U.S. Health Reform—Monitoring and Impact

Are Medicare Advantage Plans Using New Supplemental Benefit Flexibility to Address Enrollees' Health-Related Social Needs?

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URBAN INSTITUTE

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

INTRODUCTION

Though socioeconomic and demographic factors are important drivers of health and health outcomes,[1] the Medicare program generally does not cover benefits and services to address beneficiaries' social needs. In 2017, 9.2 percent of Americans ages 65 and older, or 4.7 million older adults, had incomes below the federal poverty level, and over 30 percent of all older adults (15.4 million) had incomes less than 200 percent of the federal poverty level.[2] In addition, an estimated 7.7 percent of Americans ages 60 and older were food insecure in 2017,[3] and 4.7 percent of Americans ages 62 and over experienced homelessness that year.[4] Unmet health-related social needs, including food and housing insecurity, are associated with higher health care utilization and spending.[5]

Though the Medicaid program has increasingly attempted to address beneficiaries' health-related social needs,[6,7,8] among Medicare beneficiaries, most of the work to address social needs has focused on limited demonstrations[9] and private plans covering those dually eligible for Medicare and Medicaid (Medicare Advantage Dual Eligible Special Needs Plans, or D-SNPs).[10] Though this approach generally targets lower-income Medicare beneficiaries, the narrow focus on dual eligibles may exclude beneficiaries whose health-related social needs are less directly tied to income, as well as beneficiaries eligible for supplemental Medicaid coverage but unenrolled.[11] For example, nearly half of Medicare beneficiaries have functional limitations or difficulty with activities related to independent living that make mobility, personal care, transportation, grocery shopping, food preparation, housework, and/or other activities problematic, all of which can negatively affect health outcomes.[12] A recent study found that 10.8 million community-dwelling Medicare beneficiaries rarely or never drive, and 2.3 million were classified as transportation disadvantaged.[13] In addition, in-home hazards, like unstable furniture and lack of railings and guardrails, also contribute to as many as half of falls among older adults, which are a significant causes of fractures and traumatic brain injuries.[14] Finally, about one in five older adults is socially isolated,[15] which is associated with higher health care utilization and Medicare spending.[16]

Recent Changes to the Medicare Advantage Program

As of March 2019, Medicare Advantage (MA) plans covered over one-third of Medicare beneficiaries, or 22 million Americans. The MA program allows Medicare beneficiaries to receive their Parts A and B benefits through private plans, and most also receive integrated Part D prescription drug coverage. To participate in the program, private plans submit a bid to the Centers for Medicare & Medicaid Services (CMS) equal to the expected cost, including administrative costs and profits, of providing Medicare Parts A and B benefits to an average-risk Medicare enrollee in a county.[17] This bid is compared with a predetermined county-level benchmark set by CMS, which is based on traditional Medicare spending in each county, with adjustments for counties with particularly high or low traditional Medicare spending, and therefore varies widely across the country.[17] Plans bidding below the benchmark receive a portion of the difference between the benchmark and their bid as a rebate, which must be used to provide lower cost sharing or supplemental health care benefits, like dental and vision coverage, to enrollees.

Before the 2019 plan year, supplemental benefits funded by rebates had to be items or services not covered by Medicare, were primarily health related, and incurred a direct medical cost for the MA plan. For plan year 2019, CMS expanded the acceptable uses of rebate dollars by reinterpreting

supplemental benefits to include those that "are used to diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization."[18] In 2019, CMS began allowing MA plans to target supplemental benefits to enrollees by health condition. The 2018 Bipartisan Budget Act expanded allowable uses of supplemental benefits to include any item or service that could reasonably improve or maintain health or function for enrollees with certain chronic conditions (called Special Supplemental Benefits for the Chronically Ill or SSBCI).[19]

Initial research on MA plan supplemental benefits for 2019 indicated that some plans used the new flexibility to provide or expand transportation benefits, home-delivered meals, and personal care services, but that take-up of the new flexibility was limited.[20,21,22] This report expands on that research to describe the potential resources available to MA plans to address enrollees' health-related social needs and summarize qualitative interviews with representatives of MA insurers, service providers, and MA experts that focused on the following questions:

- How are MA insurers using the new benefit flexibility?
- What factors affect MA insurers' decisionmaking on new benefits to address health-related social needs?
- How do MA insurers anticipate this new flexibility will affect the market?

METHODS

We describe the amount of and geographic variation in MA rebate funds available for supplemental benefits by calculating state- and county-level rebate averages. This analysis uses publicly available data from CMS for the 2015 plan year, the most recent year of data available.[23]

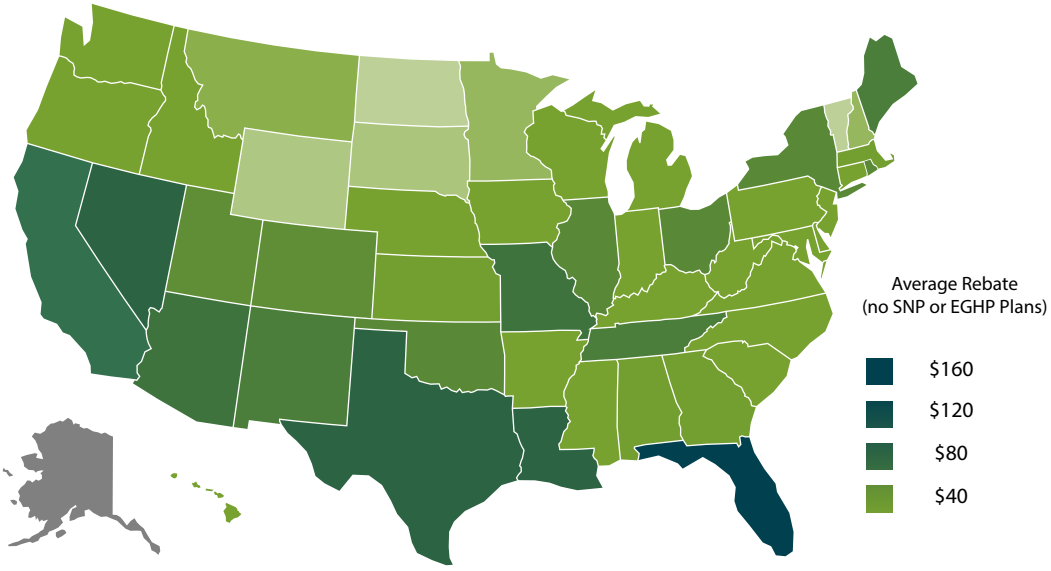
In addition, between February and May 2019, we conducted 10 semistructured interviews with a convenience sample of MA insurers, industry experts, and stakeholders to better understand how health plans were responding to CMS's new flexibilities in offering supplemental benefits for 2019 and 2020. Because bids for the 2020 coverage year were not due to CMS until June 3, 2019,[24] our interviewees had not yet made final decisions about benefit packages. We interviewed five Medicare Advantage insurers, including both national and regional insurers, together representing 38 percent of the market.[25] We conducted an additional five interviews with industry experts and stakeholders, including a professional association, consumer advocates, a service provider, and a consultant. Interviews were conducted by phone and lasted between 30 and 60 minutes.

RESULTS

Substantial Geographic Variation in Rebate Amounts

In 2019, the average MA plan received $107 per member per month in rebates to spend on cost-sharing reductions or supplemental benefits.[26] However, rebate amounts substantially varied across states (Figure 1, Appendix Table 1). For example, the average 2015 rebate for MA plans (excluding Special Needs Plans and employer-sponsored plans) was $159 per member per month in Florida but just $2 per member per month in North Dakota. In states that had SNP plans in 2015, average rebates in those plans ranged from $0 per member per month in Idaho to $282 per member per month in Nevada (Figure 2, Appendix Table 1).

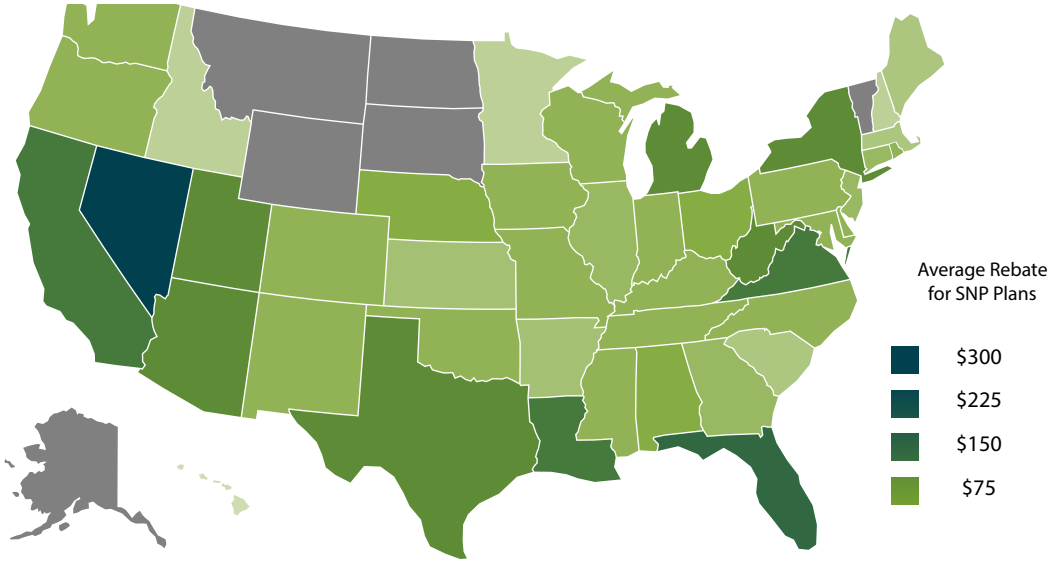
Figure 1: Average Per Member Per Month Rebate in Medicare Advantage Plans, 2015



Source: Centers for Medicare & Medicaid Services data on Medicare Advantage plan payments in 2015.

Notes: SNP = special needs plan. EGHP = employer group health plan. Average rebates are weighted by enrollment in each county-plan pair within the state. These estimates therefore reflect the average rebate for a Medicare Advantage enrollee in a state. Alaska is shown in gray because it did not have Medicare Advantage plan rebate data reported in the Centers for Medicare & Medicaid Services 2015 Medicare Advantage plan payment files.

Figure 2: Average Per Member Per Month Rebate in Medicare Advantage Special Needs Plans, 2015



Source: Centers for Medicare & Medicaid Services data on Medicare Advantage plan payments in 2015.

Notes: SNP = special needs plan. Average rebates are weighted by enrollment in each county-plan pair within the state. These estimates therefore reflect the average rebate for a Medicare Advantage enrollee in a given state. States in gray have no special needs plan rebate data reported in the Centers for Medicare & Medicaid Services 2015 Medicare Advantage plan payment files.

Rebate variations were even more stark across counties in 2015, with MA plans (not including SNP and employer plans) in Miami-Dade County having an average rebate of $341 per member per month in 2015, while 81 counties had an average rebate of $0 (data not shown).

Because the new supplemental benefits allowed under the 2019 and 2020 benefit flexibility must be financed through rebates, these results indicate that benefits will not fully address unmet social needs, given the relatively small amount of funds available (an average of $107 per member per month in 2019). In addition, MA plans were already using these rebate funds for other priorities before 2019, so the full rebate amount is not available for new supplemental benefits unless the plans eliminate previously provided benefits. Because rebate amounts vary substantially across the country, the opportunity to add supplemental benefits addressing enrollees' health-related social needs will be uneven. Importantly, this new benefit flexibility does not apply to the traditional Medicare program, which covers two-thirds of all Medicare beneficiaries.

Interviewee Responses to Newly Available Flexibility from CMS

Though interviewees generally viewed the new supplemental benefit flexibility as a positive step, industry experts reported that plans added few new benefits to address social needs using the new flexibility in 2019. Interviewees largely attributed the lack of uptake in 2019 to the short time plans had to respond to CMS's new regulations. Interviewees also expressed more long-term concerns regarding the lack of additional funding for new benefits, MA plans' lack of experience addressing social needs, and plans' concerns about investing in benefits that reach a small number of enrollees and therefore have limited appeal to a broad group of beneficiaries. One interviewee noted, "You don't want to design benefits that speak to 1 percent of your population; you try to cover as many [enrollees] as you can."

These sentiments were consistent across our interviews with MA insurers, though four out of five insurers did report adding new benefits or expanding existing benefits in 2019 in response to CMS's guidance. These additions included both benefits to address social needs and long-term services and supports (LTSS), like in-home personal care benefits (Table 1). The most commonly added or expanded benefit was meal delivery, reported by three insurers and noted by industry experts as being of great interest to insurers. The next most commonly added benefits (added by two insurers each) were adult day care, improvements to home safety, personal home helpers, and telephone navigator support. Finally, one insurer reported expanding transportation in response to CMS's guidance in 2019, and another insurer added acupuncture and massage therapy. Though all five insurers covered meal delivery and transportation for at least some members before 2019, they rarely offered the other benefits described above. All insurers that added or expanded benefits said they offered these benefits in a few markets based on the cost of the benefits, the rebate dollars available for that plan, and/or service providers' availability. In addition, MA insurers often noted that new benefits focused on SNP enrollees, rather than enrollees in general MA plans, because SNP enrollees have higher health care costs and are more likely to have health-related social needs. One insurer added multiple benefits as a menu of newly available services and has employed social workers to help beneficiaries select one benefit from the menu, and then provides referrals to additional services as it discovers the members' needs.

Additional details on each reported benefit type are described below.

- *Meals.* All five insurers offered home-delivered meals in some plans before 2019, and three reported expanding their existing meal delivery benefit in response to CMS's new interpretation of what supplemental benefits are primarily health related. Of the insurers who expanded the benefit, one removed the requirement that meal delivery could only be provided after a hospital discharge. Because CMS specified the benefit must be directly tied to chronic conditions and clinical care, this insurer now provides 16 meals per event for four events per year (64 meals). An "event" can either be a discharge or a determination by a physician that a food issue is contributing to a beneficiary's clinical condition.

  In addition, two insurers reported expanding meal delivery from a benefit in SNP plans to some of their general Medicare Advantage plans. One insurer used clinical criteria to target enrollees with two of the following three diseases: congestive heart failure, chronic obstructive pulmonary disease, and diabetes. The insurer reportedly selected these to target the benefit, which allows two weeks of meals following a discharge, to its most frail and high-cost patients. The other limited its expansion to one county "to see if it was an attractor for sales." In plans from this insurer, beneficiaries work with a care navigator to determine how many meals are needed after each hospitalization, totaling up to 30 days of meal delivery per patient per year.

- *Adult day care.* Two insurers reported adding an adult day care benefit in response to CMS's guidance. Though adult day care generally provides respite for caregivers, these insurers felt it could also help address social isolation. For example, one insurer is providing access to an adult day

center for up to one day a week in some plans. Another insurer provided a weekly credit for adult day care in some plans.

- *Home safety improvements.* Two insurers reported adding benefits intended to improve home safety in some plans. In one example, for any member requesting the benefit, an occupational therapist evaluates the member's home environment for risks or hazards that could cause falls. This insurer then reviews findings with the member and connects him or her with community resources that can install the recommended equipment. Another insurer added a $500 credit members can use to purchase assistive devices, such as sticky mats for the shower floor, add-ons to toilet seats, and ramps and handrails that do not require mounting. The benefit "stopped short of putting holes in people's walls" out of concerns that more significant renovation would open the plan to legal liability issues.

- *Personal home helpers.* Two insurers reported adding this benefit to some plans. For example, one insurer provides up to four hours of light housework per day for up to 31 days per year to help keep the home safe and help the individual remain independent. To qualify for the benefit, beneficiaries must have two limitations to activities of daily living, which the insurer says they included to adhere to CMS's requirement that benefits remain as clinically relevant as possible. Another insurer made this benefit available after a hospital stay, with the members working with a navigator to determine how much in-home help is needed.

- *Telephone navigator support for enrollees and caregivers.* Two insurers reported adding this benefit. One reported the benefit is available to enrollees who proactively reach out to the call center, and it is intended to provide both facilitation and emotional support, helping members and their caregivers navigate issues ranging from legal or financial support to handyman services. Another insurer reported making this benefit available as a component of its in-home assessment to help ensure member needs are met, such as by connecting the member with community-based organizations that can provide help.

- *Transportation.* All insurers provided some transportation benefits before 2019. Only one insurer reported expanding this benefit in response to CMS's guidance. This insurer reported using the new flexibility to allow members of some plans to use the benefit beyond transportation to a health care visit, for example to access the pharmacy or their gym benefit. In the interviewee's words, "The line we drew was if you need transportation to get to any one of your filed benefits, then you can use it for that." This insurer also increased the number of covered rides per beneficiary to allow for these new uses of the benefit. Another insurer reported they considered adding transportation for nonmedical purposes but have not yet done so out of concern that a member may use the limited number of covered rides for nonmedical activities then have none left when they need to go to the doctor.

- *Acupuncture and massage therapy.* One insurer reported adding this benefit to provide culturally relevant care to its members.

Industry experts said they expect to see more use of the MA benefit flexibility in 2020, including scaling up the geographic reach of some benefits introduced in 2019 as insurers gain more experience. The five insurers we interviewed reported planning to add benefits in 2020, though they could share few details because the benefits were still being developed. Many described the potential for scaling up recently added benefits to more geographic areas. Benefits planned or considered for 2020 included pest control, programs to reduce social isolation, palliative care, and dental care for people with certain diseases. However, there remained some reported uncertainty around what CMS would include in the final call letter defining the new SSBCI benefits because these interviews were conducted before the letter had been released.[27] This uncertainty caused some hesitation because, reportedly, after CMS released its guidance on the supplemental benefits, they rejected some plans' proposals focused more on social determinants of health. Therefore, some insurers wanted more clarity on the SSBCI benefits before submitting new social needs–focused proposals.

Factors Affecting MA Plan Decisionmaking

Interviewees reported several interrelated factors affecting their decisions to add new benefits, including the upfront cost of the benefits, the potential return on investment, necessary trade-offs, the amount of time they had to respond to CMS's guidance, and the organizations available to provide the benefit.

Upfront cost. Health insurers reported the primary factors in their decision to add new benefits were (1) the cost of the benefit and (2) whether they could afford to add it without taking away existing benefits at each plan-geography combination, given the county-level rebate available. One insurer reported considering adding LTSS-related benefits but, based on the cost, ultimately decided not to. However, though the per user costs for LTSS benefits can be substantial, if benefits are highly targeted to a small number of enrollees, the per enrollee cost could be small.

Return on investment. The potential return on investment of the benefit, through lower care costs, was also a consideration for some insurers. This concern is distinct from upfront costs because return on investment accounts for future cost savings, potentially allowing larger upfront investments for high-value benefits. However, some interviewees were skeptical that supplemental benefits would reduce hospitalization or other medical costs, which prevented them from adding more supplemental benefits. Other interviewees were open to adding benefits that improved outcomes while maintaining costs.

Trade-offs among benefits. Insurers discussed several trade-offs in the decision to add a benefit, many of which closely related to costs. For example, insurers noted that adding new supplemental benefits often requires reducing a current supplemental benefit to free up funding. Insurers were particularly hesitant to remove benefits consumers were already familiar with because such changes may affect member satisfaction scores. In turn, this could influence their star ratings, which would affect the rebate amount available to fund new benefits.

One insurer also noted trade-offs between investing in lower-cost benefits that may broadly attract more enrollees and investing in higher-cost benefits that reduce spending on very high–cost patients. In particular, benefits targeted to high-cost patients are difficult to advertise, because only a small subset of members may be eligible for them. In MA, supplemental benefits are used to attract enrollees and can confer a competitive advantage,[28] so interviewees also reported considering competitors' benefits.

Time to respond. Because of the short time insurers had to submit proposed benefit plans in spring 2018, some interviewees reported retaining the same benefits in their SNPs, given their experience with these benefits and existing relationships with service providers. Similarly, interviewees expressed some uncertainty about CMS's plans for SSBCI benefits, which were finalized in a call letter after our interviews were conducted.[27]

Available providers. Another consideration mentioned was community-based organizations' capacity to provide these new benefits under contract with MA insurers. One interviewee felt it is easier to implement LTSS benefits because LTSS providers typically have experience working with Medicaid-managed care and therefore are adept at submitting claims and working with insurance companies. Conversely, because they are typically grant funded, community-based organizations working to address social needs are less likely to have established relationships with insurance companies or the infrastructure to quickly ramp up providing new benefits to the MA population.

Anticipated Effect of New Flexibility on the Market

Though interviewees generally saw the new benefit flexibility as a step in the right direction, they also felt it is currently insufficient to spur big changes in the market. As one interviewee said, "I think it's awesome that the opportunity is here now, but in order to get plans to buy in and this to be scalable and sustainable, I think there are just some other changes that are going to have to happen." These changes are described in more detail below.

CMS limits on targeting. Several interviewees noted that CMS only allows these benefits to be targeted based on clinical criteria, rather than social needs. One interviewee suggested, "If you really want to be impactful, then you should let your plans use these [benefits] and target these not based on the fact that somebody has diabetes or congestive heart failure, but rather that maybe they're a frequent flyer at the ED [emergency department]." Another suggested that "the social determinants, with some reasonable guard rails, should be a trigger for a benefit." Relatedly, several interviewees suggested encouraging providers to use ICD-10 Z codes that document social adversity to help flag patients for targeted interventions.[29] These diagnosis codes document, for example, homelessness, inadequate housing, illiteracy, and extreme poverty.[29] They reported that providers do not currently use these codes consistently.

Also, some interviewees noted preexisting opportunities insurers can use to cover nonmedical benefits and target benefits to certain members. One expert noted that programs to address social isolation can count as quality improvement programs under the MA medical loss ratio rules, allowing insurers to count that spending as medical related. Insurers also already target higher-need members through their SNPs, so it was unclear to some interviewees how useful this SSBCI flexibility will be.

Inexperience among insurers and providers. Industry experts also noted that MA insurers seldom have experience addressing social needs and must learn how to do so. Interviewees varied in their perceptions on how useful the lessons will be for insurers who have worked on social determinants of health through a Medicaid product, given the Medicare population is different. MA insurers also expressed that, for benefits addressing unmet social needs to be scalable, considerable technical assistance is needed to prepare the service provider community. The need to identify providers and negotiate contracts by county makes implementation on a larger scale challenging for health plans. As one interviewee noted, "Even the Meals on Wheels

programs, which have been quasi-recommended in the CMS guidance, have tremendous diversity of capacities there, and if you have a big service area, even if you want to do business with Meals on Wheels, you're doing it with dozens of local providers." This fact may instead steer some plans toward a national, for-profit vendor for ease of contracting.

This interviewee also recognized that though more technical assistance on benefit design and contracting for social needs (particularly for smaller insurers) may be needed, providing it may counter the MA market structure, where "you're supposed to kind of let the market sort it out and if the shark eats the minnows, that's how the market is supposed to work." This interviewee also added, "As a practical matter, there are people who are not well resourced to go into this as quickly as CMS might want." Given the challenges health insurers face contracting with local providers, one interviewee mentioned that there are new intermediary vendors that contract with health insurers to deliver multiple community-based services and then contract with other programs, such as food banks and transportation companies, who ultimately deliver such services. However, some interviewees expressed concern that, as this type of intermediary becomes more common, payment rates to the service providers will be further reduced.

Effect on consumers. Interviewees also had several concerns that the new supplemental benefit flexibilities will affect consumers inequitably. Several noted that expanding the scope of "primarily health-related" supplemental benefits will give beneficiaries in MA access to services unavailable for traditional Medicare beneficiaries. In addition, the variation in how new benefits are implemented across MA plans, by geographic market based on rebates and available providers, was a concern. One interviewee also raised a concern around the deleterious effect this change could have on Medicaid efforts to address social needs if service providers are now able to receive Medicare rates for serving MA patients and no longer want to accept the lower negotiated Medicaid rates.

Advocates also worried about how targeted benefits will be advertised. Clinical eligibility guidelines may not be clearly communicated in advertising materials, leading beneficiaries to sign up for plans expecting to receive a particular supplemental benefit for which they are ultimately ineligible. In addition, research has shown that many Medicare beneficiaries rely on recommendations from friends and family when choosing a plan.[30] Because benefit packages will differ by diagnosed conditions, word-of-mouth recommendations may mislead beneficiaries about the benefits available in MA plans if benefits are targeted extensively.

CONCLUSION

The introduction of new flexibility for MA plans to cover benefits that may address enrollees' health-related social needs was met with enthusiasm in the press for its potential to address the social determinants of health and LTSS needs among Medicare beneficiaries. The new benefit flexibilities in MA do provide an opportunity for plans to address health-related social needs, and this policy has resulted in expansion and/or introduction of transportation benefits, meal delivery services, and limited LTSS services, like in-home personal care and adult day care. However, none of the MA insurers we spoke with have rolled out nationwide benefits, and many enhancements have been focused on a limited set of beneficiaries or geographic areas.

As noted, take-up of the new benefit flexibility was limited in 2019. Similarly, these benefits' potential to address unmet social needs may be limited for the foreseeable future. First, the new benefit flexibility was not accompanied by any new funding. The funds available from MA plan rebates to innovate supplemental benefits are small, averaging $107 per member per month in 2019. Second, interviewees noted that the availability of community-based organizations that can provide a given benefit and bill an insurance company varies by region, and the need to negotiate contracts by county adds great complexity for MA insurers. Third, MA insurers did not think they had sufficient information to select benefits with a high likelihood of a positive return on investment, and some expressed skepticism that addressing health-related social needs would affect health care costs. Finally, interviewees expressed that addressing enrollees' health-related social needs is complicated, leading MA insurers to focus on expanding existing benefits, like transportation or home-delivered meals, rather than commit substantial resources to exploring new benefits like housing assistance.

In addition to the factors limiting MA insurers' approaches to these benefits, interviewees expressed deeper concerns about equity between MA and traditional Medicare, as well as geographic variation in benefits within MA. Because of differences in MA plan resources and community-based organization availability, benefits to address MA enrollees' health-related social needs will always vary geographically. In addition, these benefits will not be available to traditional Medicare enrollees, leading to concerns about equity in

benefits and outcomes across the Medicare program. Because of geographic variation in MA and plans' ability to target benefits based on health conditions, it will also be difficult to make benefit eligibility clear and market these benefits fairly to consumers.

Overall, MA insurers generally reported that the new benefit flexibilities do not sufficiently allow plans to target where social needs are greatest and new benefits could have the biggest impact. Interviewees had several recommendations for improving benefit flexibility policies. First, they suggested that CMS provide additional funding to plans, though their ideas for how CMS could allocate such rebates varied. One suggested that CMS determine the allocation by how well plans use new benefits to improve patient outcomes. Another recommended higher rebate percentages for D-SNPs because they serve populations with greater social needs. Other interviewees felt CMS should work on incentivizing longer-term services (such as housing), which they felt would provide the greatest health improvements. Finally, interviewees felt that CMS should allow plans more flexibility in targeting benefits to social determinants of health rather than clinical criteria. Interviewees suggested these changes would allow plans to more creatively and effectively target health-related social needs.

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Appendix Table 1: Average Per Member Per Month Rebate in Medicare Advantage Plans and Special Needs Plans, 2015

State	Average Rebate (No SNP or EGHP Plans)	Average Rebate for SNP Plans
AL	$50	$63
AR	$42	$29
AZ	$83	$86
CA	$110	$114
CO	$68	$52
CT	$30	$38
DC	$40	$32
DE	$19	$47
FL	$159	$167
GA	$48	$39
HI	$28	$32
IA	$32	$57
ID	$44	$0
IL	$58	$66
IN	$32	$59
KS	$53	$24
KY	$27	$43
LA	$111	$94
MA	$48	$24
MD	$34	$52
ME	$65	$27
MI	$31	$84
MN	$19	$21
MO	$83	$47
MS	$38	$50
MT	$23	N/A
NC	$49	$48
ND	$2	N/A
NE	$37	$62
NH	$26	$1
NJ	$45	$67
NM	$74	$49
NV	$132	$282
NY	$58	$84
OH	$43	$60

OK	$54	$38
OR	$42	$48
PA	$36	$49
RI	$53	$44
SC	$42	$34
SD	$16	N/A
TN	$74	$51
TX	$113	$76
UT	$64	$84
VA	$40	$127
VT	$9	N/A
WA	$31	$45
WI	$45	$52
WV	$25	$74
WY	$11	N/A

Source: Centers for Medicare & Medicaid Services data on Medicare Advantage plan payments in 2015.

Notes: SNP = special needs plan. EGHP = employer group health plan. Average rebates are weighted by enrollment in each county-plan pair within the state. These estimates therefore reflect the average rebate for a Medicare Advantage enrollee in a given state.