. Other work from the RUPRI Center reports the differences in MA plan enrollment across metropolitan and nonmetropolitan counties.[14, 15]

Results

In 2017, a total of 2,543 Part D plans—775 PDPs and 1,768 MA-PD plans—were offered by 235 different organizations.[b] In terms of benefits covered, a total of 359 basic and 416 enhanced PDPs and 126 basic and 1,642 enhanced MA-PD plans were available to Medicare beneficiaries. In Tables 1 and 2, and in the text that follows, we report both the differences *within plan type across* counties and *between plan types within county type.*

Differences within plan type across counties

As expected, we found very few significant differences with PDPs across county classifications. However, some are notable. Differences shown in Table 1 are as follows:

- The average monthly premium was slightly but significantly lower in metropolitan ($52.75) and micropolitan ($52.87) counties compared to noncore ($53.60) counties.
- The percentage of PDPs offering $0 deductible was slightly but significantly higher in noncore counties (38.0 percent compared to 37.0 percent in metropolitan counties).
- The percentage of plans offering premiums below the regional benchmark was lower in noncore counties (25.7 percent) than in metropolitan or micropolitan counties (27.0 percent and 27.1 percent, respectively).

When separately considering basic and enhanced PDPs (Table 2), other differences were apparent:

- The average monthly premium was higher in noncore counties for both basic and enhanced plans ($40.32 and $65.16, respectively) than in metropolitan counties ($39.86 and $63.89, respectively).
- The average deductible was lower in enhanced plans in noncore counties than in metropolitan counties ($147.82 vs. $155.98), and a higher percentage of noncore counties had enhanced plans offering $0 deductible (62.4 percent vs. 60.4 percent).
- There were significant differences in the percentage of plans with the highest deductible in both types of PDPs, but in different directions. Among basic plans, noncore counties had the highest percentage of plans with the highest deductible (78.1 percent vs. 76.0 percent in

[b] Numbers reported in this brief will differ slightly from those reported by CMS as the data used in this brief includes only plans offered in the 50 states and DC (i.e., it excludes plans offered in U.S. territories).

metropolitan); among enhanced plans, noncore counties had the lowest percentage of plans with the highest deductible (29.6 percent vs. 31.6 percent in metropolitan).

There were significant differences in all of the MA-PD plan comparisons across county classifications. The differences across counties among MA-PD plans shown in Table 1 are as follows:

- Fewer plans were available in noncore (6.4) and micropolitan (8.1) counties than in metropolitan counties (12.7), on average.
- The highest average monthly premium ($34.09) was in noncore counties, followed by micropolitan ($33.67), and the lowest premium was in metropolitan counties ($26.73).
- The highest average deductible was in noncore counties ($178.69 vs. overall of $160.49).
- The percentage of plans offering $0 deductible was highest in metropolitan counties (35.9 percent) and lowest in noncore counties (26.7 percent).
- The percentage of plans with the highest deductible ($405) was lowest in metropolitan counties (6.1 percent) and highest in noncore counties (7.6 percent).
- The percentage of plans offering enhanced benefits was highest in metropolitan counties (87.8 percent) and lowest in noncore counties (77.3 percent).
- The percentage of plans with premiums below the regional benchmark was highest in noncore counties (13.0 percent) and lowest in metropolitan counties (8.1 percent).
- The percentage of plans with additional coverage in the coverage gap was lowest in noncore counties (20.9 percent) and highest in metropolitan counties (31.1 percent) (micropolitan was 26.5 percent).

Similar patterns of differences across county classifications were evident when considering basic and enhanced MA-PD plans separately, as shown in Table 2, with some variation:

- The highest average monthly premium for basic plans was in noncore counties ($29.88), compared to metropolitan counties ($27.88) and micropolitan counties ($28.47).
- The highest average plan deductible was in metropolitan counties ($313.38), significantly higher than in noncore counties ($300.68).

Differences between plan types within county type

A general finding evident in Table 1 is that the landscape of available plans tilted toward PDPs and away from MA-PD plans in a movement from metropolitan counties (65.2 percent of plans are PDPs) to noncore counties (80.3 percent of plans are PDPs). Further, Table 2 shows that among each plan type and across all county types, the MA-PD plan landscape was more concentrated in enhanced plans (on average, 87.8 percent of plans offered in metropolitan counties, 77.3 percent of those offered in noncore counties). In contrast, an average of only 53.5 percent of PDPs offered in all counties were enhanced plans.

MA-PD plan availability

Table 3 shows that 10.6 percent of noncore counties have no MA-PD plans available, and 8.7 percent have only one plan offered. The numbers are more striking if examining only enhanced plans—20.0 percent of noncore counties have no such plan offered and 11.8 percent have only one.

Table 1. PDP and MA-PD Plan Characteristics[i]

	Overall	Metropolitan	Micropolitan	Noncore	Sig. Dif.[ii]
Percentage of All Plans Offered in Each Geography Type					
MA-PD	27.1%	34.8%	25.1%	19.7%	a,b,c
PDP	72.9%	65.2%	74.9%	80.3%	
Average Number of Available Plans					
MA-PD	9.2	12.7	8.1	6.4	a,b,c
PDP	23.4	23.4	23.4	23.4	--
Average Plan Premium[iii]					
MA-PD	$30.08	$26.73	$33.67	$34.09	a,b
PDP	$53.14	$52.75	$52.87	$53.60	b,c
Average Plan Deductible					
MA-PD	$160.49	$151.38	$159.15	$178.69	a,b,c
PDP	$244.41	$246.21	$243.74	$243.16	--
Percentage of Plans with $0 Deductible Within Each Plan Type and Each Geography Type					
MA-PD	32.5%	35.9%	31.5%	26.7%	a,b,c
PDP	37.6%	37.0%	37.6%	38.0%	b
Percentage of Plans with Highest Deductible ($405)					
MA-PD	6.5%	6.1%	6.2%	7.6%	b,c
PDP	52.0%	52.2%	51.6%	52.1%	--
Percentage of Enhanced Plans[iv]					
MA-PD	84.0%	87.8%	83.2%	77.3%	a,b,c
PDP	53.6%	53.7%	53.5%	53.5%	--
Percentage of Plans with Premium Below Regional Benchmark Within Each Plan Type and Each Geography Type					
MA-PD	10.0%	8.1%	10.8%	13.0%	a,b,c
PDP	26.4%	27.0%	27.1%	25.7%	b,c
Percentage of Plans with Additional Coverage in the Coverage Gap					
MA-PD	27.4%	31.1%	26.5%	20.9%	a,b,c
PDP	34.9%	34.9%	34.8%	34.9%	--

i. Reported at the county level. Excludes National PACE plans and Medicare-Medicaid plans. Data are not weighted.

ii. Statistically significant differences at the 5% level: a - Metropolitan v. Micropolitan; b - Metropolitan v. Noncore; and c - Micropolitan v. Noncore.

iii. Total Premium

iv. Enhanced plans may include additional coverage in the coverage gap, lower cost-sharing than standard coverage plans, or coverage of nonPart D drugs.

Table 2. Basic and Enhanced Plan Characteristics[i]

		Overall	Metropolitan	Micropolitan	Noncore	Sig. Dif.[ii]
Percentage of Plans Offered Within Each Plan Type and Each Geography Type						
MA-PD	**Basic**	16.0%	12.2%	16.8%	22.7%	a,b,c
	Enhanced	84.0%	87.8%	83.2%	77.3%	
PDP	**Basic**	46.5%	46.4%	46.5%	46.5%	--
	Enhanced	53.5%	53.6%	53.5%	53.5%	
Average Number of Available Plans						
MA-PD	**Basic**	1.9	2.0	1.9	1.9	
	Enhanced	8.2	11.3	7.1	5.5	a,b,c
PDP	**Basic**	10.9	10.8	10.9	10.9	--
	Enhanced	12.5	12.5	12.5	12.5	--
Average Plan Premium[iii]						
MA-PD	**Basic**	$28.79	$27.88	$28.47	$29.88	b,c
	Enhanced	$30.32	$26.57	$34.72	$35.32	a,b
PDP	**Basic**	$39.97	$39.86	$39.45	$40.32	b,c
	Enhanced	$64.56	$63.89	$64.51	$65.16	b
Average Plan Deductible						
MA-PD	**Basic**	$306.08	$313.38	$301.86	$300.68	a,b
	Enhanced	$132.75	$128.90	$130.27	$142.84	b,c
PDP	**Basic**	$351.42	$350.65	$350.07	$352.74	--
	Enhanced	$151.59	$155.98	$151.44	$147.82	b
Percentage of Plans with $0 Deductible Within Each Plan Type and Each Geography Type						
MA-PD	**Basic**	1.2%	1.6%	1.4%	0.6%	b,c
	Enhanced	38.5%	40.6%	37.6%	34.4%	a,b,c
PDP	**Basic**	10.0%	10.0%	10.0%	10.0%	--
	Enhanced	61.5%	60.4%	61.5%	62.4%	b
Percentage of Plans with Highest Deductible ($405)						
MA-PD	**Basic**	24.3%	28.6%	22.1%	21.1%	a,b
	Enhanced	3.1%	3.0%	2.9%	3.6%	b
PDP	**Basic**	76.9%	76.0%	75.9%	78.1%	b,c
	Enhanced	30.5%	31.6%	30.5%	29.6%	b

i. Reported at the county level. Excludes National PACE plans and Medicare-Medicaid plans. Data are not weighted.
ii. Statistically significant differences at the 5% level: a - Metropolitan v. Micropolitan; b - Metropolitan v. Noncore; and c - Micropolitan v. Noncore.
iii. Total Premium

Table 3. Availability of MA-PD Plans by Location[i]

% of Counties with # of Plans	Any MA-PD Plan			Enhanced MA-PD Plan		
	Metro	Micro	Noncore	Metro	Micro	Noncore
0 Plans	1.8%	3.7%	10.6%	3.3%	8.3%	20.0%
1 Plans	1.6%	6.7%	8.7%	2.3%	10.0%	11.8%
2-5 Plans	15.8%	34.0%	41.5%	20.0%	37.9%	37.5%
More than 5 Plans	80.8%	55.5%	39.2%	74.5%	43.8%	30.6%

i. Reported at the county level. Excludes National PACE plans and Medicare-Medicaid plans. Data are not weighted.

Discussion

Similar to earlier analyses of metropolitan-nonmetropolitan data regarding availability of Medicare Part D plans, our analysis found widespread availability of at least some alternative plans in all three county types (metropolitan, micropolitan, and noncore). Because PDP providers are required to offer their plans throughout all of the regions they serve, PDPs are available in all noncore counties, with an average of 23.4 PDPs in all counties. That availability, and more years for plans to be established, has apparently resulted in increased enrollment in Part D.[16] The RUPRI Center's most recent update of enrollment (2017) showed that nonmetropolitan beneficiaries enrolled in higher numbers than in 2008 (69.8 percent vs. 54.0 percent) and that the percentage of enrollees in MA-PD plans increased (14.0 percent to 25.0 percent).[3]

Equity in plan offerings exists for PDPs within regions, and there is only modest variation across regions, as detected in our report of differences in monthly premiums, plans offering $0 deductibles, and premiums below the regional benchmark. From the perspective of what is available to nonmetropolitan Medicare beneficiaries, the variation has both a negative effect (slightly higher monthly premiums, lower percentage of plans with premiums below regional benchmarks) and a positive effect (higher percentage of plans offering $0 deductibles).

However, availability of comparable MA-PD plans is not uniform across all county classifications. This brief shows an increased percentage in the number of noncore counties without any, or only one, MA-PD plan since the 2011 data reported in the O'Connor et al. brief (noncore counties with no MA-PD plan: 2011 – 1.6 percent, 2017 – 10.6 percent; one plan: 2011 – 1.1 percent, 2017 – 8.7 percent).[1] As shown in the data in this brief, the consequences of lower availability of MA-PD plans are fewer opportunities to select plans with lower monthly premiums, lower deductibles, and enhanced benefits.

The differences in availability of MA-PD plans is to be expected, given the decisions of MA plans to not enter all nonmetropolitan county markets. MA plans have a calculus for entering markets that includes an ability to form provider networks and a potential for market size (intersection of market size and potential for market penetration). Those considerations mitigate the attractiveness of remote, sparsely populated counties. As a consequence, MA plans are not in all U.S. counties.[17] The same market considerations are less likely to affect plans focused exclusively on prescription drugs. Further, the federal policy intervention of creating 34 regions (plus 5 territories) within which any PDP must offer the same benefits throughout changes the dynamics of firm entry.[16] Thus, policy created markets that maintain equity across geography.

Medicare Part D is a program that appears to be achieving its policy objectives by using a blend of public policy and independent market actions. Enrollment should continue to be monitored, both in the aggregate and by plan type. Differences in types of plans available suggest continuous monitoring to detect any glaring inequities based on differences across geography (metropolitan,

micropolitan, noncore). Should the differences raise equity concerns (e.g., beneficiaries in noncore areas having fewer alternatives with low deductibles while paying higher premiums), policy makers may want to consider a combination of payment change, modified service area requirements, and other incentives to address the needs of rural beneficiaries.

References

1. O'Connor H, Henning-Smith, C, Casey M, and Moscovice I (2015) "Differences in Part D Plans Offered to rural and Urban Medicare Beneficiaries" Policy Brief. University of Minnesota Rural Health Research Center. http://rhrc.umn.edu/wp-content/files_mf/ruralurbanpartd.pdf

2. The Medicare Part D Prescription Drug Benefit. The Henry J. Kaiser Family Foundation, 2014. (Accessed 03/11/2015, at http://files.kff.org/attachment/medicare-prescription-drug-benefit-fact-sheet).

3. Weigel P, Ullrich F, Mueller K (2017) "Rural-Urban Enrollment in Part D Prescription Drug Plans: June 2017 Update." Policy Brief 2017-7. RUPRI Center for Rural Health Policy Analysis. (Accessed 10/21/2019, at https://rupri.public-health.uiowa.edu/publications/policybriefs/2017/Rural-Enrollment%20in%20Part%20D.pdf).

4. CMS defines four coverage stages that Part D beneficiaries move through annually (in order):
   - Annual deductible – The beneficiary pays full cost of prescription medication until their spending adds up to the amount of the deductible. Some plans offer $0 deductibles, so beneficiaries automatically move to the second stage.
   - Initial coverage – The plan covers some portion of the prescription medication and the beneficiary pays the remainder of the cost either through a copayment (a fixed dollar amount) or coinsurance (a percentage of the medication cost). This stage of coverage ends when the beneficiary total spending for the year adds up to the coverage limit set by Medicare.
   - Coverage gap – Frequently referred to as the "donut hole", plans are limited to paying 75% of medication costs for beneficiaries in this stage. Beneficiaries exit this stage when their total out-of-pocket costs for medication (not including premiums) reach a limit set by Medicare.
   - Catastrophic coverage – Beneficiaries in this stage pay a low coinsurance or copayment amount (set by Medicare) for covered prescription drugs.

5. Medicare Prescription Drug Benefit Manual – Chapter 5. Centers for Medicare & Medicaid Services, 2011. (Accessed 07/19/2019, at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf).

6. McBride TD, Terry TL, Mueller KJ (2006) "Medicare Part D: early findings on enrollment and choices for rural beneficiaries." Policy Brief 2015-7. RUPRI Center for Rural Health Policy Analysis. (Accessed 10/21/2019 at https://rupri.public-health.uiowa.edu/publications/policybriefs/2015/Health%20Insurance%20Marketplaces.pdf).

7. Kemper L, Barker A, Ullrich F, Pollack L, McBride TD, and Mueller KJ (2012) "Stand-Alone Prescription Drug Plans Dominated the Rural Market in 2011." Policy Paper P2012-2. RUPRI Center for Rural Health Policy Analysis. (Accessed 10/21/2019 at https://rupri.public-health.uiowa.edu/publications/policypapers/Part%20D%20Stand-Alone%20FINAL.pdf).

8. Prescription Drug Coverage - General Information. Centers for Medicare & Medicaid Services. (Accessed 07/09/2019, at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/.)

9. 42 U.S.C. 1395mm.

10. Core Differences Between PACE and MA Plans. National PACE Association. (Accessed 07/09/2019 at https://www.npaonline.org/sites/default/files/PDFs/Core%20Differences%20Between%20PACE%20and%20MA%20Plans.pdf)

11. PACE. Centers for Medicare & Medicaid Services. (Accessed 07/09/2019 at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/pace.html.)

12. Counties with 2013 Urban Influence Codes (UIC) of 1 or 2 are 'Metropolitan', while codes 3, 5 and 8 are 'Micropolitan' and codes 4, 6, 7, 9, 10, 11 and 12 are 'Non-core'. UIC codes are determined by the Economic Research Service division of the United States Department of Agriculture (Accessed 10/21/2019

at https://www.ers.usda.gov/data-products/urban-influence-codes.aspx).

13. A map of PDP regions is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/downloads/PDPRegions.pdf (accessed 1/10/2020).

14. Oyeka O, Ullrich F, and Mueller K (2019) "Medicare Advantage Enrollment Update 2018." Policy Brief 2019-2. RUPRI Center for Rural Health Policy Analysis. (Accessed 10/21/2019 at https://rupri.public-health.uiowa.edu/publications/policybriefs/2019/Medicare%20Advantage%20Enrollment%20Update%202018.pdf).

15. Barker AR, Nienstedt L, Kemper L, McBride TD, and Mueller K (2019) "Comparing Rural and Urban Medicare Advantage Beneficiary Characteristics." Policy Brief 2019-1. RUPRI Center for Rural Health Policy Analysis. (Accessed 10/21/2019 at https://rupri.public-health.uiowa.edu/publications/policybriefs/2019/Rural%20and%20Urban%20MA%20Beneficiary%20Characteristics.pdf).

16. McBride TD, Kemper L, Mueller K (2009) "Rural enrollment in Medicare Part D is growing slowly." Policy Brief 2009-2. (Accessed 10/21/2019, at https://rupri.public-health.uiowa.edu/publications/policybriefs/2009/b2009-2%20Medicare%20Part%20D.pdf).

17. Barker AR, McBride TD, Mueller KJ, and Huntzberry KA (2019) "The Market Mechanism and Health Insurance in Rural Places: Lessons Learned from an Economics and Policy Perspective." Policy Paper. RUPRI Center for Rural Health Policy Analysis. (Accessed 10/21/2019 at https://rupri.public-health.uiowa.edu/publications/policypapers/Market%20Structures%20in%20Rural.pdf).