RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

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Rural Beneficiary Access to Medicare Advantage-Part D plans

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Background and Purpose

The Medicare Part D prescription drug benefit, authorized under the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA), helps Medicare beneficiaries pay for outpatient prescription drugs.[1] This voluntary prescription drug benefit is provided by private plans under a federal government contract. Beneficiaries can choose stand-alone prescription drug plans (PDPs) to supplement the health care benefits provided by Traditional Medicare or a Medicare Advantage (MA) plan that does not provide prescription drug coverage aside from limited coverage under Part B. Conversely, beneficiaries can enroll in a Medicare Advantage Prescription Drug Plan (MA-PDs) that covers all Medicare benefits and includes prescription drugs.[2]

The number of MA-PDs has steadily increased in the last decade, with 56 percent of all people with Medicare Part D coverage currently enrolled in MA-PDs and 44 percent in PDPs under traditional Medicare.[3] The RUPRI Center previously published a brief in 2020 using 2017 data examining MA-PD and PDP plan characteristics. Using 2023 MA and PDP Landscape Source files from the Centers for Medicare & Medicaid Services (CMS), this brief updates RUPRI's analysis of MA-PDs, enhanced benefit plan availability, and variations in characteristics across metropolitan, micropolitan, and noncore areas (note that micropolitan and noncore represent gradations of rural areas).

PDPs are offered in CMS-defined regions consisting of one or more entire states (there were 34 PDP regions in 2023). This means there is no distinction between plans offered in metropolitan, micropolitan, and noncore counties. Therefore, much of this report will focus only on MA-PDs.

Key Findings

- A greater proportion of noncore counties (6.4 percent) do not offer any enhanced MA-PDs in comparison to micropolitan counties (5.6 percent) and metropolitan counties (3.9 percent). Enhanced MA-PDs may include additional coverage in the coverage gap[a], lower cost-sharing than standard coverage plans, or coverage of drugs excluded under Part D, but have higher premiums.

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[a] The coverage gap is also known as the "donut hole"- a stage in some Medicare Part D prescription drug plans where beneficiaries pay a higher share of costs for their medications after initially spending a certain amount for the year – the beneficiary exits the coverage gap after reaching a set level of out-of-pocket cost for covered drugs.

- The proportion of enhanced MA-PD plans offering additional coverage in the coverage gap is lower (58.0 percent) in noncore than in micropolitan counties (60.2 percent) and metropolitan counties (61.8 percent).
- The average monthly MA-PD premiums are slightly higher in noncore than in micropolitan and metropolitan counties. In 2023, the average monthly plan premiums were $17.85, $17.55, and $15.20 for noncore, micropolitan, and metropolitan counties, respectively. However, the proportion of MA-PDs with premiums below the regional benchmark is higher in noncore counties (3.9 percent) than in micropolitan counties (3.7 percent) and metropolitan counties (2.9 percent).
- The average MA-PD annual drug deductible is consistently higher in noncore counties ($152.49) than in micropolitan ($141.75) and metropolitan ($128.97) counties. Noncore counties have the largest proportion (11.5 percent) of MA-PDs with the highest annual drug deductible (set by CMS in 2023 at $505). The proportion of MA-PDs with $0 annual drug deductibles is higher in metropolitan counties (55.5 percent) than in micropolitan (52.3 percent) or noncore counties (50.8 percent).

Methods

Data on MA-PD availability was obtained from the CMS 2023 MA and PDP Landscape Source files (as of October 2023).[4] We examine plan availability and characteristics in counties classified using 2013[b] Urban Influence Codes (UIC): metropolitan (UICs 1, 2), micropolitan (UICs 3, 5, 8), and noncore (UICs 4, 6, 7, 9-12)[5]. The analysis in this brief is limited to PDPs and the following MA-PD 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).

National Programs of All-Inclusive Care for the Elderly (PACE) plans (plans for the frail elderly who require nursing home levels of care), Medicare-Medicaid plans, and Special Needs plans were excluded. Sanctioned plans closed to new enrollees were also excluded. Publicly available Medicare Advantage/Part D Contract and Enrollment Data were downloaded from CMS websites. CMS regularly updates these data resources, so the numbers reported herein may not agree with those in previous reports.

Glossary of Terms

Coverage Gap: Most Medicare drug plans have a coverage gap (aka, "donut hole") that starts when a beneficiary spends a certain amount for covered drugs. During the coverage gap, the plan will limit the amount that it covers for drugs. The coverage gap is exited when the beneficiary reaches a set level of out-of-pocket costs for covered drugs.

Deductible: The out-of-pocket amount of money that must be paid by the beneficiary every year before the Part D plan pays any of the cost.

Enhanced MA-PD: MA-PDs with a broader range of benefits. They may offer additional coverage in the coverage gap, lower cost-sharing than standard coverage plans, or coverage of non-Part D drugs.

MA Plan: A type of health insurance plan that is offered by a private company that is approved by Medicare and must follow its rules. Companies may offer many plans with varying fee and benefit structures.

Premium: The monthly payment made to a plan in order to obtain and maintain coverage.

Regional Benchmark: The maximum amount that CMS will pay in the area where a plan operates; calculated as a weighted average of the beneficiary premiums for basic drug coverage.

Zero Deductible: MA-PDs that have no annual deductible.

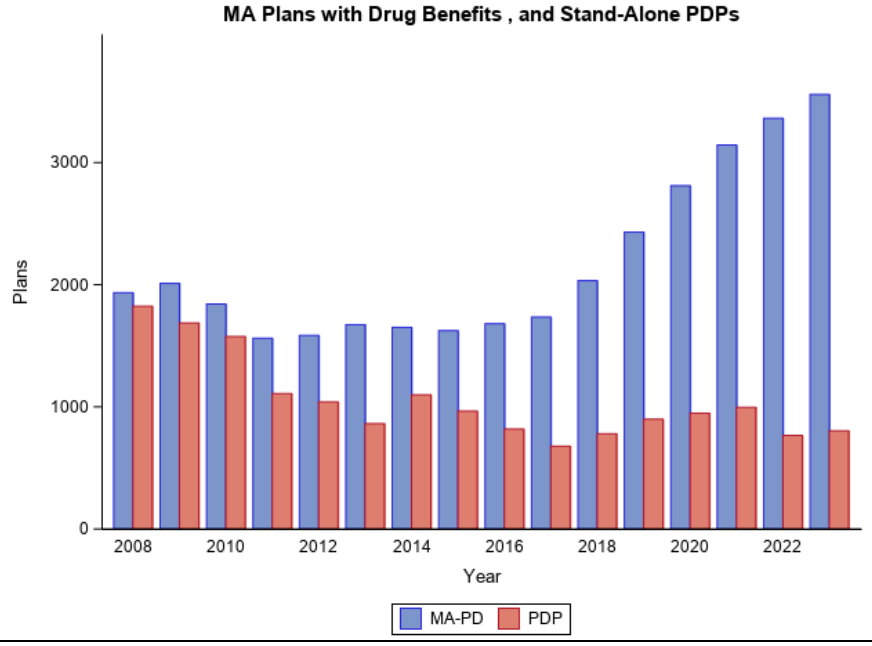
Zero Premium: MA-PDs that have no monthly premium other than the Medicare Part B premium coverage in a given region.

[b] Latest version available at the time of analysis.

Results and Findings

The total number of MA-PDs has increased steadily since 2015, doubling since 2017 (Figure 1/Table 1). The number of PDPs nationally has generally declined since 2008, with the sharpest decline ending around 2011. There is little difference in the number of PDPs available between county geographies because PDP providers are required to offer their plans in all of the counties in the regions they serve.

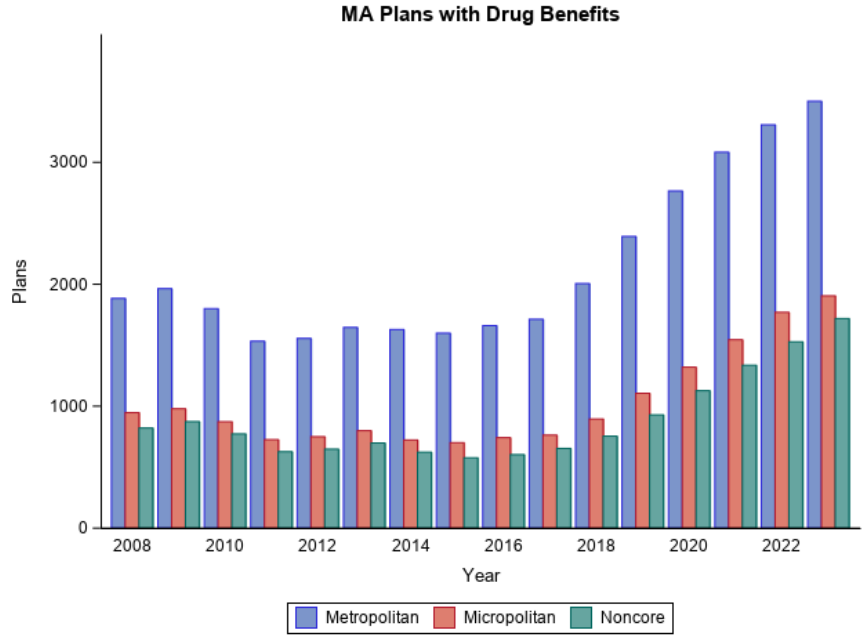
Figure 1/Table 1. Available MA-PDs and PDPs, 2008-2023



	Plan Count	
Year	MA-PD	PDP
2008	1,935	1,824
2009	2,011	1,687
2010	1,842	1,576
2011	1,562	1,109
2012	1,585	1,041
2013	1,673	863
2014	1,651	1,099
2015	1,624	965
2016	1,681	818
2017	1,735	678
2018	2,033	780
2019	2,430	899
2020	2,811	948
2021	3,144	996
2022	3,363	766
2023	3,558	804

Note: Excludes plans in the territories, sanctioned plans closed to new enrollees, Special Needs Plans, Medicare-Medicaid plans, PACE plans, and MA plans without drug coverage.
Data source: Medicare Advantage/Part D Contract and Enrollment Data[6]

Figure 2/Table 2. Available MA-PDs by Metropolitan, Micropolitan, Noncore County, 2008-2023



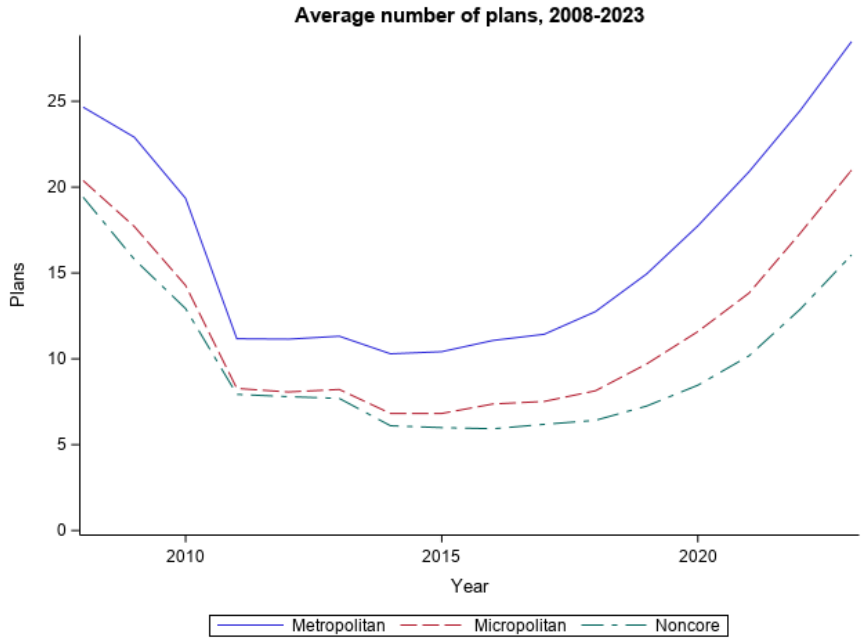
	Plan Count		
Year	Metro	Micro	Noncore
2008	1,884	947	821
2009	1,964	979	874
2010	1,800	873	773
2011	1,533	726	627
2012	1,556	750	648
2013	1,646	799	698
2014	1,629	723	623
2015	1,599	701	577
2016	1,661	742	603
2017	1,713	763	654
2018	2,006	895	754
2019	2,392	1,106	929
2020	2,765	1,320	1,127
2021	3,083	1,545	1,336
2022	3,308	1,770	1,528
2023	3,501	1,905	1,719

Note: Excludes plans in the territories, sanctioned plans closed to new enrollees, Special Needs Plans, Medicare-Medicaid plans, PACE plans, and MA plans without drug coverage.
Data source: Medicare Advantage/Part D Contract and Enrollment Data[6]

The trends in the total number of MA-PDs by metropolitan, micropolitan, and noncore counties (Figure 2/Table 2) are similar to those seen in the overall distribution shown in Figure 1/Table 1. The number of plans generally declined between 2008 and 2015, followed by continuous growth. The number of MA-PDs has always been markedly higher in metropolitan counties than in either micropolitan or noncore counties.

The same longitudinal trend is seen in the average number of plans available in metropolitan, micropolitan, and noncore counties (Figure 3/Table 3). The average number of available plans declined from 2008 until approximately 2015 and has steadily increased since then. Again, the average number of available MA-PDs is markedly higher in metropolitan counties than in either micropolitan or noncore counties.

Figure 3/Table 3. Average Number of Available MA-PDs by Metropolitan, Micropolitan, Noncore County, 2008-2023

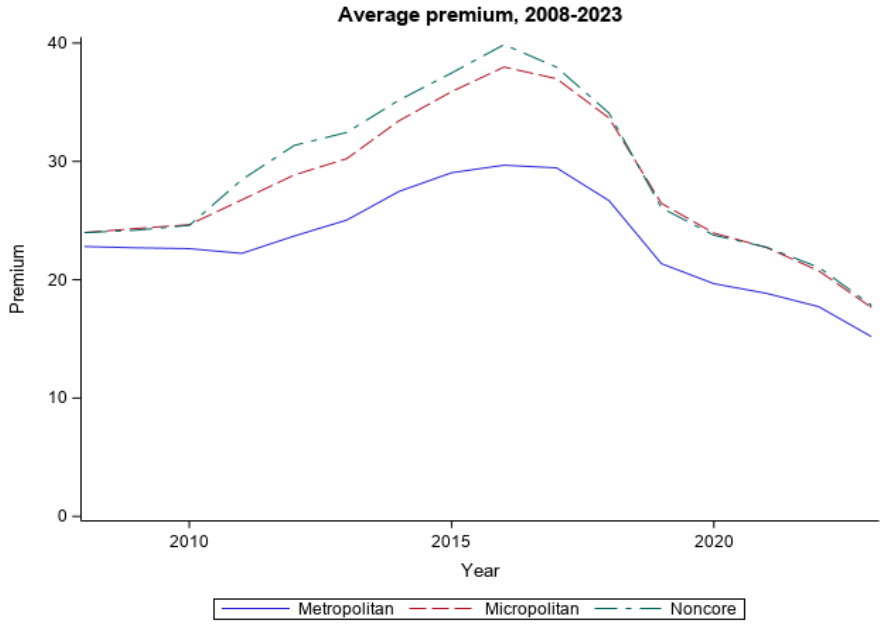


	Plan Count		
Year	Metro	Micro	Noncore
2008	24.7	20.4	19.4
2009	22.9	17.7	15.8
2010	19.3	14.3	12.9
2011	11.2	8.3	7.9
2012	11.1	8.1	7.8
2013	11.3	8.2	7.7
2014	10.3	6.8	6.1
2015	10.4	6.8	6.0
2016	11.1	7.4	5.9
2017	11.4	7.5	6.2
2018	12.7	8.1	6.4
2019	14.9	9.7	7.2
2020	17.7	11.6	8.5
2021	20.9	13.8	10.2
2022	24.5	17.3	12.9
2023	28.5	21.0	16.0

Note: Excludes plans in the territories, sanctioned plans closed to new enrollees, Special Needs Plans, Medicare-Medicaid plans, PACE plans, and MA plans without drug coverage.
Data source: Medicare Advantage/Part D Contract and Enrollment Data[6]

While previous figures and tables showed a period of decline followed by growth in the number of available plans, Figure 4/Table 4 shows the average MA-PD premiums for metropolitan, micropolitan, and noncore counties generally increased between 2008 and 2016 and have decreased significantly since then. The average plan premium has been consistently lower in metropolitan counties than in either micropolitan or noncore counties.

Figure 4/Table 4. Average Monthly MA-PD Premium by Metropolitan, Micropolitan, Noncore County, 2008-2023

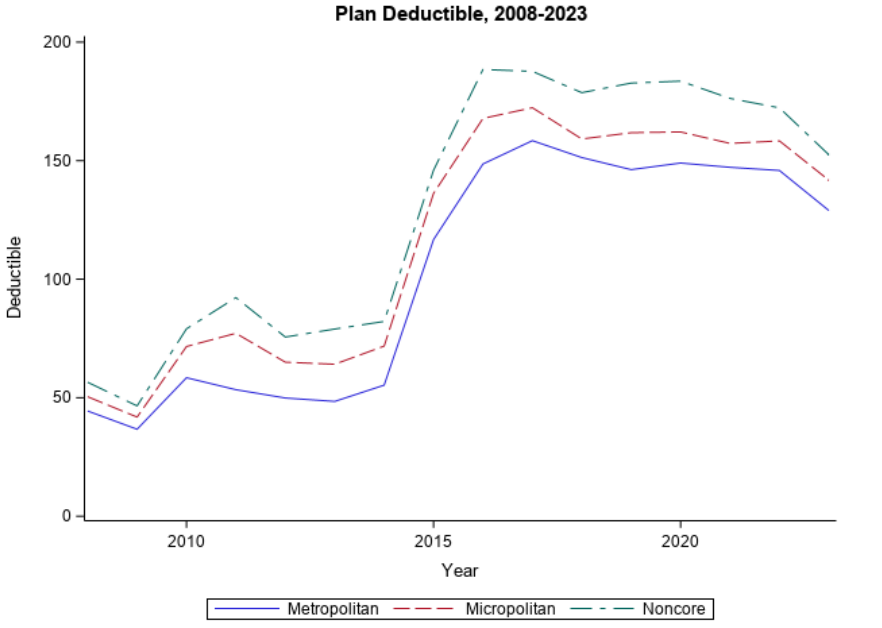


	Average Premium		
Year	Metro	Micro	Noncore
2008	$22.81	$23.99	$23.98
2009	$22.70	$24.33	$24.19
2010	$22.63	$24.65	$24.60
2011	$22.23	$26.75	$28.45
2012	$23.70	$28.86	$31.35
2013	$25.04	$30.23	$32.45
2014	$27.47	$33.44	$35.19
2015	$29.04	$35.90	$37.47
2016	$29.68	$37.98	$39.87
2017	$29.45	$36.99	$37.96
2018	$26.69	$33.67	$34.09
2019	$21.36	$26.45	$26.07
2020	$19.67	$23.94	$23.76
2021	$18.85	$22.73	$22.75
2022	$17.72	$20.75	$21.04
2023	$15.20	$17.66	$17.85

Note: Excludes plans in the territories, sanctioned plans closed to new enrollees, Special Needs Plans, Medicare-Medicaid plans, PACE plans, and MA plans without drug coverage.
Data source: Medicare Advantage/Part D Contract and Enrollment Data[6]

Over this same period, average annual plan deductibles appear to show an inverse relationship to the average monthly plan premiums (Figure 5/Table 5). There was a sharp increase in the average plan deductible between 2014 and 2017, with gradual decreases since then. Again, the average plan deductible in metropolitan counties has been consistently lower than the average plan deductible in micropolitan and noncore counties. And while the average plan deductible increased sharply after 2014, the proportion of plans offering $0 ('zero dollar') deductibles decreased sharply until 2018, when they began increasing gradually (Figure 6/Table 6).

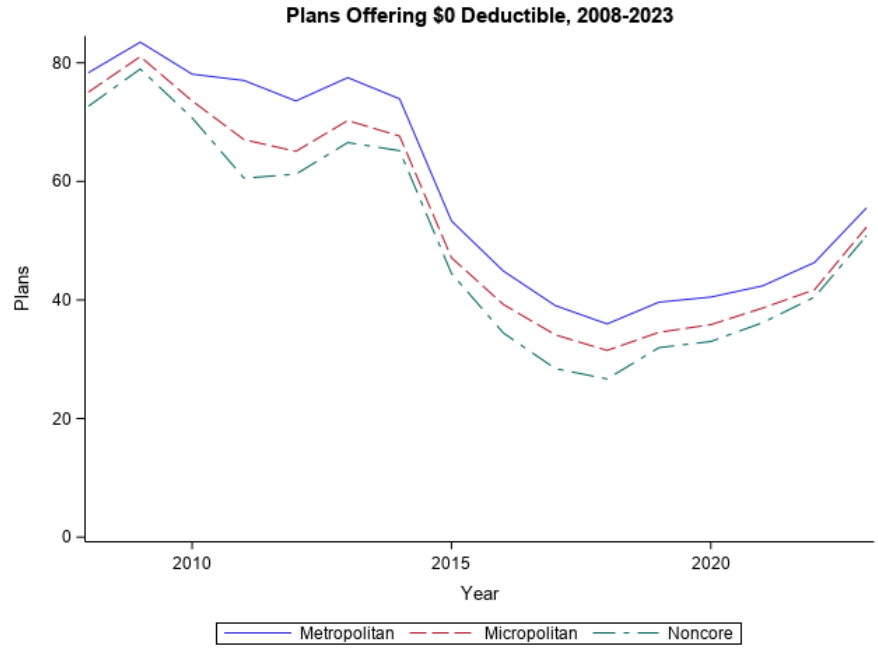
Figure 5/Table 5. Average MA-PD Deductible by Metropolitan, Micropolitan, Noncore County, 2008-2023



	Average Deductible		
Year	Metro	Micro	Noncore
2008	$44.39	$50.41	$56.51
2009	$36.70	$41.83	$46.54
2010	$58.44	$71.60	$79.07
2011	$53.38	$77.18	$92.23
2012	$49.87	$64.98	$75.60
2013	$48.44	$64.13	$78.97
2014	$55.30	$71.77	$82.18
2015	$116.72	$136.20	$145.97
2016	$148.60	$167.82	$188.47
2017	$158.44	$172.33	$187.68
2018	$151.31	$159.15	$178.69
2019	$146.22	$161.80	$182.74
2020	$149.00	$162.12	$183.55
2021	$147.20	$157.29	$176.27
2022	$145.87	$158.34	$172.28
2023	$128.97	$141.75	$152.49

Note: Excludes plans in the territories, sanctioned plans closed to new enrollees, Special Needs Plans, Medicare-Medicaid plans, PACE plans, and MA plans without drug coverage.
Data source: Medicare Advantage/Part D Contract and Enrollment Data[6]

Figure 6/Table 6. Percent of MA-PD With $0 Deductible by Metropolitan, Micropolitan, Noncore County, 2008-2023



	Plans with $0 Deductible		
Year	Metro	Micro	Noncore
2008	78.3%	75.1%	72.7%
2009	83.5%	81.1%	79.0%
2010	78.1%	73.6%	70.7%
2011	77.0%	67.0%	60.6%
2012	73.6%	65.1%	61.2%
2013	77.5%	70.3%	66.5%
2014	73.9%	67.6%	65.2%
2015	53.3%	47.1%	44.5%
2016	44.9%	39.2%	34.4%
2017	39.1%	34.1%	28.4%
2018	36.0%	31.5%	26.7%
2019	39.6%	34.5%	32.0%
2020	40.5%	35.8%	33.0%
2021	42.4%	38.6%	36.2%
2022	46.3%	41.7%	40.5%
2023	55.5%	52.3%	50.8%

Note: Excludes plans in the territories, sanctioned plans closed to new enrollees, Special Needs Plans, Medicare-Medicaid plans, PACE plans, and MA plans without drug coverage.
Data source: Medicare Advantage/Part D Contract and Enrollment Data[6]

Table 7. Percentages of Additional MA-PD Characteristics by Metropolitan, Micropolitan, and Noncore Counties, 2008-2023

	MA-PDs with Highest Deductible*			Enhanced** MA-PDs			MA-PDs with Premiums below Regional Benchmark			MA-PDs with Additional Coverage in the Coverage Gap		
Year	Metro	Micro	Noncore	Metro	Micro	Noncore	Metro	Micro	Noncore	Metro	Micro	Noncore
2008	12.9%	14.5%	16.7%	90.3%	89.9%	88.3%	9.0%	9.5%	11.2%	46.5%	45.4%	43.5%
2009	4.7%	5.8%	7.0%	75.6%	72.3%	69.8%	22.2%	24.8%	26.7%	45.3%	44.3%	43.3%
2010	13.5%	17.1%	19.1%	70.7%	66.3%	63.1%	17.5%	20.3%	22.3%	43.7%	44.1%	41.2%
2011	11.1%	15.5%	17.9%	79.6%	71.0%	65.8%	17.7%	25.8%	30.8%	44.1%	42.6%	37.6%
2012	10.1%	13.2%	16.2%	80.5%	70.3%	63.7%	14.7%	23.2%	28.4%	40.9%	36.3%	32.3%
2013	10.4%	13.5%	18.4%	82.4%	74.1%	70.2%	13.5%	20.8%	24.4%	40.9%	39.0%	35.9%
2014	10.8%	14.7%	19.2%	78.8%	72.1%	68.4%	11.6%	15.4%	18.8%	40.9%	38.9%	34.7%
2015	20.9%	26.6%	29.9%	68.8%	63.2%	58.8%	16.1%	19.0%	22.2%	37.3%	34.1%	29.3%
2016	23.1%	27.0%	29.7%	77.9%	70.5%	65.7%	12.5%	15.6%	17.9%	41.4%	40.2%	35.5%
2017	13.1%	14.8%	15.1%	81.2%	75.2%	68.8%	10.7%	14.9%	18.3%	46.7%	41.9%	36.6%
2018	6.2%	6.2%	7.6%	87.8%	83.2%	77.3%	8.1%	10.8%	13.0%	31.2%	26.5%	20.9%
2019	6.8%	7.4%	8.8%	93.0%	88.3%	83.5%	5.7%	9.0%	11.1%	38.2%	31.7%	26.3%
2020	7.8%	8.3%	8.5%	94.0%	90.5%	88.2%	4.3%	6.2%	7.8%	39.3%	34.3%	29.4%
2021	9.0%	8.7%	10.5%	95.0%	92.1%	90.6%	3.5%	5.1%	6.0%	39.2%	33.9%	28.9%
2022	10.9%	12.2%	14.1%	96.4%	94.6%	93.7%	2.2%	2.9%	2.9%	52.9%	49.5%	46.3%
2023	8.3%	10.6%	11.5%	96.1%	94.4%	93.6%	2.9%	3.7%	3.9%	61.8%	60.2%	58.0%

Note: Excludes plans in the territories, sanctioned plans closed to new enrollees, Special Needs Plans, Medicare-Medicaid plans, PACE plans, and MA plans without drug coverage.
Data source: Medicare Advantage/Part D Contract and Enrollment Data[6]
* Maximum deductibles ranged from $265 in 2007 to $505 in 2023.
** Enhanced plans may include additional coverage in the coverage gap, lower cost-sharing than standard coverage plans, or coverage of non-Part D drugs.

Additional MA-PD characteristics by geography over time are displayed in Table 7:

- The proportion of plans with the highest deductibles spiked between 2014 and 2016 and has been very low since 2018.
- The proportion of plans offering enhanced benefits (these plans generally have higher premiums but can include additional coverage in the coverage gap, lower cost-sharing than standard coverage plans, or coverage of non-Part D drugs) has fluctuated over time but has gradually grown since 2015.
- The proportion of plans with premiums below the regional benchmark has decreased since 2011 and was below 4 percent across the country in 2023.
- The percentage of MA-PDs with additional coverage in the coverage gap (also known as the "donut hole") generally trended downward until 2018 and has increased since then, with sharp increases since 2021.

Plan averages in metropolitan counties have been more favorable for nearly all these characteristics than those in micropolitan and noncore counties. However, plans in noncore counties are more likely to have premiums below the regional benchmark.

Discussion

Enrollment in Medicare Advantage plans accounted for more than half of the eligible Medicare population in 2023.[7] The steady climb in enrollment corresponds with an increasing number of plans available in the market. In 2023, the average Medicare beneficiary could choose from 43 MA plans, more than twice the number available in 2015. MA-PDs enrollment and plan availability follow a similar pattern, with the number of MA-PDs nationally increasing from 1,624 in 2015 to 3,558 in 2023 (Figure 1/Table 1). Eighty-nine percent of MA plans include prescription drug coverage.[8] Moreover, the average Medicare beneficiary can choose from 35 MA-PDs.[8] Several factors may make MA-PDs attractive to Medicare beneficiaries: They offer lower premiums and cost-sharing, and benefits coverage is bundled into one plan that beneficiaries can easily manage.[8] Seventy-three percent of MA-PD enrollees are in plans with $0 premiums. The average premium for MA-PDs is substantially lower than for drug coverage in PDPs.[9] Deductibles are also significantly lower in MA-PDs. Further, 60 percent of MA-PD enrollees do not pay a deductible.[9]

The geographical differences in MA-PD characteristics may place noncore enrollees at higher risk for financial hardship. In 2023, there were twice as many MA-PD plans in metropolitan counties as in noncore counties, averaging about 29 plan choices for enrollees in metropolitan counties compared to 16 plans available to enrollees in noncore counties (Figure 2/Table 2 and Figure 3/Table 3). The average monthly MA-PD premium is slightly higher in noncore counties than in metropolitan counties. The same pattern is found for cost-sharing responsibilities. More than half (55.5 percent) of MA-PDs in metropolitan counties have $0 deductibles, with a smaller proportion of such plans available in noncore counties (50.8 percent) (Figure 6/Table 6).

On average, enrollees living in metropolitan counties paid lower deductibles, while deductibles for enrollees in noncore counties were higher (Figure 5/Table 5). About 12 percent of MA-PDs in noncore counties have the highest deductibles compared to 8 percent in metropolitan counties. A greater proportion (61.8 percent) of MA-PDs in metropolitan counties have additional coverage for the coverage gap ("donut hole") compared to plans with additional coverage in noncore counties (58 percent) (Table 7). Notably, the coverage gap is eliminated by statute as of the end of 2025. The differences in MA-PD characteristics between noncore and metropolitan counties may be creating disparities in accessing prescription drugs associated with affordability and access issues.

Significant changes to Medicare Part D policies and benefit structure affected MA-PDs between 2014 and 2016. Figures/Tables 3-6 show that this period saw increasing trends in the availability of MA-PDs, sudden increases in the average deductible, sudden decreases in the percentage of such plans with $0 deductibles, and a gradual reduction in the average premium across geographies. The Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 may have affected these trends; they introduced significant modifications to the Medicare Part D drug benefit to lower the out-of-pocket costs for Part D enrollees when they reach the coverage gap. The law further reduced the out-of-pocket costs for those qualifying for catastrophic coverage between 2014 and 2019.[10] Within the same period, enrollment growth was associated with lower premiums offered to capture a larger market share.[11] Another factor for lower premiums was rebate increases and price concessions provided by drug manufacturers to Part D plan sponsors and pharmacy benefit managers. The rebate surge increased between 2014 and 2016, counterbalancing the rising costs of prescription drugs and lowering premiums for beneficiaries.[12]

Significant changes have been made to the Medicare Part D program under the Inflation Reduction Act of 2022. Several provisions aim to lower prescription drug spending and started taking effect in 2023, with complete implementation phasing in over the next several years. The most recent provisions included:[13]

- Limits on the price of insulin products to a maximum of $35 per month in all Part D plans.
- Eliminating cost sharing for adult vaccines covered under Medicare Part D.
- Expanding eligibility for Part D Low-Income subsidies.
- Requiring drug manufacturers to pay rebates to the federal government when prices for covered drugs under Part D and Part B increase faster than the inflation rate.
- Expanding eligibility for full benefits under the Part D Low-Income Subsidy program.
- Capping out-of-pocket spending by removing coinsurance above the catastrophic threshold in 2024 and adding a $2000 cap on spending in 2025.
- Negotiated prices for 10 Part D drugs available in 2026, with 10 additional drugs by 2029.

Significant changes to Medicare Part D plans can affect people living in nonmetropolitan counties. It is crucial to continue examining the effects of such policy changes to ensure support for beneficiaries across geographies, especially residents in rural areas, where poverty rates are higher, access to health services is lower, and health status is poorer. As the market grows and enrollment climbs among MA-PDs, it is essential to determine how well they serve rural populations.

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