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Differences in Part D Plans Offered to Rural and Urban Medicare Beneficiaries

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Key Findings

- Standalone Medicare Part D prescription drug plans (PDPs) available to beneficiaries varied little in premiums, copays, deductibles, the availability of enhanced plans, and gap coverage across urban and rural areas.
- The average number of available Medicare Advantage Part D plans (MA-PDPs) was significantly higher in urban counties compared to more-densely populated and less-densely populated rural counties.
- The average deductible and average premium for available MA-PDPs varied significantly among the three geographic areas. Urban areas had the lowest costs, followed by more-densely populated and less-densely populated rural areas.
- Enhanced MA-PDPs showed more differences (e.g., in premiums, deductibles, and copayments) between more-densely populated and less-densely populated rural areas than the basic MA-PDPs.

Purpose

This policy brief builds on past research to analyze how the plan options available to rural and urban beneficiaries differ in terms of premiums, deductibles, and copayments, as well as differences in plan options within rural areas.

Background

The Medicare Part D program enables private insurers to offer prescription drug coverage to Medicare enrollees. Benefit packages must meet a floor in terms of their offerings, and must be priced equivalent to a federally-determined actuarial standard. Insurers may offer standalone prescription drug plans (PDPs) or provide prescription drug coverage as part of a Medicare Advantage plan (MA-PDP).

PDPs are available at a regional level; the 34 PDP regions nationwide cover as few as one or as many as seven states. PDPs must be offered to all eligible beneficiaries within the region. MA-PDPs are offered at the county level. Under most circumstances, Medicare Advantage providers must provide at least one MA-PD option, and enrollees in these plans may not choose PDPs.

Although Part D plans must offer a federally-defined standard benefit, many provide actuarially-fair equivalents instead; for example, providers may raise deductibles but lower premiums. Many plans also adjust the cost-sharing amounts for different drug types, pricing them in up to six tiers. The federally-defined standard benefit lacks such tiers, but only 11 percent of all available PDPs and five percent of MA-PDPs operated without them in 2011.[1]

Most plans offer "enhanced benefits" that carry greater actuarial value than the standard benefit. For example, plans may offer non-mandatory coverage in the coverage gap* between a plan's spending limit and federally-supplied catastrophic coverage. Plans may also offer lower deductibles, cost-sharing levels, or premiums, or they may offer different tiers or cost levels for grouping of different drugs.

*The Affordable Care Act is phasing this "donut hole" out for beneficiaries in this situation by decreasing their share of drug costs annually until it reaches 25 percent in 2020.

Previous research has explored the differences in enrollment rates and plan premiums between rural and urban areas.[2,3] These analyses found that rural residents were slightly less likely than urban residents to be enrolled in Part D plans, were less likely to be enrolled in MA-PDPs, and faced higher MA-PD premiums.

Approach

Data from the Centers for Medicare and Medicaid Services' (CMS) 2011 Part D Plan Characteristics File (PCF) were analyzed to determine whether rural and urban beneficiaries can choose from a similar number of plans at similar prices as measured by premiums, deductibles, and copayments. Within the PCF, plans are listed by contract and plan designations; providers may offer more than one plan under each contract.

In 2011, 1,177 unique PDP contract-plan combinations were offered across the nation's 34 PDP regions, and 1,943 unique MA-PDs were identified. The following Part D plan types were included in this analysis: Health Maintenance Organization (HMO), Health Maintenance Organization Point of Service (HMOPOS), Local Preferred Provider Organization (LOCAL PPO), Private Fee for Service (PFFS), 1876 Cost (a plan operated by an HMO under section 1876 of the Social Security Act), Prescription Drug Plan (PDP), and Regional Preferred Provider Organization (PPO). Special Needs Plans were not included because these plans are

Table 1. Availability of MA-PDPs by Location

		Rural	
% of Counties with # of Plans[a]	Urban	Micropolitan	Non-Core
0 Plans	0.3%	0.5%	1.6%
1 Plan	0.1%	0.5%	1.1%
2-5 Plans	16.4%	28.2%	30.1%
More than 5 Plans	83.3%	70.8%	67.2%

[a]Only MA-PDPs are listed here, since all counties have more than five PDPs.

Table 2. Urban/Rural Differences in Plan Offerings and Characteristics

		Urban	Micropolitan	Non-Core	Significant Differences
County Makeup	Overall	37.1%	20.4%	42.4%	
	%MA-PD	28.9%	21.4%	20.4%	d
	%PDP	71.1%	78.6%	79.7%	d
Average # of Plans	Overall	46 (31-82)	43(31-64)	43(31-62)	a, b
	MA	11(1-47)	8(1-24)	8(1-22)	a, b
	PDP	35(30-40)	35(30-40)	35(31-40)	
Average Premium (Total Premium Net of Rebate)	Overall	$46.82	$49.12	$49.95	d
	MA	$22.52	$26.78	$28.45	d
	PDP	$54.43	$54.35	$54.75	
% with Enhanced Plans	Overall	51.6%	48.2%	47.1%	d
	%MA-PD	79.3%	71.0%	65.8%	d
	%PDP	42.9%	42.8%	42.3%	
Deductible Amount *Range is $0-$310*	Overall	$133.13	$143.14	$147.02	d
	MA	$54.16	$77.35	$92.23	d
	PDP	$157.89	$158.53	$159.27	
% with $0 Deductible	Overall	48.8%	44.7%	43.0%	d
	%MA-PD	76.5%	66.7%	60.4%	d
	%PDP	40.0%	39.6%	39.1%	b
% with Highest Deductible ($310)	Overall	35.9%	38.4%	39.2%	a, b
	%MA-PD	11.3%	15.6%	17.9%	d
	%PDP	43.6%	43.7%	43.9%	
Avg 1-Month Copay for In-Network Pharmacy, Pre Coverage	Total	$17.18	$16.94	$16.71	d
	MA	$19.87	$19.74	$19.28	b, c
	PDP	$16.24	$16.23	$16.10	b

[a]Urban vs. Micropolitan; [b]Urban vs. Non-Core; [c]Micropolitan vs. Non-Core; [d]All significantly different.

Table 3. Urban/Rural Differences between Basic and Enhanced MA-PDPs

		Urban	Micropolitan	Non-Core	Significant Differences
County Makeup	% MA-PD	**28.89%**	**21.42%**	**20.35%**	d
	Basic	20.68%	29.03%	34.16%	d
	Enhanced	79.32%	70.97%	65.84%	d
Average # of Plans	MA-PD	**11 (1-47)**	**8(1-24)**	**8(1-22)**	a, b
	Basic	2.46 (1-8)	2.52(1-7)	2.80(1-11)	b, c
	Enhanced	8.77 (1-47)	5.94(1-23)	5.31(1-20)	d
Average Premium	MA-PD	**$22.52**	**$26.78**	**$28.45**	d
	Basic	$24.46	$24.35	$24.23	
	Enhanced	$22.02	$27.78	$30.64	d
Deductible Amount	MA-PD	**$54.16**	**$77.35**	**$92.23**	d
	Basic	$211.80	$218.75	$221.31	b
	Enhanced	$13.07	$19.51	$25.26	d
% with $0 Deductible	MA-PD	**76.5%**	**66.7%**	**60.4%**	d
	Basic	19.4%	16.9%	14.8%	b
	Enhanced	91.4%	87.0%	84.0%	d
% with Highest Deductible ($310)	% MA-PD	**11.26%**	**15.55%**	**17.88%**	d
	Basic	53.66%	53.43%	52.28%	
	Enhanced	0.21%	0.05%	0.03%	b
Average Copay Across All Tiers	MA-PD	**$19.87**	**$19.74**	**$19.28**	b, c
	Basic	$19.69	$18.67	$18.42	a, b
	Enhanced	$19.90	$20.02	$19.57	b, c

[a]Urban vs. Micropolitan; [b]Urban vs. Non-Core; [c]Micropolitan vs. Non-Core; [d]All significantly different.

specifically for persons with certain diseases or characteristics; they only include a very small percentage of the population.

Beneficiaries were classified as residing in urban (metropolitan), micropolitan, (more-densely populated rural), or non-core (less-densely populated rural) counties based on Office of Management and Budget (OMB) definitions; we also analyzed all rural counties together.

SAS 9.3 software was used to compare both PDP and MA-PD plan characteristics between counties. Differences in plan offerings were tested using proc means and anova tests, and are reported where they are statistically significant at a 95% confidence level.

Results

Across all counties, PDPs account for 71.1% of Part D plans in urban counties, 78.6% in micropolitan counties, and 79.7% in non-core counties (all significantly different from each other) (Table 2).

All urban and rural counties have more than five PDPs available, and the vast majority of counties, including 99.5% of micropolitan and 98.4% of non-core counties, have at least one MA-PDP. On average, counties have 35 PDPs, regardless of rurality. Beneficiaries in urban areas have more choices of MA-PDPs. Just over two-thirds (67.2%) of non-core counties have more than five MA-PD options, compared to 70.8% of micropolitan and 83.3% of urban counties (Table 1).

Consistent with past research showing that rural and urban premiums differ very little for PDPs,[4] our analysis showed that PDPs do not differ by location across many of the plan characteristics examined, including premiums, the percent of enhanced plans, and deductibles. This is to be expected—because PDP markets are determined on a regional level, a rural county resident will have access to the same plans as an urban county resident within the same PDP region. Across all areas, MA-PDPs have lower average premiums compared to PDPs. MA-PDPs can use rebate money to lower their monthly premiums and offer enhanced benefits; this is common practice, resulting in enhanced offerings and lower average monthly premiums compared to PDPs.[5]

The average number of MA-PDPs in urban areas (11) is significantly higher than micropolitan (8) and non-core areas (8) (Table 3). When the availability of enhanced plans is examined, all areas are significantly different from each other (averages of 9, 6, 5, respectively). The average premium is significantly different among the geographic areas for MA-PDPs overall and within the enhanced

plans. Urban areas have the lowest premium followed by micropolitan and non-core areas. Deductibles differ among all areas in the enhanced plans with urban areas having the lowest followed by micropolitan and then non-core areas. This is largely due to the higher percentage of MA-PDPs with a $0 deductible in urban areas.

No gap coverage is offered among the basic MA-PDPs. Urban areas have a significantly lower percentage of enhanced MA-PDPs offering some gap coverage across most tiers than rural areas. With the exception of Tier 4, pharmacy copay amounts are lower in urban areas than in rural areas.

A zero-deductible plan offering is offered in a higher percentage of basic and enhanced plans in urban areas, followed by micropolitan and non-core; all are significantly different from each other.

The highest federally-allowed deductible in 2011 was $310. Urban counties have a lower percentage of plans with the highest deductible than rural counties. However, among only basic plans, more than half have the highest deductible, with no differences by location.

Discussion

Consistent with previous literature,[2-4] we found few urban/rural differences in the availability and characteristics of PDPs, but did identify significant differences among MA-PDPs. This is likely due to the nature of the geographic structure of PDPs.

Before it can be understood whether a lack of MA-PDP offerings may harm rural residents, further research is needed on how rural residents choose between PDPs and MA-PDPs, and how satisfied they are with their current plan offerings. This should take place within the context of a broader investigation of how rural residents decide between traditional Medicare and Medicare Advantage.

This analysis indicates that MA-PDPs differ between urban and rural areas, with further differences by micropolitan and non-core areas. In particular, urban areas have more MA-PDPs to choose from; those plans, on average, have lower premiums, deductibles, and copays than plans available to rural residents. This should raise concerns for policymakers, as it suggests increased financial barriers for rural residents, which may prevent them from filling necessary prescriptions. More research needs to be done to better understand how plan satisfaction, prescription drug behavior, and resulting health outcomes differ by urban/rural status.

Our results also identified important differences between micropolitan and non-core areas, with non-core areas having the highest cost burden across most measures. In the future, research on rural access to Part D plans should analyze differences in micropolitan and non-core counties, in addition to rural-urban differences.

Conclusions

This brief identifies important urban/rural differences in the availability and characteristics of Part D plans, as well as differences by degree of rurality. We find that urban beneficiaries tend to have access to more plans and lower cost burdens than rural residents, a disparity which could have important health and financial consequences for rural residents. Our analysis of plan options revealed further differences between micropolitan and non-core rural counties, with the fewest plan options and highest cost burdens in the most-rural areas. Separating the two categories provides more clarity on the relationships between geography and Part D plan markets.■

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