

Table 12.11
Access to Medicare+Choice (M+C)/Medicare Advantage (MA) Coordinated Care Plans (CCP),
Private Fee-for-Service (PFFS) Plans, or Preferred Provider Organization (PPO)
Demonstration Projects, Rural Areas, by Type of Coverage: Calendar Years 1999-2009

Year	Any M+C/MA CCP, PFFS Plan, or PPO Demo Plan	Any M+C/MA CCP Plan	Any Zero Premium Plan	Any Plan with Drug Coverage
			Percent	
1999	---	23	14	19
2000	62	21	9	16
2001 ¹	60	14	4	8
2002	59	13	2	9
2003	59	13	2	8
2004 ²	62	15	13	26
2005 ^{2, 4}	97	40	54	94
2006 ^{3, 4}	98	41	55	94
2007 ^{3, 4}	100	48	90	100
2008 ^{3, 4}	100	59	91 ⁵	100
2009 ^{3, 4}	100	65	100 ⁵	96

¹Includes 53 counties, with 99,000 beneficiaries, where PFFS became available in December 2001.

²The 2004 and 2005 data reflect the reclassification of the metropolitan statistical area (MSA) status of a number of counties. There was a net reduction in the number of Medicare beneficiaries residing in non-MSA (rural) counties of about one million. About 1.5 million beneficiaries were in the counties changing from non-MSA to MSA status, and about half a million beneficiaries were in counties that changed from MSA status to non-MSA status (generally because of being assigned to the new category of micropolitan areas).

³The 2006 and 2007 data used the same definition of rural that CMS had used in a number of other published studies. It was felt that for purposes of consistency this definition should be used: Metropolitan areas were considered urban while micropolitan areas and areas that were neither metropolitan nor micropolitan were considered rural.

⁴The 2005 data are as of October 2005. The 2006-2009 data are as of December. In all years, only plans available to all Medicare beneficiaries in a county are included. That is, plans such as those available only to members of an employer group, or Special Needs Plans (SNP) available as of 2005, are excluded. In 2006-2009, the first two columns used Local CCP and PFFS types. Employer only plans were excluded but SNP were included since they frequently were either targeted to local enrollees and/or allowed disproportionate shares of non-targeted enrollees. In 2006-2009 the Zero-premium and Drug-Coverage column data included all plan types except Prescription Drug Coverage plans, Employer Direct plans, and Regional PPO. The 2007-2009 data also excluded Part B only, ESRD I, ESRD II and SHMO Demos, since these plans provided access to a very limited population. The Zero-premium plans only included plans with both a zero part C premium and a zero part D premium. Eligibles are December 2009 Part D eligibles (Part A or Part B eligibles) residing in the 50 states, the District of Columbia, or the five protectorates. Miscoded eligibles are excluded.

⁵In 2008, MSA plans were excluded from the computation of rural access to zero premium plans. Although MSA plans are one type of Medicare Advantage plan, prior to 2007 there was no enrollment in MSA plans. In 2008, the MSA plans provided 99% access to rural eligibles but only had roughly 3,500 enrollees. Similarly, in 2009 there were only about 3,500 enrollees. In 2010 there is only one MSA plan in Pennsylvania with about 600 enrollees. Consequently, including them in the analysis would be misleading since they provide access that is disproportionate to their actual enrollment.

NOTES: ESRD is End Stage Renal Disease. SHMO is Social Health Maintenance Organization.

SOURCES: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Analysis of Health Plan Management System (HPMS) data; MedPAC Annual Reports 1999 and 2000; data development by the Office of Research, Development, and Information.