# Patterns and Drivers of Medicare Advantage Enrollment Growth, 2017–2023

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*October 2024*

**In 2024, over half of Medicare enrollees received coverage through Medicare Advantage (MA) plans (Freed et al 2024a). MA has grown rapidly in the past decade, from about a third of Medicare enrollment in 2015 to over half in 2024. The growth of MA has important implications for the financial sustainability of the Medicare program because Medicare, on average, pays more for a beneficiary enrolled in MA than for a similar beneficiary enrolled in traditional Medicare (TM). As MA continues to grow, reducing overpayment will become more critical to preserve the long-term sustainability of the Medicare program. However, it is unclear how policy options to reduce overpayment may affect enrollment, as relatively few studies have explored what has driven MA enrollment growth in recent years. This brief builds on prior work to explore the patterns and drivers of MA enrollment growth from 2017 to 2023 (Skopec et al. 2019).**

The Affordable Care Act (ACA) included provisions designed to reduce overpayment to MA plans, and early projections suggested the ACA would reduce plan participation in the MA program and beneficiary enrollment (Foster 2010; Nicholas 2014).[1] However, MA has grown steadily since ACA implementation, increasing one to two percentage points per year as a share of Medicare enrollment between 2010 and 2019 (Freed et al. 2024a). Prior research exploring MA enrollment growth between 2009 and 2017 found that employer plans grew substantially over the study period and that MA enrollment grew more where beneficiaries had access to $0 premium plans and plans with quality

ratings of four or five stars (Skopec et al. 2019). Since then, MA enrollment growth has accelerated, from about 35 percent of Medicare enrollees in 2017 to 54 percent in 2024 (Freed et al. 2024a).

Medicare beneficiaries may enroll in MA coverage for a variety of reasons, including the supplemental benefits offered in MA plans (e.g., coverage for dental services, reduced cost-sharing), the streamlining of Medicare services across Parts A, B, and D coverage, MA advertising or advice from agents and brokers, and/or because their employer offers MA as a retiree benefit. MA plans are not expensive for beneficiaries; 75 percent of MA enrollees were in a plan that charged no premium in addition to the required Part B premium in 2024 (Freed et al. 2024a). On the other hand, enrollees may prefer TM for the program's wider hospital and provider networks or potentially greater access to post-acute care services from skilled nursing facilities or home health providers (Skopec et al. 2020a, 2020b; Huckfeldt et al. 2024). Although there are clear incentives for lower-income and potentially more price-sensitive enrollees to select MA coverage, particularly zero premium plans, TM coverage provides considerable access to care and financial protections for chronically ill patients or those who need specialized care. However, evidence suggests that only about one-third of Medicare beneficiaries actively compared their coverage options during open enrollment in 2022, suggesting enrollment choices may be quite sticky (Ochieng et al. 2024).

Given these incentives, we expect substantial differences across types of individuals in their propensity to enroll in MA over TM and differences in where MA insurers choose to expand. To investigate such patterns at the county level, we use several sources of MA administrative data from the Centers for Medicare and Medicaid Services (CMS), which we merged and aggregated where needed to the county level. This brief builds on prior research to explore the demographic, utilization, and MA market factors associated with changes in county-level MA enrollment over the 2017–23 period.

# Data and Methods

To explore the patterns and potential drivers of MA enrollment growth over the 2017–23 period, we used the following primary data sources from CMS:

- MA plan payment data, including payments, rebates, and average risk scores at the state-county-plan-type level[2]

- MA enrollment by contract, plan, state, and county files[3]

- MA landscape files, which describe out-of-pocket maximums, drug deductibles, premiums, and quality stars for MA plans[4]

- monthly Medicare enrollment files, including the number and demographic characteristics of beneficiaries[5]

- Medicare geographic variation files, including characteristics and health care utilization of TM beneficiaries[6]

- quality-adjusted MA benchmarks by county, constructed using data and methods described in Shartzer, Pugazhendhi, and Garrett (2024)

We conducted both descriptive and multivariate analyses. Our descriptive analyses explore how MA enrollment grew by plan type over the 2017–23 period using the plan types shown in table 1 below. We also examined how MA enrollment growth varied by region.

Our analysis excluded Programs of All-Inclusive Care for the Elderly and demonstration plans, including dual eligible demonstrations. Our analysis included plans reimbursed based on 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.

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 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. |

**Source:** Laura Skopec, Stephen Zuckerman, Eva H. Allen, and Joshua Aarons, "Why Did Medicare Advantage Enrollment Grow as Payment Pressure Increased?," Washington, DC: Urban Institute, April 24, 2019.
**Notes:** CMS = Centers for Medicare & Medicaid Services; MA = Medicare Advantage.

Our multivariate analyses examine how county characteristics in 2017 drove changes in MA enrollment shares from 2017 to 2023. Specifically, we estimate a linear regression model of county-level growth in the MA share of Medicare enrollees from 2017 to 2023 across counties on the 2017 MA market share and 2017 county variables that capture the following:

- total MA enrollment

- distribution of all Medicare enrollees by age and race/ethnicity

- quality-adjusted MA benchmarks

- MA market concentration

- characteristics of MA plans offered

- characteristics of TM enrollees (average age, share with dual status, and average risk scores)

- selected measured of TM utilization (emergency department [ED] visits, inpatient stays, skilled nursing facility stays, and home health episodes)

We show the specific measures that capture each of these variable categories and their summary statistics in table 4.

# Findings

## Descriptive Analyses of MA Enrollment Growth

Enrollment in MA HMO, PPO, and Special Needs Plans (SNPs) grew substantially between 2017 and 2023 (table 2). The largest growth over this period was in PPO plans, which added 4.2 million beneficiaries and accounted for 35 percent of the growth in MA. SNPs—which enroll Medicare beneficiaries who are dually eligible for Medicare and Medicaid, have certain chronic conditions, or are institutionalized—added 3.6 million enrollees and accounted for nearly 30 percent of the growth in MA between 2017 and 2023. SNPs had just 2.1 million enrollees nationally in 2017, and as of 2023, more than 90 percent of enrollees in SNPs were dual eligibles.[7]

In contrast, enrollment in Employer Group Wavier Plans, which expanded rapidly between 2010 and 2017 (Skopec et al. 2019), grew by only 1.7 million between 2017 and 2023. Employer Group Wavier Plans are only open to retirees of participating employers, and the decline in the availability of employer-sponsored health insurance for retirees may have limited growth in these plans (Skopec and Zuckerman 2024). Finally, cost plans and private fee-for-service plans have largely fallen out of favor with beneficiaries and insurers, and as of 2023, fewer than 1 million beneficiaries were enrolled in those two plan types combined.

TABLE 2

**Changes in Medicare Advantage Enrollment by Plan Type, 2017–23**

| Plan type | 2017 | | 2023 | | 2017–23 | |
|---|---|---|---|---|---|---|
| | Millions enrolled | Share of MA enrollees (%) | Millions enrolled | Share of MA enrollees (%) | Change | Share of change |
| HMO | 9.1 | 48.2 | 12.2 | 39.4 | 3.1 | 25.6 |
| PPO | 3.4 | 17.9 | 7.6 | 24.5 | 4.2 | 34.9 |
| PFFS | 0.2 | 1.0 | 0.0 | 0.1 | -0.1 | -1.2 |
| Cost | 0.6 | 3.0 | 0.2 | 0.6 | -0.4 | -3.2 |
| SNP | 2.1 | 11.1 | 5.7 | 18.3 | 3.6 | 29.8 |
| EGWP | 3.6 | 18.9 | 5.3 | 17.0 | 1.7 | 14.1 |
| **Total** | **18.9** | **100.0** | **30.9** | **100.0** | **12.0** | **100.0** |

**Source:** Urban Institute analysis of CMS 2017 and 2023 Medicare Advantage Enrollment Files.

**Notes:** MA = Medicare Advantage; HMO = health maintenance organization; PPO = preferred provider organization; PFFS = private fee-for-service; SNP = special needs plan; EGWP = employer group waiver plans.

MA enrollment growth also varied across regions between 2017 and 2023, though all regions saw increases in MA enrollment (table 3). The South Atlantic region accounted for 22.7 percent of the MA enrollment growth over the study period, while the next fastest-growing region, East North Central, accounted for 16.8 percent of enrollment growth. New England, expanding from 0.7 million to 1.4 million between 2017 and 2023 contributed the least to MA enrollment growth. Overall, the South Atlantic, East North Central, and Pacific regions were home to over half of all MA enrollees in 2023.

TABLE 3

**Changes in Medicare Advantage Enrollment by Region, 2017–23**

| Region | 2017 | | 2023 | | 2017–23 | |
|---|---|---|---|---|---|---|
| | Millions enrolled | Share of MA enrollees (%) | Millions enrolled | Share of MA enrollees (%) | Change | Share of change |
| New England | 0.7 | 3.6 | 1.4 | 4.4 | 0.7 | 5.6 |
| Middle Atlantic | 2.7 | 14.5 | 4.0 | 13.0 | 1.3 | 10.7 |
| East North Central | 2.8 | 15.0 | 4.9 | 15.7 | 2.0 | 16.8 |
| West North Central | 1.2 | 6.3 | 1.9 | 6.2 | 0.7 | 5.9 |
| South Atlantic | 3.7 | 19.7 | 6.5 | 20.9 | 2.7 | 22.7 |
| East South Central | 1.2 | 6.2 | 2.1 | 6.7 | 0.9 | 7.4 |
| West South Central | 1.9 | 9.9 | 3.4 | 11.1 | 1.6 | 13.0 |
| Mountain | 1.3 | 7.1 | 2.2 | 7.1 | 0.8 | 7.0 |
| Pacific | 3.3 | 17.7 | 4.7 | 15.0 | 1.3 | 10.9 |
| **Total** | **18.9** | **100.0** | **30.9** | **100.0** | **12.0** | **100.0** |

**Source:** Urban Institute analysis of CMS 2017 and 2023 Medicare Advantage Enrollment Files.

**Note:** MA = Medicare Advantage. A list of states in each Census region is available in Appendix table A.1.

As an exploratory analysis, we examined how the change in MA penetration (share) from 2017 to 2023 related to the base year level of the MA share, shown in the scatterplot of figure 1. Each small circle represents a single county. The scatterplot suggests there is a nonlinear bivariate relationship between a county's starting MA penetration in 2017 and its growth in MA penetration between 2017 and 2023. We fit a smoothed regression curve to the scatterplot data, which produced the pronounced

inverted U-shape curve, also shown in figure 1. The pattern indicates that a higher initial penetration rate is associated with higher growth for counties with initial MA penetration levels below about 20 percent. However, above 20 percent, a higher MA share is associated with lower growth, which suggests there may be a saturation point beyond which it becomes more difficult for MA to expand within a market. The curve in figure 1 approximates a quadratic function, and so in the multivariate regression analysis that follows, we include both the 2017 MA share and the squared MA share as explanatory variables to capture the nonlinear relationship and test whether it remains after we condition on other covariates. In an analysis of similar data from 2007 to 2014, Johnson et al. (2016) found that counties in the highest quartile of growth over the period had the highest MA share in their baseline year. This was interpreted as indicating that the national increase in MA penetration was driven more by plans increasing their share in existing markets than by plans entering new markets. Figure 1 suggests the pattern has shifted from prior years, with MA growth tapering off or maxing out in markets with high MA penetration in 2017.

**Nonlinear Relationship Between 2017 MA Enrollment Share and 2017–23 Change in Enrollment**
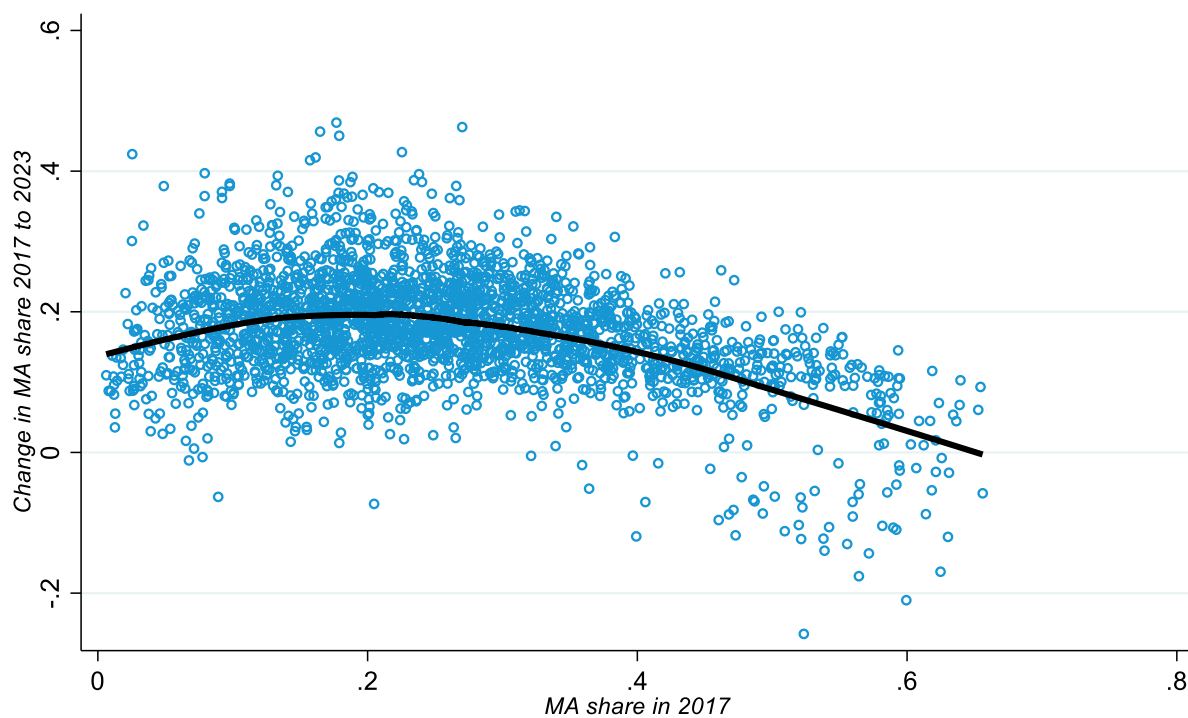
**Source:** Urban Institute analysis of CMS 2017 and 2023 Medicare Advantage Enrollment Files.
**Notes:** MA = Medicare Advantage. Each point in the scatterplot represents a county in 2017. The curve in black is a locally weighted scatterplot smoothing (LOWESS) fit to the data, showing an approximately quadratic relationship. LOWESS bandwidth = 0.8.

## Multivariate Analyses of the Drivers of MA Enrollment Growth

Table 4 reports summary statistics for variables used in the regression analysis. The mean change in MA share (dependent variable) from 2017 to 2013 was 17.5 percent, with a standard deviation of 7.6 percent. The mean MA share across counties in 2017 was 25.3 percent, with a standard deviation of 13.1 percent. On average, nearly 16 percent of Medicare beneficiaries were under age 65 and therefore qualified for Medicare through disability, end-stage renal disease, or ALS. The average county Herfindahl–Hirschman index (HHI) was more than 5,700, reflecting a very high level of MA insurer concentration in many markets. The Department of Justice considers a market highly concentrated with an HHI above 2,500. The average share of TM enrollees dually eligible for Medicare and Medicaid (i.e., enrolled) was nearly 22 percent.

TABLE 4
**Summary Statistics for Analysis Variables**

| Variable | Mean | Standard deviation |
|---|---|---|
| Change in MA share 2017 to 2023 | 0.175 | 0.076 |
| MA share in 2017 | 0.253 | 0.131 |
| Squared MA share in 2017 | 0.081 | 0.079 |
| Share of Medicare beneficiaries under age 65 | 0.159 | 0.052 |
| Share of Medicare beneficiaries ages 65 to 69 | 0.253 | 0.021 |
| Share of Medicare beneficiaries ages 70 to 74 | 0.219 | 0.019 |
| Share of Medicare beneficiaries who are Black, non-Hispanic | 0.088 | 0.139 |
| Share of Medicare beneficiaries who are Hispanic | 0.040 | 0.101 |
| Share of Medicare beneficiaries who are Asian or Pacific Islander | 0.007 | 0.023 |
| Dual share of TM beneficiaries | 0.218 | 0.086 |
| Average risk score of TM beneficiaries | 0.971 | 0.090 |
| Enrollment-weighted share with zero additional premium to enrollee | 0.280 | 0.288 |
| County has a 5-star contract plan | 0.051 | 0.220 |
| Enrollment-weighted average overall quality stars | 3.68 | 0.44 |
| Log of MA enrollment | 7.44 | 1.60 |
| Hirschman-Herfindahl Index / 1,000 | 5.72 | 2.26 |
| Average age of TM beneficiaries | 71.1 | 1.6 |
| County enrollment-weighted quality-adjusted MA benchmark | 837.6 | 48.0 |
| Enrollment-weighted average additional premium to enrollee | 46.0 | 26.8 |
| Enrollment-weighted average deductible for drug plan for plans with drug plan | 195.8 | 100.7 |
| Enrollment-weighted average maximum out-of-pocket | 5862.4 | 882.1 |
| Inpatient covered stays per 1,000 TM beneficiaries | 271.5 | 47.0 |
| Emergency department visits per 1,000 TM beneficiaries | 722.2 | 136.5 |
| Skilled nursing facility stays per 1,000 TM beneficiaries | 65.8 | 17.8 |
| Home health episodes per 1,000 TM beneficiaries | 172.5 | 120.9 |

**Source:** Urban Institute analysis of CMS Medicare Advantage administrative data.
**Note:** MA = Medicare Advantage; TM = traditional Medicare. N = 2,649.

Table 5 presents the results of our multivariate regression model of the change in MA enrollment share from 2017 to 2023 as a function of baseline county characteristics in 2017. Overall, the model explains 61 percent of the variation in MA enrollment share growth. The MA enrollment share and its square are statistically significant individually and jointly. The marginal effect of the 2017 share on the

change in MA share depends on the level of the 2017 MA share and is shown in the upper-left graph of figure 2. The shape of the curve, shown with its 95-percent confidence interval range at each point, is similar to that in figure 1. Holding other variables fixed at their average values, the predicted change in MA share is around 20 percentage points for counties with 2017 MA shares of 25 percent or less. Counties with initial MA shares that are increasingly greater than 25 percent have smaller and smaller predicted increases in MA shares until MA shares reach about 60 percent, after which predicted changes in 2017 to 2023 MA shares are zero or negative.

After controlling for the 2017 baseline share of Medicare enrollees in an MA plan, we find that characteristics of all Medicare beneficiaries in a county, the MA market, and aspects of TM all explain the change in MA penetration between 2017 and 2023 (table 5). Counties with larger shares of Medicare enrollees under age 65 experienced substantially greater growth in MA penetration. For each one percentage point increase in the share of Medicare enrollees under age 65, MA penetration increased by 0.36 percentage points. This can be seen from the regression coefficient, and the magnitude can also be seen in context in the upper-right chart in figure 2. The share of beneficiaries who were Black or Hispanic was also significantly related to the growth in MA penetration, but the magnitudes of the relationships were smaller. For either of these racial or ethnic groups, a one percentage point higher share of Medicare enrollees was only associated with about a 0.03 to 0.04 percentage-point higher increase in MA penetration. A one-percentage-point greater share of Asian Americans and Pacific Islanders among Medicare enrollees was associated with about 0.2-percentage-point smaller change in MA penetration.

TABLE 5

**Linear Regression Estimates of 2017–23 MA Enrollment Change as Function of 2017 County Characteristics**

| | Change in MA share 2017 to 2023 | |
|---|---|---|
| MA share in 2017 | 0.1864 | (4.97) |
| Squared MA share in 2017 | -0.8137 | (-13.55) |
| Share of Medicare beneficiaries under age 65 | 0.3626 | (6.49) |
| Share of Medicare beneficiaries ages 65 to 69 | -0.0318 | (-0.43) |
| Share of Medicare beneficiaries ages 70 to 74 | 0.1329 | (1.57) |
| Share of Medicare beneficiaries who are Black, non-Hispanic | 0.0348 | (3.80) |
| Share of Medicare beneficiaries who are Hispanic | 0.0393 | (3.28) |
| Share of Medicare beneficiaries who are Asian or Pacific Islander | -0.1913 | (-3.02) |
| Dual share of TM beneficiaries | 0.1198 | (5.20) |
| Average risk score of TM beneficiaries | 0.0830 | (3.82) |
| Enrollment-weighted share with zero additional premium to enrollee | 0.0096 | (1.85) |
| County has a 5-star contract plan | -0.0121 | (-2.41) |
| Enrollment-weighted average overall quality stars | 0.0073 | (2.07) |
| Log of MA enrollment | 0.0024 | (2.19) |
| Herfindahl-Hirschman index / 1,000 | -0.0033 | (-5.94) |
| Average age of TM beneficiaries | -0.0053 | (-2.83) |
| County enrollment-weighted quality-adjusted MA benchmark | -0.000103 | (-3.71) |
| Enrollment-weighted average additional premium to enrollee | 0.000089 | (1.42) |
| Enrollment-weighted average deductible for drug plan for plans with drug plan | 0.0000043 | (0.34) |
| Enrollment-weighted average maximum out-of-pocket | 0.0000020 | (1.18) |
| Inpatient covered stays per 1,000 TM beneficiaries | -0.0000702 | (-1.99) |
| Emergency department visits per 1,000 TM beneficiaries | 0.0000448 | (4.13) |
| Skilled nursing facility stays per 1,000 TM beneficiaries | -0.0002254 | (-2.97) |
| Home health episodes per 1,000 TM beneficiaries | 0.0000547 | (4.85) |
| Intercept | 0.418 | (2.63) |
| Number of observations | 2,649 | |
| R-squared | 0.61 | |

**Source:** Urban Institute analysis of CMS Medicare Advantage administrative data.
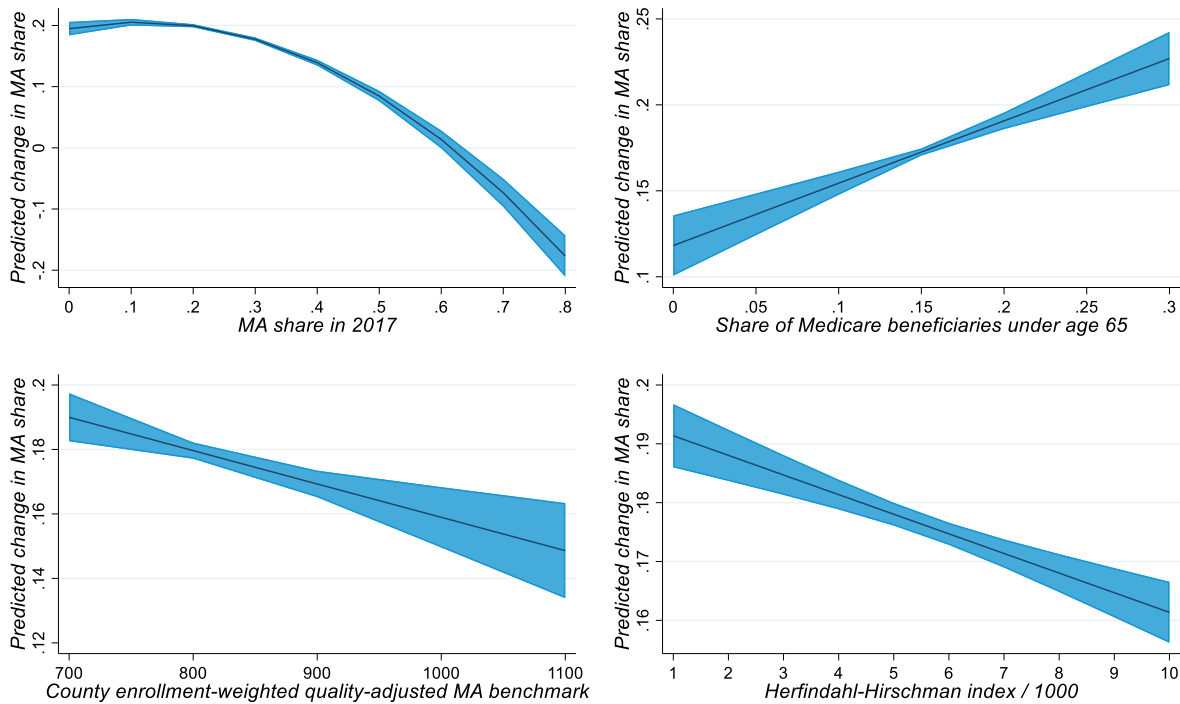
**Note:** MA = Medicare Advantage; TM = traditional Medicare. Linear regression coefficients reported with t-statistics in parentheses based on robust standard errors.

The results also show that counties in which the MA market was already relatively concentrated in 2017, as measured by the HHI, and in which plans faced high quality-adjusted benchmarks were likely to experience smaller changes in MA penetration. A $100 higher MA benchmark was related to about a one percentage point smaller change in MA penetration (figure 2, bottom-left chart). As the HHI increases from, say, 4,000 to 5,000, the model estimates that MA penetration changes would be 0.3 percentage points smaller (figure 2, bottom-right chart).

Since MA draws enrollment from new Medicare beneficiaries or existing beneficiaries in TM, it is unsurprising that the characteristics of TM enrollees and their health care use are related to changes in MA penetration. Counties with TM enrollees who are, on average, younger, more likely to be dually eligible for Medicaid, and have higher risk scores are also more likely to experience greater growth in MA penetration. The findings also suggest that counties in which TM enrollees use more institutional

care (inpatient or skilled nursing facility stays) see smaller changes in MA penetration, while those with more ED or home health use have larger increases in MA penetration.

**Predicted 2017–23 Change in MA Share at Levels of Selected Explanatory Variables Holding Other Covariates Fixed**

**Source:** Urban Institute analysis of CMS Medicare Advantage administrative data.
**Note:** MA = Medicare Advantage. Linear regression coefficients reported with t-statistics in parentheses based on robust standard errors. Scales of y-axes differ across panels.

Table 6 groups counties into quintiles based on the regression model's predicted change in MA penetration and shows how the actual change in penetration and selected explanatory variables vary across these quintiles. This table aims to show how well actual changes in MA penetration track the model's predictions of MA penetration changes and its relations to the other predictors in the model. Between the first and fifth quintiles based on the predictions, there is more than a two-and-a-half-fold difference in the actual change in MA penetration growth. In the lowest quantile, the actual change in share was 9.4 percentage points and the 2017 share was 35.4 percent. In the highest quintile, the actual change in share was 25.3 percentage points, and the initial share was 20.6 percent.

TABLE 6
**County Characteristics by Quintile of Predicted 2017 to 2023 Change in Enrollment Share**

| Quintile of predicted change in enrollment share | 2017 to 2023 change in MA enrollment share | 2017 MA enrollment share | Medicare share under age 65 | Dual share in TM | Medicare share Black, non-Hispanic | Medicare share Hispanic | ER visits per 1,000 TM beneficiaries | Home health episodes per 1,000 TM beneficiaries |
|---|---|---|---|---|---|---|---|---|
| 1 | 0.094 | 0.354 | 0.112 | 0.170 | 0.029 | 0.033 | 625 | 117 |
| 2 | 0.149 | 0.245 | 0.127 | 0.166 | 0.043 | 0.038 | 652 | 134 |
| 3 | 0.181 | 0.241 | 0.152 | 0.196 | 0.068 | 0.043 | 710 | 168 |
| 4 | 0.203 | 0.228 | 0.179 | 0.239 | 0.109 | 0.037 | 770 | 194 |
| 5 | 0.253 | 0.206 | 0.225 | 0.321 | 0.194 | 0.048 | 855 | 247 |

**Source:** Urban Institute analysis of CMS Medicare Advantage administrative data.

**Note:** MA = Medicare Advantage; TM = traditional Medicare. Quintiles are computed for predicted values from the regression model reported in table 5. N = 2,649.

The differences in mean levels of predictors across the quintiles in table 6 generally track the coefficient estimates in the regression model, but because predictor variables are correlated, their total variation with the predicted value can be more or less than the partial regression effect. The Medicare share under age 65 in the highest quintile (22.5 percent) is twice that in the lowest quintile (11.2 percent). The dual share in TM is also substantially higher (32.1 percent in the highest quintile of the prediction and 17.0 percent in the lowest quintile). The share of Medicare enrollees who are Black varies by more than six-fold across the quintiles, although the regression would have suggested a more modest relationship. That is because the share who are Black is highly correlated with other covariates (e.g., share of Medicare enrollees under age 65 and share dual enrollees). ED visits and home health episodes per 1,000 TM beneficiaries are substantially higher in the highest quintile than in the lower quintiles, indicating higher expected MA growth in counties with higher utilization of these services.

## Discussion

Between 2017 and 2023, over one-third of the growth in MA was in PPOs. MA PPO premiums, including Part D coverage, declined from an average of $55 in 2017 to $17 in 2023, making them far more competitive with MA HMOs, which had average premiums of $28 in 2017 and $14 in 2023 (Freed et al. 2024b). During this period, MA rebates also increased substantially, which allowed PPOs to offer supplemental benefits alongside their broader provider networks, attracting more beneficiaries (MedPAC 2024).

SNPs also accounted for a large share of the growth in MA over the 2017–23 period (29.8 percent), and most new SNP enrollees were dual eligible.[8] Research shows that, between 2018 and 2024, D-SNP plan offerings more than doubled (Freed et al. 2024c), making these plans available to more beneficiaries and increasing competition in the D-SNP market. As of 2024, D-SNPs were more likely than other MA plans to offer supplemental benefits that may be attractive to dual-eligibles, like over-the-counter drug benefits, transportation, meals, and in-home supportive services (Freed et al. 2024c). Our multivariate analysis found that MA grew more in counties with a higher share of traditional Medicare beneficiaries who are duals, suggesting that MA plans may be disproportionately entering markets with large numbers of dual eligibles or more successfully competing for enrollment in those markets.

Our multivariate analysis identified multiple factors associated with MA growth over the study period. We found that growth was faster in counties that started with fewer beneficiaries in MA, suggesting that MA enrollment growth may be starting to top out in high-penetration counties. This has important implications for modeling likely MA growth patterns and potential policies to adjust MA benchmarks to rely less on TM spending. We similarly found that MA growth was faster in counties with lower benchmarks, which at first blush seems counterintuitive. However, counties with high MA benchmarks already had high MA penetration in 2017 and therefore had less room for growth over the study period.

We also found that counties with more ED use and more home health use but fewer inpatient hospitalizations and less SNF use had more MA enrollment growth. This suggests MA plans may be disproportionately entering or competing for enrollment in markets where there appears to be utilization that MA can control. MA enrollees tend to receive less post-acute care, particularly home health care, than traditional Medicare enrollees, and MA payment policies and prior authorization requirements likely play a role in these differences (Skopec et al. 2020a, 2020b). Some studies also suggest MA enrollees with high health care needs or chronic conditions have fewer ED visits than similar traditional Medicare enrollees (Antol et al. 2022; Avalere Health 2023), though a 2023 study found more potentially avoidable ED visits in overall MA (Beckman et al. 2023).

Overall, MA growth between 2017 and 2023 appears to be driven by populations and in geographic areas that were not historically the primary source of MA enrollment. Dual eligibles, beneficiaries interested in broader networks via PPOs, and geographic areas with historically low MA penetration all saw significant increases in MA enrollment over our study period. The growth in SNPs, in particular, raises questions about whether MA can integrate Medicare and Medicaid services more effectively than other approaches (MACPAC 2020), as well as whether low-income, high-need beneficiaries receive high-quality care in MA plans (Freed et al 2024c).

The growth of MA has important implications for the long-term financial sustainability of the Medicare program, as MA plans are generally overpaid through a combination of their payment benchmarks, the quality bonus program, and the risk adjustment system (MedPAC 2024). New populations entering MA may have implications for policy approaches to addressing these overpayments. For example, the long-standing pattern of MA plans coding more diagnoses to receive additional risk adjustment payments will likely accelerate with the influx of dual eligibles and beneficiaries with chronic conditions into MA (Skopec, Garrett, and Gangopadhyaya 2023), while the growth of PPOs may make it more difficult for MA plans to tightly manage costs through referral requirements. Additional research is needed to assess how policy changes to reign in MA overpayments may affect MA markets and beneficiary choices in the current era.

# Appendix

**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 |

**Source**: Laura Skopec, Stephen Zuckerman, Eva H. Allen, and Joshua Aarons. "Why Did Medicare Advantage Enrollment Grow as Payment Pressure Increased?," Washington, DC: Urban Institute, April 24, 2019, https://www.urban.org/research/publication/why-did-medicare-advantage-enrollment-grow-payment-pressure-increased.

# Notes

[1] "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.

[2] "Plan Payment Data," CMS.gov, accessed October 16, 2024, https://www.cms.gov/medicare/health-drug-plans/plan-payment-data.

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# Acknowledgments

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