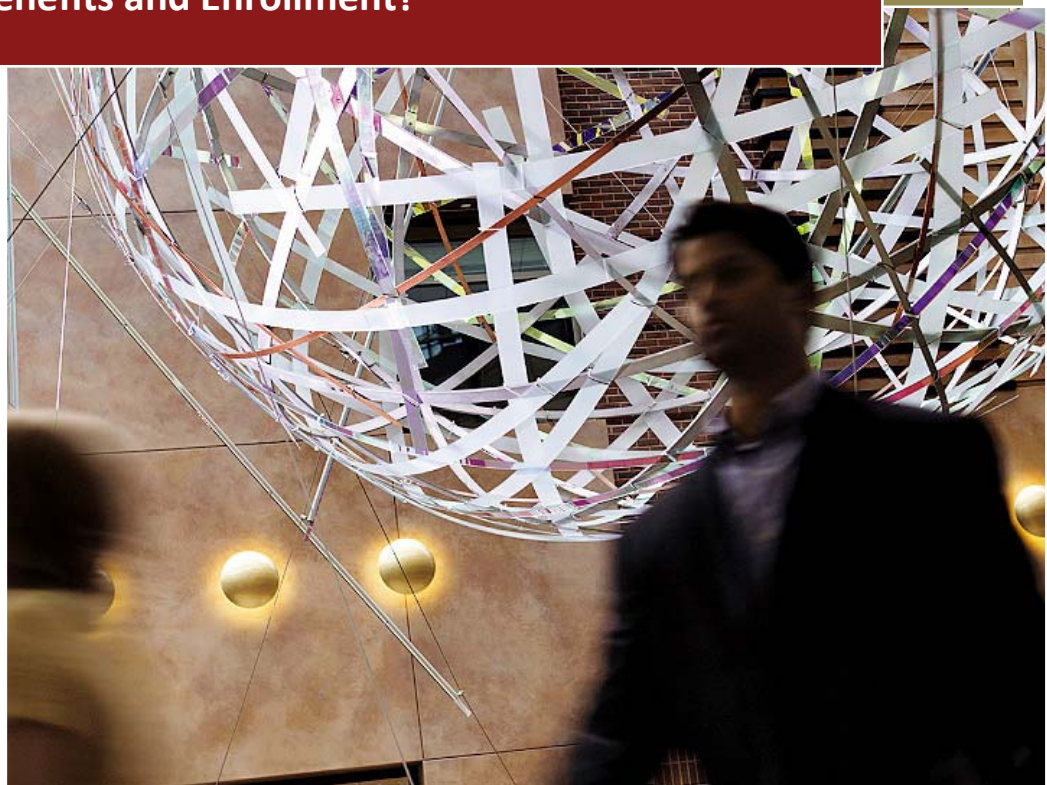


**Medical Industry  
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**What Changes will Health Reform Bring to Medicare Advantage  
Plan Benefits and Enrollment?**



***WORKING PAPER SERIES***

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# What Changes will Health Reform Bring to Medicare Advantage Plan Benefits and Enrollment?

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## Introduction

For over three decades, Medicare beneficiaries have had the option to receive their Medicare benefits through the traditional fee-for-service (FFS) Medicare program itself or through approved private managed care health plans, which now cover about one-fourth of Medicare's 47 million enrollees.<sup>1</sup> Since 2005, the number of beneficiaries enrolled in Medicare Advantage (MA) private plans has more than doubled from 5.3 million to 11.1 million.<sup>2</sup> The Medicare program pays MA plans a fixed monthly fee, which varies by county (or county-like jurisdiction<sup>3</sup>) and is adjusted for each enrollee's health status, to provide Medicare services to plan enrollees. Medicare Advantage provides Medicare beneficiaries the opportunity to enroll in private plans with different delivery options than FFS Medicare and, in many cases, to obtain benefits not available in the FFS program. Most MA plans also offer better coverage and lower co-pays and deductibles than provided by Medicare FFS.

Health reform as prescribed by the Patient Protection and Affordable Care Act (PPACA)<sup>4</sup> modifies the formula used for calculating payments to MA plans<sup>5</sup> in such a way as to impose deep cuts to the MA program as a whole—though with substantial geographic variation in the relative level of cuts. In both the existing and the new system, payments are based on a “benchmark” amount determined individually for each county in the U.S. Insurers submit a “bid” for each MA plan in each county<sup>6</sup> in which they offer the plan, representing the monthly amount for a standard beneficiary (before adjusting for health status). If the bid is lower than the benchmark, the difference is split between the government and the beneficiaries in what is called a “rebate.” This “rebate” may consist of an actual rebate of a portion of the standard Part B premium, or it may come in the form of additional covered services (beyond standard Medicare FFS benefits), lower cost-sharing than Medicare FFS, or a blend of these three options. If, however, the bid is higher than the benchmark, Medicare pays the amount of the benchmark and the enrollee who chooses the plan pays the difference in the form of a plan premium.

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<sup>1</sup> Services, C.f.M.a.M., *The History of Medicare*, September 2010.

<sup>2</sup> Brown, J., et al., *How does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program*, 2011, National Bureau of Economic Research.

<sup>3</sup> Most states are divided into counties, but some states have independent cities that are not part of any county, and others have a few “consolidated” city-county jurisdictions. Louisiana calls its subdivisions parishes instead of counties. All of these jurisdictions are treated the same way under the relevant legislation. For convenience, we refer to all of them as “counties,” regardless of their specific local designation.

<sup>4</sup> The Patient Protection and Affordable Care Act (Public Law 111–148) was enacted on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), enacted on March 30. For convenience in this paper, we refer to the final amended legislation as the Patient Protection and Affordable Care Act (PPACA).

<sup>5</sup> The altered payment formula for Medicare Advantage plans is given in Section 3210 of the PPACA, as amended. The new formula is to be phased in over six years.

<sup>6</sup> Technically, insurers submit a bid for each plan they wish to offer in each “service area.” A service area may consist of one county or multiple counties; in the latter case, benchmark rates for the counties involved are “blended” based on the enrollment in that plan from each county. The effect is mathematically equivalent to submitting a separate bid in each county (though it is simpler, administratively, for insurers), so for the purpose of this analysis we refer to bids as applying to each county; this simplifies the explanation of our methodology, but does not affect the results in any way.

Our calculations show that by the time the new formula for calculating benchmarks is fully phased-in in 2017, every county in the country will have a lower benchmark than it would have had in the absence of PPACA—in many cases, much lower. This will have two primary results. First, MA plans will have to cut health care benefits, increase cost-sharing, or increase premiums (or some combination thereof) to stay within the constraints imposed by the payment formula, making the program less beneficial to patients and thus reducing enrollment. Second, with lower payments and fewer enrollees, fewer MA plans will be able to stay solvent, resulting in a reduction in plan choices available to beneficiaries (which will, in turn, further reduce enrollment). Medicare beneficiaries will either lose their MA coverage altogether as plans withdraw from the market, or be faced with higher out of pocket costs and/or benefit reductions. See Table 1 for a summary of the predicted impacts.

From the beneficiaries' perspective, the cuts reduce the level of access to health care services by reducing the value of the MA plans that will survive the cuts and by eliminating desired MA plans, forcing some patients into the FFS system they otherwise would have rejected. In other words, many of those who would have chosen MA under prior law may be unable to enroll in their preferred (or perhaps any) MA plan or will no longer find it attractive to do so due to the reduced benefits or higher costs. In the latter case, those who would otherwise have preferred an MA plan will instead find themselves under Medicare FFS—which will also be subject to substantial cuts. Regardless of which outcome a particular patient experiences, *every* patient who would have enrolled in an MA plan under prior law will experience a loss in the actuarial value of his or her Medicare coverage.

The beneficiaries' loss due to the reduced level of benefits and higher out-of-pocket costs can be estimated directly as the dollar-value reduction in health care services consumed.<sup>7</sup> We calculate this on an average per-beneficiary basis, taking into account the average reduction in benefits for those beneficiaries who remain in the reduced-value MA program, the cuts sustained by those who are transitioned to FFS, and the projected percentage of beneficiaries who experience each of those two outcomes.

The loss in MA plan variety is an additional blow to beneficiaries that is just as real as the dollar value loss, but more difficult to measure directly. MA plans vary substantially in their benefit and co-pay structures, provider networks, and additional benefits. Many offer disease management services for people with chronic conditions, coordination of care among different physicians, on-call nurses available by phone, and other similar services. These services may be particularly important for patients with multiple chronic conditions—and they are not available in the Medicare FFS system at any price.

Further, while one of FFS's most touted benefits is the ability to see "any doctor," some physicians and other providers are in fact available only through MA. For example, some physicians are members of particular MA plan provider networks established by insurers (similar to private insurance PPO networks), but do not accept Medicare FFS patients. These providers are available only through MA plans. A patient who sees such a physician (say, through a private-sector PPO) prior to age 65 and then transitions to Medicare may be able to continue seeing the same physician through MA—but may be forced to change physicians if he or she transitions to FFS.

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<sup>7</sup> It is worth noting that, in this case, the value being counted is the price paid to the provider, which may not be the same as the value placed on the service by the patient. While this is a legitimate point, in an administered-pricing system such as Medicare, there is no way to directly measure the value of the services to the patients without making some controversial assumptions. Moreover, the FFS pricing system determines payments based on a complex formula that takes into account various components of providers' costs, but completely ignores the value of the services to patients. So while the approach taken here is not ideal, it is the best that can be done with the available data and is consistent with practically all other work on the subject.

Similarly, a patient who was a member of staff-model HMO before becoming eligible for Medicare may want to continue seeing the same physicians, but may be able to do so only if those physicians are available through an MA plan. If the MA plan is withdrawn, the patient might end up in the ostensibly “more flexible” FFS system but be forced to change doctors.

For someone with multiple chronic conditions who is seeing multiple specialists, the disruption in the continuity of care caused by changing doctors, not to mention the loss of their new specialists’ ability to coordinate with each other, can significantly inconvenience the patient and even adversely affect the patient’s health.

The goal of this paper is to estimate, based on the new MA benchmark formula and available CMS baseline projections and program data, the reduction in enrollment, the loss in benefits (to the extent that it is quantifiable), and the reduction in plan choices that will come about as a result of the PPACA’s changes to the Medicare Advantage program. These estimates are provided on a state-by-state basis. Nationwide, compared to what would have been the case under prior law, by 2017, when the changes are fully phased-in, enrollment is projected to be 50 percent lower, the average would-be beneficiary will lose \$3,700 in benefits (accounting for both those who remain in MA and those who leave), and the number of choices available in the average county will be reduced by about two-thirds.

## Methodology

Our basic approach is to compare baseline projected MA benchmarks and enrollment levels under prior law with the projected MA benchmarks and enrollment under the PPACA. This approach considers the effects of the MA provisions in isolation and then combines them with the effects of cuts in the FFS program, which will flow through to future MA benchmarks according to the formula specified in the new law.

All data used in this analysis were obtained from CMS, including average FFS spending for each county<sup>8</sup> for 2009; MA benchmarks and enrollment for each county under then-current law for 2009; baseline (i.e., the prior law) forecasts for Medicare FFS spending growth;<sup>9</sup> and the CMS Office of the Actuary’s projections of the overall impact of the PPACA.<sup>10</sup> All assumptions used in the calculations are specified in the bill or are the same as those used by the Office of the Actuary to the extent that they have been publicly disclosed.

*Benchmark Calculations.* The first objective is to calculate MA benchmarks for each county for future years. These are then compared to what the benchmarks would have been in those same years under prior law. For consistency, all forecasts of future parameters are taken from the CMS PB2010 baseline forecast, constructed in conjunction with the release of the President’s budget and calculated before the PPACA was passed.<sup>11</sup> The same parameters are used for both prior-law and new-law benchmarks.

Prior-law spending figures—both the FFS average spending and the MA benchmarks—were calculated by increasing the 2009 published figures for each county by the growth rate derived from comparing

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<sup>8</sup> The Indirect Medical Education component is excluded from the average, as specified in the PPACA. This is an adjustment paid to teaching hospitals at the same rate regardless of whether a given patient participated in MA or not. It is disregarded in this analysis because the PPACA specified that it be disregarded when calculating benchmarks.

<sup>9</sup> Centers for Medicare and Medicaid Services, Medicare Part A Tables for FY2010 President’s Budget, March 18, 2009; Medicare Part B Tables for FY2010 President’s Budget, March 26, 2009; and Medicare Part D Tables for FY2010 President’s Budget, March 6, 2009.

<sup>10</sup> Richard S. Foster, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended,” Centers for Medicare and Medicaid Services, Office of the Actuary, April 22, 2010, at [http://www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf) (accessed June 14, 2011).

<sup>11</sup> These baseline projections were also prepared before various short-term demonstration projects (ending in 2014) were implemented.

the overall (national baseline) projections for each future year under prior law to the 2009 figures.

This study follows the Actuary's assumption that MA bids track the benchmarks on average.<sup>12</sup> The Medicare beneficiary population for each county, as well as the prior-law MA enrollment in each county, was assumed to grow at the same rate as the total population of Medicare beneficiaries.<sup>13</sup> Average FFS spending for each county was calculated based on the Actuary's forecast of total FFS spending growth under the PPACA in future years.

After making this calculation for each county, we calculated the effect of changes mandated by mandated by Section 3201 of the PPACA. Counties were sorted by their per-beneficiary FFS averages,<sup>14</sup> with each county assigned an "applicable percentage" based on its quartile rank.<sup>15</sup> That percentage was used to determine the county's base benchmark for 2017 under the PPACA. The applicable percentages are as follows:

- For counties ranked in the highest quartile (the top 25 percent) by FFS spending, the MA benchmark will be 95 percent of the measured FFS spending for that county.
- For counties in the second quartile, the benchmark will be equal to the county's measured FFS spending.
- For counties in the third quartile, the benchmark will be 107.5 percent of the county's measured FFS spending.
- For counties in the lowest quartile, the benchmark will be 115 percent of the county's measured FFS spending.

The PPACA includes provisions for a "quality" bonus of up to 5 percent, which is doubled for certain "qualifying counties."<sup>16</sup> The Office of the Actuary assumed that the enrollment-weighted bonus would be about 4.5 percent in practice, including the extra amount for qualifying counties. Based on enrollment projections, this works out to an average bonus of 6.28 percent for qualifying counties and 3.14 percent for other counties. These amounts were added to the base benchmarks to determine the final benchmark for each county.<sup>17</sup>

The new benchmark calculation begins to take effect in 2013, along with the reduction in the rebate described previously, and is "phased-in" in each county over and up to 6 years, depending on the difference between the prior-law benchmark and the PPACA benchmark for that county. During the phase-in period, the actual benchmark will be a weighted average of the prior-law benchmark and the PPACA benchmark.

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<sup>12</sup> CMS does not publish actual MA bids, since MA plans consider them proprietary information.

<sup>13</sup> The Office of the Actuary used more specific forecasts based on county-level demographic information and proprietary information about specific MA plan bids, but this information is not publicly available. We were advised that calculations based on aggregation of counties (for example, at the state level) would be generally accurate under this assumption.

<sup>14</sup> In this ranking, each county is given the same weight, regardless of population, the number of Medicare beneficiaries, or MA enrollment.

<sup>15</sup> We calculated estimates for the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. We did not have the necessary data for Guam, but excluding this territory does not affect the final projections for other jurisdictions.

<sup>16</sup> A qualifying county is defined as a jurisdiction that meets three criteria: (1) it is part of a metropolitan statistical area that has total population above 250,000; (2) at least 25 percent of eligible beneficiaries are enrolled in MA; and (3) average spending on behalf of FFS beneficiaries in that jurisdiction is less than the national average for FFS spending.

<sup>17</sup> Without access to more detailed information, which has not yet been made publicly available, we cannot estimate the actual bonus for each county. However, we can apply the average bonus for each type of county to all counties of that type.

*Enrollment.* The net change in MA enrollment in each county was projected by first calculating the overall elasticity of enrollment with respect to benchmarks based on the enrollment projections in the actuary's report<sup>18</sup> and the change in the overall weighted average benchmark across all counties, assuming constant enrollment. That elasticity was then applied to the change in the benchmark for each county, relative to what it would have been in the same year under prior law. The actuary forecast corresponds to an elasticity of 2.0. In other words, for every change of 1 percentage point in the benchmark, MA enrollment will change by 2 percentage points.<sup>19</sup> This elasticity was applied to the benchmark in each county to calculate the percentage change in MA enrollment in that county, which, itself, was applied to the projected enrollment in that county under prior law to obtain the projected country enrollment under the PPACA. County-level results were then aggregated by state.

*Value of Lost Benefits.* Following the assumptions in the Actuary's report, we calculated the dollar loss in benefits for each beneficiary who would have enrolled in MA under prior law as the difference between the prior-law benchmark and the new benchmark for that county for beneficiaries who remain enrolled in MA. This difference represents the average combined effect of the changes in cost-sharing and benefits (the "rebate") and the change in additional premiums (for those plans which charge premiums beyond the standard Part B premium). For beneficiaries who would have enrolled in MA under prior law but will not under the PPACA, the change in benefits is calculated as the difference between the prior-law benchmark and the county FFS average under the PPACA. For each county, the average loss in benefits is the average of these two figures, with weighting based on the percentage of beneficiaries in that county who remain in MA and who transition to FFS.

*Plan Choices.* To calculate the average reduction in the number of plan choices available to Medicare beneficiaries in each county, we first calculated an estimate of the elasticity of supply with respect to the benchmark based on changes in MA plan offerings in prior years.<sup>20</sup> Available data—a sample size of 9,580—indicates that average elasticity is -2.985. This means that for every 1 percentage point decrease in the benchmark in a given county, we should expect a 3 percent decrease in the number of plans available in that county. We applied this elasticity to the projected percentage benchmark change in every county for the years 2013 through 2017 to obtain an estimate of the percentage change in that county, then calculated each state's average change in the number plans per county.

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<sup>18</sup> Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," p. 11.

<sup>19</sup> In general, "elasticity" means the percentage change in one variable divided by the percent change in another variable. The elasticity used here is slightly different from the elasticities explained in elementary economics textbooks. Those elasticities are typically the "price elasticity of supply" and the "price elasticity of demand," which measure the effect of a change in price on either supply or demand in isolation from the other. The price elasticity of demand is the ratio of the percent change in the quantity demanded to the percentage change in the price, assuming the supply function stays the same. Likewise, the elasticity of supply assumes the demand function remains unchanged. However, this study follows the example of the CMS Actuary and calculates a "benchmark elasticity of enrollment," a combined elasticity that is the ratio of the percent change in the MA benchmark to the percent change in MA enrollment. This elasticity captures both the supply effect and the demand effect. The supply effect results from lower revenue to MA plan providers, and demand effect results from MA plans having to provide less generous benefits.

<sup>20</sup> Based on data for the benchmark and the number of plans available in each county for the years 2006-2009, we calculated the arc-elasticity for each annual change in the number of plans with respect to the benchmark in each county. (The arc-elasticity is an estimate of the elasticity based on data from two known price-quantity pairs. This is the best estimate of the true elasticity when two pairs are known, but the true supply function is not known, as is the case here.) Because many counties have only a small number of plans, the measured arc-elasticity in any given annual change should be regarded as a sample drawn from a distribution. And, since the MA program requirements and provisions are rather uniform nationwide except for variation in benchmarks, it is reasonable to assume that there is one "true" elasticity, best estimated as the average of the measured values for arc-elasticity.

## Results and Discussion

*Enrollment.* As seen in Table 2, Medicare Advantage enrollment will decline dramatically. Relative to the prior-law baseline, there will be a reduction of 5 percent in 2013 leading to a 50 percent reduction (7.4 million fewer enrollees) by 2017, when the new benchmark formula is fully phased-in. Note: these percentages include only those enrollees who lose MA entirely, not those who would lose access to their preferred MA plan but would enroll in another MA plan rather than default to Medicare FFS.

There will be substantial geographic diversity in this effect, ranging from 38 percent in Montana to 62 percent in Louisiana, with a 67 percent loss in the District of Columbia and a striking 84 percent loss in Puerto Rico. Arizona is the only state in which a decline in MA enrollment is not observed in 2013. Among the remaining states and territories, the reduction in MA enrollment in 2013 ranges from 2 to 20 percent. All states experience annual losses in MA enrollment after 2013. By 2017, MA enrollment in Louisiana will be 62 percent lower than would have been expected without PPACA, while MA plan enrollments in Texas, California, and Pennsylvania will be reduced by 60, 51, and 49 percent respectively.

*Value of Lost Benefits.* By 2017, according to the pre-PPACA (PB2010) baseline, 14.8 million would-be MA enrollees will sustain a loss in the value of their health care coverage. Of those, about 7.4 million will either lose their access to MA plans entirely or drop out of MA “voluntarily” because the reduced benefits make MA less attractive. Taking into account both the loss in benefits within the MA program and the loss sustained by switching from MA to FFS, by 2017 the average prior-law enrollee will lose \$3,700 in health care services per year, totaling almost \$55 billion for all such beneficiaries. These figures include both the direct effect of the change in the MA benchmark formula, as well as cuts to Medicare FFS that will “flow through” to MA via the new benchmark formula. The benefit losses will vary widely by state, from a low of \$2,780 in Montana to a high of \$5,092 in Louisiana (Table 3).

*Plan Choices.* In 2013, when the new benchmark formula is still only partly phased-in, we project an average 8.7 percent reduction in the number of choices available in each county, relative to what would have been available under prior law. By 2017, when the new formula is fully phased-in, we expect a 66.5 percent average reduction in the number of plans available in each county.<sup>21</sup>

A steady decline in the average number of Medicare Advantage plans offered by county per each state is projected for each of the years from 2013 through 2017. While the degree of average plan loss by state varies, the negative trend line for the period is persistent across time and consistent across each of the states and territories.

For certain states, the decline in the average number of plan offerings per county is particularly dramatic. In Texas, for example, an average 11.5 percent reduction in MA plans per county in 2013 is the first step toward an average cumulative loss of three quarters of plan offerings per county by 2017. Similarly, Louisiana is expected to see an average county percentage loss of MA plans of 14.2 percent in 2013, leading to an average loss of 84.2 percent in 2017. Lesser impacts are observed in other states, but even Arizona, the state experiencing the least degree of change, will experience an average 57.5 percent decrease in MA plans per county by the end of 2017.

The initial drop-off is more precipitous in some states than in others. For example, New York is predicted to experience a 31.7 percent reduction in average county plan choices by the end of 2014, while the percentage loss in Ohio in the same time period may only be 20.7 percent. However, a

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<sup>21</sup> These are average figures; the result in any given county could be quite different. While these estimates are based on the best data available, numerical estimates for changes substantially outside the range of historical experience should be viewed with some caution. However, it is virtually certain that, with a very large change in the benchmarks, there will be a very large reduction in both the quality and the quantity of choices available to Medicare beneficiaries.

decrease in average county plan offerings of at least 20 percent is expected in all but two states in the first two years. By the end of 2015, plan reductions of at least 30 percent are calculated for all states, and, by the end of 2016, a majority of the states are projected to have lost at least half of their plan choices (Table 4).

Another question is how many counties will not have any MA plans at all. In 2009, every county in the U.S. (except the two in the U.S. Virgin Islands) had at least one MA plan. Based on our model's projections, by 2017 at least 152 counties—and perhaps as many as 180—will be without MA plans.

## **Conclusion**

Our results are unambiguous. PPACA will dramatically reduce the number and variety of plan choices available to Medicare Advantage patients. The benefits of remaining programs will be curtailed. These changes will lead to a huge reduction in enrollment. Nearly all MA enrollees will find that the plan they have chosen is either no longer available, or available only with a reduced benefit structure, higher out-of-pocket costs, or both. By 2017, seniors will have, on average, only one-third as many choices as before, and the choices that remain will have substantially lower levels of benefits. About half will choose to stay in Medicare Advantage despite the reduced benefits; the other half will drop out and make do with the fee-for-service program they would otherwise have rejected as insufficient for their needs.

As noted previously, the loss in *variety* of MA plans is just as damaging to beneficiaries as the loss in dollar value, though it is more difficult to measure directly. Today's MA plans vary substantially in their benefit and co-pay structures, provider networks, and additional benefits. Many offer disease management services for people with chronic conditions, coordination of care among different physicians, on-call nurses available by phone, and other services—and in some cases, certain physicians—that are not available in the Medicare FFS system at any price.



**Table 1:**  
**PPACA's Impact on Medicare Advantage – National Summary**  
**Projection of PPACA impact, compared to prior law (PB2010) baseline**

	2013	2014	2015	2016	2017
<i>Enrollment:</i>					
Number of Beneficiaries Losing MA	0.66 mil	1.6 mil	2.9 mil	4.4 mil	7.4 mil
As a percentage of prior-law baseline enrollment	5%	12%	21%	31%	50%
<i>Loss in Benefits:</i>					
Cut in Benefits per beneficiary, dollars	\$403	\$940	\$1,626	\$2,307	\$3,714
Cut in Benefits per beneficiary, percentage	4%	8%	13%	18%	27%
<i>Loss in Plan Choices:</i>					
Average percentage change in plan choices per county	-9%	-17%	-30%	-41%	-67%
Average change in plan choices per county	-2.3	-4.7	-8.0	-11.0	-17.8

**Table 2:  
Beneficiaries Losing Medicare Advantage due to PPACA**

	2013		2014		2015		2016		2017	
	Number of Beneficiaries	Percent of prior-law Enrollees	Number of Beneficiaries	Percent of prior-law Enrollees	Number of Beneficiaries	Percent of prior-law Enrollees	Number of Beneficiaries	Percent of prior-law Enrollees	Number of Beneficiaries	Percent of prior-law Enrollees
<b>NATIONAL TOTALS:</b>	<b>0.66 mil</b>	<b>5%</b>	<b>1.6 mil</b>	<b>12%</b>	<b>2.9 mil</b>	<b>21%</b>	<b>4.4 mil</b>	<b>31%</b>	<b>7.4 mil</b>	<b>50%</b>
ALABAMA	6,467	3%	20,163	9%	39,845	18%	61,014	26%	107,922	45%
ALASKA	67	8%	132	16%	219	25%	316	35%	508	55%
ARIZONA	-831	0%	22,191	6%	56,054	14%	93,448	22%	179,372	41%
ARKANSAS	3,686	4%	8,778	10%	16,326	18%	23,690	26%	41,178	43%
CALIFORNIA	81,832	4%	227,894	12%	424,476	21%	645,518	31%	1,091,580	51%
COLORADO	6,530	3%	23,267	10%	46,336	19%	71,912	28%	125,586	48%
CONNECTICUT	6,173	6%	13,451	12%	23,600	20%	35,104	29%	59,796	48%
DELAWARE	392	5%	896	11%	1,615	19%	2,434	27%	4,247	46%
District of Columbia	1,184	13%	2,175	22%	3,412	34%	4,777	46%	7,169	67%
FLORIDA	23,514	2%	90,033	8%	186,445	16%	295,977	24%	543,963	43%
GEORGIA	13,845	7%	28,441	13%	48,897	22%	70,189	30%	116,339	49%
HAWAII	5,689	6%	14,247	15%	25,271	26%	37,545	37%	60,405	58%
IDAHO	1,771	2%	5,968	8%	12,225	16%	18,754	24%	34,109	42%
ILLINOIS	11,531	6%	23,919	11%	42,274	19%	61,138	26%	105,360	44%
INDIANA	9,315	5%	20,816	12%	37,303	20%	53,760	28%	90,922	46%
IOWA	4,458	6%	9,531	12%	16,758	20%	24,250	29%	40,937	47%
KANSAS	3,801	7%	7,569	14%	12,778	22%	18,455	31%	30,405	50%
KENTUCKY	7,643	6%	15,773	12%	27,653	19%	40,005	27%	68,287	45%
LOUISIANA	16,202	9%	33,746	18%	56,004	29%	80,684	41%	125,352	62%
MAINE	1,878	6%	3,605	11%	6,260	19%	8,805	26%	15,062	43%
MARYLAND	3,886	6%	8,451	12%	14,824	20%	21,981	29%	37,371	48%
MASSACHUSETTS	16,830	7%	36,137	15%	61,636	25%	90,184	35%	146,082	55%
MICHIGAN	19,101	4%	50,248	10%	94,526	19%	142,173	27%	246,895	46%
MINNESOTA	6,228	2%	26,174	8%	55,856	16%	85,881	23%	156,794	41%
MISSISSIPPI	3,536	7%	7,172	13%	12,290	21%	17,800	30%	29,741	48%
MISSOURI	8,034	3%	25,215	11%	48,767	20%	74,586	29%	128,188	49%
MONTANA	2,050	6%	3,780	11%	6,679	19%	8,498	23%	14,202	38%
NORTH CAROLINA	13,838	5%	33,609	11%	61,648	19%	91,568	28%	157,204	46%
NORTH DAKOTA	374	4%	913	9%	1,742	16%	2,546	23%	4,568	40%
NEBRASKA	2,305	6%	4,813	12%	8,395	21%	12,001	29%	20,093	47%
NEVADA	4,518	4%	11,369	9%	21,481	16%	33,012	24%	59,842	43%
NEW HAMPSHIRE	863	6%	1,825	11%	3,218	19%	4,682	27%	8,008	46%
NEW JERSEY	13,649	7%	27,758	14%	46,726	24%	68,044	33%	111,170	53%
NEW MEXICO	4,261	5%	11,251	12%	20,706	22%	30,640	32%	50,829	51%
NEW YORK	72,941	7%	157,808	15%	269,270	25%	393,175	36%	633,028	56%
OHIO	12,817	2%	53,765	9%	111,131	18%	173,345	27%	307,148	46%
OKLAHOMA	3,378	3%	10,080	10%	19,556	18%	29,936	27%	52,627	46%
OREGON	11,556	4%	33,694	11%	64,250	20%	96,225	30%	163,130	49%
PENNSYLVANIA	34,086	3%	110,960	11%	215,763	20%	331,087	29%	568,222	49%
RHODE ISLAND	4,979	7%	10,449	13%	17,936	22%	26,385	31%	43,992	50%
SOUTH CAROLINA	7,725	6%	16,513	12%	28,988	21%	41,958	29%	70,428	47%
SOUTH DAKOTA	548	5%	1,240	10%	2,322	19%	3,107	24%	5,281	40%
TENNESSEE	9,544	4%	27,569	10%	53,298	18%	80,753	27%	141,398	45%
TEXAS	58,560	9%	117,549	18%	193,184	29%	276,468	40%	430,470	60%
UTAH	2,053	2%	8,998	9%	18,758	18%	29,190	26%	51,783	45%
VERMONT	222	5%	474	9%	879	17%	1,230	22%	2,183	39%
VIRGINIA	11,666	6%	24,490	13%	42,218	22%	61,490	31%	102,258	50%
WEST VIRGINIA	4,259	4%	10,521	10%	19,735	18%	29,288	26%	51,413	44%
WASHINGTON	11,090	4%	28,672	10%	53,745	19%	80,391	27%	138,813	46%
WISCONSIN	12,590	4%	31,454	11%	58,417	19%	86,230	27%	148,205	46%
WYOMING	274	5%	577	10%	1,038	18%	1,482	25%	2,577	42%
PUERTO RICO	92,125	20%	158,135	32%	235,914	47%	320,451	61%	449,015	84%
VIRGIN ISLANDS	4	4%	6	7%	12	12%	18	17%	35	33%

**Table 3:  
Dollar Value of Benefit Cuts to Medicare Advantage Beneficiaries due to PPACA**

	2013			2014			2015			2016			2017		
	Average cut per prior-law MA beneficiary		Statewide Aggregate Cut	Average cut per prior-law MA beneficiary		Statewide Aggregate Cut	Average cut per prior-law MA beneficiary		Statewide Aggregate Cut	Average cut per prior-law MA beneficiary		Statewide Aggregate Cut	Average cut per prior-law MA beneficiary		Statewide Aggregate Cut
<b>NATIONAL TOTALS:</b>	<b>\$403</b>	<b>3.6%</b>	<b>\$5,203 mil</b>	<b>\$940</b>	<b>7.9%</b>	<b>\$12,623 mil</b>	<b>\$1,626</b>	<b>13.1%</b>	<b>\$22,615 mil</b>	<b>\$2,307</b>	<b>17.8%</b>	<b>\$33,146 mil</b>	<b>\$3,714</b>	<b>26.9%</b>	<b>\$54,970 mil</b>
ALABAMA	\$228	2.1%	\$48 mil	\$671	5.8%	\$147 mil	\$1,277	10.7%	\$290 mil	\$1,881	15.1%	\$441 mil	\$3,210	24.1%	\$775 mil
ALASKA	\$676	5.7%	\$1 mil	\$1,246	10.1%	\$1 mil	\$1,946	15.2%	\$2 mil	\$2,645	19.8%	\$2 mil	\$4,027	28.2%	\$4 mil
ARIZONA	\$15	0.1%	\$6 mil	\$407	3.6%	\$163 mil	\$1,001	8.4%	\$415 mil	\$1,614	13.0%	\$692 mil	\$3,010	22.8%	\$1329 mil
ARKANSAS	\$316	3.0%	\$26 mil	\$733	6.7%	\$63 mil	\$1,315	11.5%	\$118 mil	\$1,863	15.6%	\$173 mil	\$3,160	24.8%	\$302 mil
CALIFORNIA	\$361	3.0%	\$676 mil	\$939	7.4%	\$1831 mil	\$1,665	12.7%	\$3364 mil	\$2,402	17.5%	\$5011 mil	\$3,882	26.5%	\$8342 mil
COLORADO	\$220	2.0%	\$51 mil	\$729	6.3%	\$175 mil	\$1,384	11.5%	\$344 mil	\$2,047	16.3%	\$525 mil	\$3,432	25.5%	\$907 mil
CONNECTICUT	\$402	3.6%	\$44 mil	\$829	7.1%	\$94 mil	\$1,397	11.5%	\$163 mil	\$1,987	15.6%	\$240 mil	\$3,269	24.1%	\$407 mil
DELAWARE	\$340	3.2%	\$3 mil	\$734	6.6%	\$6 mil	\$1,271	11.0%	\$11 mil	\$1,836	15.2%	\$17 mil	\$3,097	24.1%	\$29 mil
District of Columbia	\$1,090	8.5%	\$10 mil	\$1,856	14.0%	\$18 mil	\$2,725	19.7%	\$28 mil	\$3,547	24.6%	\$37 mil	\$4,988	32.4%	\$54 mil
FLORIDA	\$166	1.3%	\$184 mil	\$583	4.5%	\$671 mil	\$1,168	8.7%	\$1393 mil	\$1,785	12.7%	\$2199 mil	\$3,203	21.3%	\$4064 mil
GEORGIA	\$492	4.5%	\$103 mil	\$958	8.5%	\$208 mil	\$1,574	13.4%	\$354 mil	\$2,169	17.6%	\$504 mil	\$3,472	26.5%	\$830 mil
HAWAII	\$546	5.0%	\$50 mil	\$1,299	11.6%	\$124 mil	\$2,190	18.8%	\$216 mil	\$3,083	25.3%	\$314 mil	\$4,693	36.1%	\$492 mil
IDAHO	\$175	1.6%	\$12 mil	\$616	5.6%	\$46 mil	\$1,237	10.8%	\$95 mil	\$1,862	15.6%	\$148 mil	\$3,298	25.9%	\$270 mil
ILLINOIS	\$387	3.5%	\$81 mil	\$773	6.7%	\$168 mil	\$1,318	11.0%	\$296 mil	\$1,845	14.7%	\$429 mil	\$3,100	23.2%	\$742 mil
INDIANA	\$402	3.7%	\$69 mil	\$861	7.7%	\$154 mil	\$1,484	12.8%	\$275 mil	\$2,072	17.1%	\$397 mil	\$3,403	26.3%	\$672 mil
IOWA	\$453	4.3%	\$35 mil	\$918	8.5%	\$73 mil	\$1,547	13.8%	\$127 mil	\$2,165	18.4%	\$184 mil	\$3,536	28.2%	\$309 mil
KANSAS	\$539	4.9%	\$28 mil	\$1,016	8.9%	\$56 mil	\$1,639	13.8%	\$93 mil	\$2,262	18.2%	\$133 mil	\$3,586	27.1%	\$217 mil
KENTUCKY	\$411	3.8%	\$54 mil	\$816	7.3%	\$112 mil	\$1,378	11.9%	\$196 mil	\$1,927	15.9%	\$283 mil	\$3,196	24.8%	\$483 mil
LOUISIANA	\$892	6.5%	\$158 mil	\$1,703	12.0%	\$314 mil	\$2,629	17.8%	\$502 mil	\$3,512	22.8%	\$693 mil	\$5,092	30.9%	\$1035 mil
MAINE	\$459	4.4%	\$14 mil	\$861	7.9%	\$28 mil	\$1,447	12.8%	\$48 mil	\$1,994	16.9%	\$68 mil	\$3,334	26.5%	\$118 mil
MARYLAND	\$429	3.5%	\$29 mil	\$878	7.0%	\$62 mil	\$1,473	11.3%	\$108 mil	\$2,084	15.3%	\$157 mil	\$3,417	23.5%	\$266 mil
MASSACHUSETTS	\$577	4.9%	\$135 mil	\$1,146	9.4%	\$278 mil	\$1,848	14.5%	\$464 mil	\$2,548	19.1%	\$661 mil	\$3,927	27.7%	\$1050 mil
MICHIGAN	\$287	2.6%	\$135 mil	\$733	6.4%	\$358 mil	\$1,330	11.2%	\$672 mil	\$1,927	15.5%	\$1006 mil	\$3,240	24.4%	\$1742 mil
MINNESOTA	\$133	1.2%	\$44 mil	\$531	4.7%	\$183 mil	\$1,096	9.4%	\$391 mil	\$1,638	13.4%	\$603 mil	\$2,916	22.4%	\$1106 mil
MISSISSIPPI	\$489	4.3%	\$26 mil	\$933	7.9%	\$52 mil	\$1,520	12.4%	\$88 mil	\$2,100	16.4%	\$126 mil	\$3,374	24.7%	\$208 mil
MISSOURI	\$268	2.4%	\$62 mil	\$812	7.1%	\$194 mil	\$1,506	12.6%	\$373 mil	\$2,202	17.6%	\$564 mil	\$3,631	27.3%	\$957 mil
MONTANA	\$428	4.2%	\$14 mil	\$767	7.3%	\$26 mil	\$1,307	12.0%	\$46 mil	\$1,659	14.6%	\$61 mil	\$2,780	23.0%	\$105 mil
NORTH CAROLINA	\$354	3.3%	\$105 mil	\$836	7.4%	\$257 mil	\$1,483	12.7%	\$471 mil	\$2,131	17.4%	\$699 mil	\$3,542	27.1%	\$1198 mil
NORTH DAKOTA	\$272	2.7%	\$3 mil	\$639	6.1%	\$7 mil	\$1,180	10.8%	\$13 mil	\$1,693	14.9%	\$19 mil	\$2,985	24.6%	\$34 mil
NEBRASKA	\$442	4.1%	\$17 mil	\$876	7.9%	\$34 mil	\$1,463	12.7%	\$59 mil	\$2,022	16.8%	\$84 mil	\$3,288	25.7%	\$141 mil
NEVADA	\$258	2.2%	\$32 mil	\$615	5.1%	\$78 mil	\$1,121	8.9%	\$148 mil	\$1,658	12.6%	\$226 mil	\$2,929	20.9%	\$411 mil
NEW HAMPSHIRE	\$417	3.8%	\$6 mil	\$845	7.5%	\$13 mil	\$1,437	12.3%	\$24 mil	\$2,024	16.6%	\$35 mil	\$3,367	25.8%	\$59 mil
NEW JERSEY	\$562	4.7%	\$104 mil	\$1,072	8.7%	\$205 mil	\$1,716	13.4%	\$341 mil	\$2,367	17.7%	\$485 mil	\$3,701	25.9%	\$781 mil
NEW MEXICO	\$412	3.8%	\$36 mil	\$1,051	9.4%	\$95 mil	\$1,851	15.9%	\$173 mil	\$2,631	21.7%	\$254 mil	\$4,177	32.2%	\$415 mil
NEW YORK	\$660	5.3%	\$657 mil	\$1,330	10.2%	\$1376 mil	\$2,145	15.9%	\$2299 mil	\$2,954	20.9%	\$3270 mil	\$4,512	29.9%	\$5145 mil
OHIO	\$167	1.5%	\$98 mil	\$664	5.8%	\$404 mil	\$1,322	11.2%	\$833 mil	\$1,983	16.0%	\$1290 mil	\$3,390	25.7%	\$2272 mil
OKLAHOMA	\$247	2.2%	\$25 mil	\$680	5.8%	\$71 mil	\$1,262	10.3%	\$137 mil	\$1,849	14.5%	\$207 mil	\$3,140	23.0%	\$362 mil
OREGON	\$320	2.9%	\$94 mil	\$906	8.1%	\$276 mil	\$1,651	14.1%	\$520 mil	\$2,377	19.5%	\$773 mil	\$3,854	29.6%	\$1292 mil
PENNSYLVANIA	\$272	2.4%	\$275 mil	\$825	7.0%	\$867 mil	\$1,524	12.4%	\$1658 mil	\$2,221	17.3%	\$2496 mil	\$3,637	26.6%	\$4210 mil
RHODE ISLAND	\$519	4.7%	\$40 mil	\$1,036	9.0%	\$82 mil	\$1,709	14.3%	\$141 mil	\$2,410	19.3%	\$205 mil	\$3,868	29.0%	\$338 mil
SOUTH CAROLINA	\$441	4.1%	\$57 mil	\$905	8.1%	\$122 mil	\$1,524	13.1%	\$213 mil	\$2,125	17.4%	\$306 mil	\$3,446	26.5%	\$512 mil
SOUTH DAKOTA	\$339	3.4%	\$4 mil	\$736	7.0%	\$9 mil	\$1,325	12.2%	\$17 mil	\$1,754	15.5%	\$23 mil	\$2,956	24.4%	\$39 mil
TENNESSEE	\$256	2.3%	\$70 mil	\$715	6.3%	\$202 mil	\$1,333	11.3%	\$391 mil	\$1,948	15.8%	\$590 mil	\$3,300	25.1%	\$1030 mil
TEXAS	\$854	6.5%	\$533 mil	\$1,582	11.7%	\$1027 mil	\$2,429	17.2%	\$1633 mil	\$3,240	22.0%	\$2250 mil	\$4,732	30.1%	\$3385 mil
UTAH	\$155	1.4%	\$15 mil	\$668	5.9%	\$69 mil	\$1,341	11.4%	\$144 mil	\$2,011	16.4%	\$222 mil	\$3,440	26.4%	\$392 mil
VERMONT	\$316	3.1%	\$2 mil	\$656	6.3%	\$3 mil	\$1,181	10.9%	\$6 mil	\$1,631	14.4%	\$9 mil	\$2,864	23.7%	\$16 mil
VIRGINIA	\$516	4.8%	\$93 mil	\$1,029	9.2%	\$193 mil	\$1,700	14.7%	\$329 mil	\$2,377	19.6%	\$476 mil	\$3,804	29.4%	\$784 mil
WEST VIRGINIA	\$296	2.8%	\$30 mil	\$720	6.5%	\$77 mil	\$1,312	11.4%	\$146 mil	\$1,895	15.8%	\$217 mil	\$3,239	25.3%	\$382 mil
WASHINGTON	\$321	3.0%	\$84 mil	\$824	7.3%	\$225 mil	\$1,495	12.8%	\$423 mil	\$2,164	17.7%	\$633 mil	\$3,611	27.7%	\$1088 mil
WISCONSIN	\$343	3.2%	\$97 mil	\$825	7.5%	\$242 mil	\$1,473	12.9%	\$448 mil	\$2,103	17.6%	\$661 mil	\$3,496	27.5%	\$1132 mil
WYOMING	\$345	3.3%	\$2 mil	\$699	6.5%	\$4 mil	\$1,211	10.9%	\$7 mil	\$1,681	14.4%	\$10 mil	\$2,860	23.0%	\$17 mil
PUERTO RICO	\$1,344	16.2%	\$631 mil	\$2,213	25.8%	\$1079 mil	\$3,104	34.8%	\$1569 mil	\$3,911	42.0%	\$2041 mil	\$5,058	50.9%	\$2719 mil
VIRGIN ISLANDS	\$234	2.9%	21,000	\$409	4.9%	39,000	\$743	8.5%	73,000	\$1,085	11.9%	110,000	\$2,082	21.5%	217,000

**Table 4:**  
**Percent Change in Number of Plan Choices**  
**(Under PPACA, Compared to Prior Law Baseline; Average by County)**

	<b>Number of Counties</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
<b>NATIONAL TOTALS:</b>	3222	-8.7%	-17.5%	-29.8%	-40.8%	-66.5%
ALABAMA	67	-7.5%	-15.1%	-26.5%	-36.7%	-61.4%
ALASKA	25	-9.2%	-18.9%	-31.9%	-44.2%	-70.0%
ARIZONA	15	-6.7%	-13.6%	-24.5%	-33.0%	-57.5%
ARKANSAS	75	-7.7%	-15.6%	-27.3%	-37.8%	-62.3%
CALIFORNIA	58	-8.1%	-18.4%	-31.6%	-44.8%	-73.5%
COLORADO	64	-6.9%	-15.4%	-27.4%	-38.1%	-64.7%
CONNECTICUT	8	-9.2%	-18.8%	-31.4%	-45.0%	-73.5%
DELAWARE	3	-5.8%	-13.8%	-24.9%	-37.0%	-64.6%
District of Columbia	1	-18.8%	-33.2%	-50.3%	-68.3%	-99.4%
FLORIDA	67	-6.4%	-15.4%	-27.6%	-39.8%	-67.2%
GEORGIA	159	-9.0%	-17.3%	-29.2%	-39.6%	-65.5%
HAWAII	5	-14.1%	-27.1%	-42.9%	-58.0%	-83.6%
IDAHO	44	-7.5%	-14.9%	-26.2%	-35.0%	-59.4%
ILLINOIS	102	-8.9%	-16.1%	-27.1%	-35.9%	-60.4%
INDIANA	92	-7.8%	-15.9%	-27.5%	-37.6%	-63.1%
IOWA	99	-8.2%	-16.4%	-28.1%	-37.7%	-64.7%
KANSAS	105	-8.0%	-15.8%	-27.1%	-37.8%	-63.5%
KENTUCKY	120	-8.6%	-15.7%	-26.6%	-36.1%	-60.7%
LOUISIANA	64	-14.1%	-26.5%	-41.8%	-57.8%	-84.1%
MAINE	16	-7.9%	-15.3%	-26.7%	-34.0%	-59.9%
MARYLAND	24	-7.3%	-16.0%	-28.0%	-39.8%	-67.4%
MASSACHUSETTS	14	-11.6%	-22.8%	-36.9%	-51.9%	-80.8%
MICHIGAN	83	-7.6%	-15.6%	-27.4%	-37.7%	-62.8%
MINNESOTA	87	-6.1%	-13.3%	-24.1%	-33.6%	-58.7%
MISSISSIPPI	82	-9.0%	-17.7%	-29.7%	-41.4%	-67.6%
MISSOURI	115	-7.2%	-15.5%	-27.3%	-36.8%	-64.5%
MONTANA	56	-8.6%	-16.8%	-28.9%	-37.6%	-61.0%
NORTH CAROLINA	100	-8.1%	-16.3%	-28.1%	-37.7%	-63.3%
NORTH DAKOTA	53	-6.7%	-14.5%	-26.2%	-34.8%	-59.2%
NEBRASKA	93	-7.7%	-15.2%	-26.5%	-35.0%	-59.6%
NEVADA	17	-7.5%	-16.3%	-28.5%	-40.3%	-67.3%
NEW HAMPSHIRE	10	-7.9%	-15.8%	-27.4%	-37.7%	-61.3%
NEW JERSEY	21	-10.4%	-20.6%	-33.8%	-47.9%	-76.8%
NEW MEXICO	33	-10.6%	-19.4%	-31.7%	-41.6%	-68.8%
NEW YORK	62	-10.0%	-20.8%	-34.6%	-47.4%	-77.2%
OHIO	88	-6.6%	-14.8%	-26.7%	-37.0%	-62.4%
OKLAHOMA	77	-7.3%	-15.5%	-27.3%	-38.4%	-64.1%
OREGON	36	-7.1%	-15.0%	-26.6%	-36.0%	-61.9%
PENNSYLVANIA	67	-6.2%	-15.4%	-28.1%	-39.5%	-66.5%
RHODE ISLAND	5	-9.5%	-19.3%	-32.2%	-45.6%	-74.5%
SOUTH CAROLINA	46	-7.8%	-16.2%	-28.3%	-38.9%	-64.7%
SOUTH DAKOTA	67	-7.3%	-15.5%	-27.5%	-36.4%	-61.9%
TENNESSEE	95	-7.5%	-16.2%	-28.5%	-39.7%	-65.9%
TEXAS	254	-11.3%	-21.9%	-35.7%	-49.5%	-76.5%
UTAH	29	-6.6%	-15.1%	-27.2%	-36.6%	-62.8%
VERMONT	14	-7.3%	-14.2%	-25.1%	-32.8%	-57.8%
VIRGINIA	136	-9.1%	-18.5%	-31.1%	-43.0%	-71.3%
WEST VIRGINIA	55	-7.1%	-15.3%	-27.3%	-37.3%	-63.0%
WASHINGTON	39	-7.5%	-14.9%	-26.2%	-35.0%	-59.8%
WISCONSIN	72	-7.2%	-15.7%	-27.8%	-37.2%	-63.7%
WYOMING	23	-8.9%	-16.9%	-28.5%	-50.4%	-63.6%
PUERTO RICO	78	-22.8%	-42.3%	-64.1%	-83.5%	-97.7%
VIRGIN ISLANDS	2	-6.2%	-10.6%	-19.0%	-25.2%	-51.3%