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DATA SPOTLIGHT

MEDICARE ADVANTAGE 2012 SPOTLIGHT: PLAN AVAILABILITY AND PREMIUMS

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Under the current Medicare program, beneficiaries may choose coverage under the fee-for-service (FFS) Medicare program, or elect coverage under private plans, such as HMOs and PPOs, now known as Medicare Advantage plans. Medicare Advantage plans receive funds from the federal government (Medicare) to provide Medicare-covered benefits to enrollees. As of September 2011, 11.9 million (25%) Medicare beneficiaries were enrolled in a Medicare Advantage plan. This *Data Spotlight* reviews trends in Medicare Advantage plan offerings, choices available to beneficiaries, and the premiums and selected characteristics of the available plans in 2012, and is part of a series of spotlights tracking key changes in the Medicare Advantage program. The analysis is based on publicly available data released by CMS.[1]

SUMMARY OF FINDINGS

The outlook for the Medicare Advantage program in 2012 looks very similar to the marketplace in 2011. Despite concerns about the potential effects of reductions in payments to plans enacted in the 2010 health reform law, beneficiaries will not see a dramatic change in either the number or type of Medicare Advantage plans offered in their area.[2] On average, beneficiaries will be able to choose among 20 Medicare Advantage plans in 2012, a decline from 24 plans, on average, in 2011. Nationwide, the number of Special Needs Plans (SNPs) will rise from 409 plans in 2011 to 500 plans in 2012, mostly due to an increase in plans for beneficiaries dually eligible for Medicare and Medicaid. Almost all beneficiaries who are enrolled in a Medicare Advantage plan in 2011 will be able to stay in the same plan, with little change in premiums from 2011 to 2012, on average.

RECENT LEGISLATIVE AND REGULATORY CHANGES FOR MEDICARE ADVANTAGE

Over the years, Congress and various Administrations have made a number of changes to payments and participation rules for private risk-bearing plans that contract with the federal government to provide Medicare covered benefits, now called Medicare Advantage plans. In the past, for example, Congress expanded the range of plans that could be offered to beneficiaries (BBA 1997 and MMA 2003) and imposed new requirements for plans, such as requiring Private Fee for Service (PFFS) plans to have networks of providers in most counties (MIPPA 2008). With respect to payments, after years of adjusting payments upward to encourage more plan participation, Congress recently enacted changes in payment policy in response to evidence that Medicare was paying more for Medicare beneficiaries enrolled in Medicare Advantage plans than it would have paid for such beneficiaries in the FFS program. The 2010 health reform law imposed a freeze on maximum payments to plans (benchmarks) through 2010 and 2011, with payment reductions phasing in beginning in 2012, based on relative per capita fee-for-service Medicare costs in the county.[3] Counties experiencing larger reductions will see them phased in over a longer period of time to minimize disruption. Also, beginning in 2012, plans' quality ratings will be used to provide bonus payments and determine which plans can enroll beneficiaries throughout the calendar year. This will boost payments to many plans based on their quality ratings.[4]

The Administration also made changes to the rules for Medicare Advantage plans, including policies seeking to encourage the consolidation of low enrollment and duplicative ("look alike") plans and limit the use of cost sharing features that might adversely affect high cost beneficiaries, beginning in 2010. In 2011, CMS began requiring plans to limit beneficiaries' out-of-pocket expenditures to no more than $6,700 annually, with reduced scrutiny of beneficiary cost-sharing for plans that limited out-of-pocket expenses to $3,400 or less.

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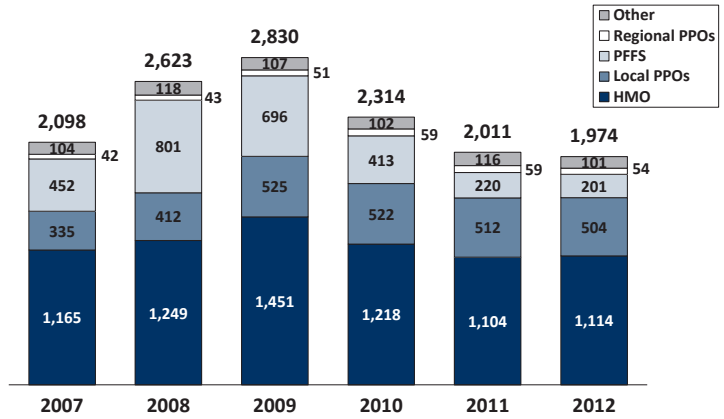
PLAN AVAILABILITY AND CHOICE

Plan Availability. Nationwide, 1,974 Medicare Advantage plans will be offered in 2012, 81 percent of which will include the Part D benefit (MA-PDs).[5]

- The number of plans available nationwide in 2012 is only slightly lower than in 2011 (a decline of less than 40 plans, including 19 PFFS plans). This reflects a stabilization of the market after the reductions in plan offerings in 2010 and 2011 that were largely associated with requirements for PFFS plans to have provider networks **(Exhibit 1)**.
- HMOs remain the most common type of plan in 2012, as in previous years, accounting for 56 percent of all Medicare Advantage plans offered nationwide. In contrast to most other plan types, which experienced a small decline, the number of HMO plans slightly increased in 2012.
- In 2012, the number of regional PPOs decreased to 54 from the historical high of 59 in 2010 and 2011. By design, regional PPOs serve large areas (comprised of one or more states), so plan counts understate their presence in the market, or the impact of a reduction, relative to other plan types.

Exhibit 1

Distribution of Medicare Advantage Plans by Plan Type, 2007-2012



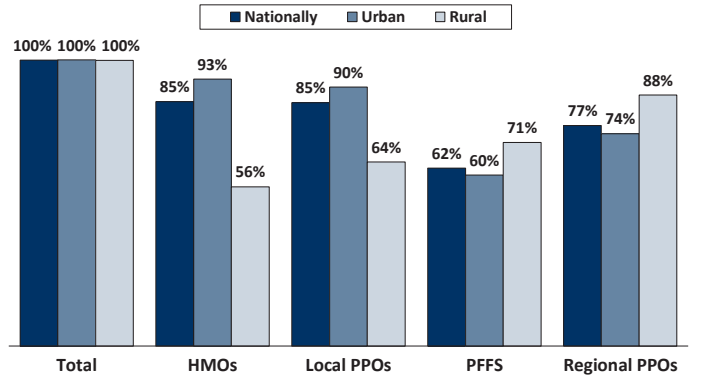
NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). HMOs include Point of Service (POS) plans.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2007 - 2012.

Plan Choices. Virtually all Medicare beneficiaries will have access to a Medicare Advantage plan as an alternative to traditional Medicare in 2012 **(Exhibit 2)**. The number of plan choices available to beneficiaries is similar to 2011 with a small increase in the proportion of rural beneficiaries having access to an HMO or local PPO in 2012.[6]

- HMOs: 85 percent of all Medicare beneficiaries will have access to one or more HMO in 2012 (93 percent in urban areas and 56 percent in rural areas).
- Local PPOs: 85 percent of all Medicare beneficiaries will have access to one or more local PPO in 2012 (90 percent in urban areas and 64 percent in rural areas).
- PFFS plans: 62 percent of all Medicare beneficiaries will have access to one or more PFFS plan in 2012 (60 percent in urban areas and 71 percent in rural areas).
- Regional PPOs: 77 percent of all Medicare beneficiaries will have access to one or more regional PPO in 2012 (74 percent in urban areas and 88 percent in rural areas).

Exhibit 2

Share of Medicare Beneficiaries with Access to One or More Medicare Advantage Plans, By Plan Type, and Urban/Rural County, 2012



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). The total includes cost and MSA plans, which are not shown separately. HMOs include POS plans. Plans in the territories are included in the total, but not in the urban/rural categories.
SOURCE: MPR/KFF analysis of CMS's Landscape and Penetration Files for 2012.

Although the number of plans available to Medicare beneficiaries will decline again in 2012 relative to a high in 2009, Medicare beneficiaries continue to have many plan choices. In 2012, the average Medicare beneficiary will have 20 plans from which to choose, including 10 HMOs, 4 local PPOs, 2 regional PPOs, and 3 PFFS plans, as well as other plans such as cost plans and Medical Savings Account (MSA) plans. Beneficiaries in urban counties can choose from among 22 plans, on average, and beneficiaries in rural counties can choose from among 13 plans **(Table A1)**. Almost all (82 percent) beneficiaries will have access to 10 or more plans in 2012, down from 88 percent in 2011 (data not shown).

Availability by Level of Medicare Fee-for-Service Spending. Historically, beneficiaries in counties with the highest Medicare per capita fee-for-service costs (top quartile) have had more Medicare Advantage plans available to them than have beneficiaries in lower cost counties **(Table A1)**. In 2012, the first year the Medicare Advantage payment reductions will begin to vary by quartile, counties in the highest cost quartile will have a larger drop in available plans than other counties. However, beneficiaries in the counties within the highest cost quartile will continue to have considerably more plan choices (24) than beneficiaries in counties within the lower cost quartiles (17 plans).

MARKET DYNAMICS AND TURNOVER

While many firms participate in the Medicare Advantage program, a small number of firms (including the Blue Cross Blue Shield affiliates) have historically accounted for a majority of plan offerings nationwide **(Table A2)**.

- In 2012, more than two-thirds of all beneficiaries will have access to plans offered by Humana and the Blue Cross Blue Shield (BCBS) affiliates (including Wellpoint's BCBS affiliated line of business), and more than half will have the option of enrolling in a Medicare Advantage plan offered by UnitedHealthcare (**Exhibit 3; Table A3**).[7]
- Few firms are offering PFFS plans that reach large numbers of beneficiaries in 2012.[8] Among national firms, only Humana and Universal American offer PFFS plans to a relatively larger share of the Medicare population (49 percent and 26 percent, respectively; data not shown).

Exhibit 3

Percent of Medicare Beneficiaries with One or More Medicare Advantage Plans Available from Particular Firms, 2012

NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). BCBS affiliates are BlueCross BlueShield affiliates. This analysis only includes Wellpoint plans offered by the BCBS affiliated lines of business. Cigna has indicated an intent to acquire Healthspring, pending regulatory approval. Percentage refers to the share of all Medicare beneficiaries nationwide who are in counties with one or more Medicare Advantage plans available from a particular firm for individual enrollment.
SOURCE: MPR/KFF analysis of CMS's Landscape and Penetration Files for 2012.`

In 2012, most firms appear to have kept their Medicare Advantage offerings relatively stable or made only marginal changes, in terms of plan availability and plan type; we did not examine changes in plans' benefits. One notable exception appears to be Wellpoint, which dropped its regional PPO in California (discussed below).

EFFECT OF CHANGES IN 2012 PLAN OFFERINGS ON CURRENT ENROLLEES

Because the Medicare Advantage market will remain relatively stable in 2012, only two percent of current Medicare Advantage enrollees (about 200,000 beneficiaries) will need to switch Medicare Advantage plans or return to the traditional Medicare program because their plan will not be offered in 2012.[9]

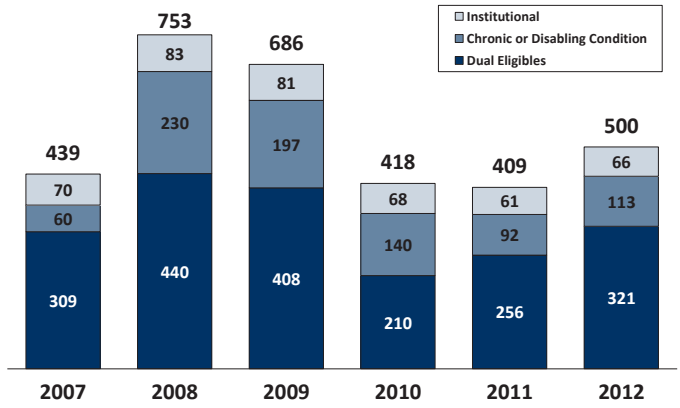
Almost two-thirds (65%) of beneficiaries who will be affected by plan withdrawals are in Wellpoint's BCBS regional PPO in California. The remaining enrollees in plans that will be discontinued in 2012 are distributed across a variety of smaller HMOs, local PPOs, PFFS plans and cost plans.

Availability of Special Needs Plans (SNPs) in 2012

Special Needs Plans, a form of Medicare Advantage plan, were authorized in 2003 to provide a managed care option for three groups of beneficiaries with significant or relatively specialized health care needs, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid (dual eligibles), beneficiaries living in nursing homes or other institutions, and beneficiaries with severe chronic or disabling conditions. Most SNPs are HMOs, but can also be local PPOs or regional PPOs.

Exhibit 4

Distribution of Special Needs Plans by Plan Type, 2007-2012



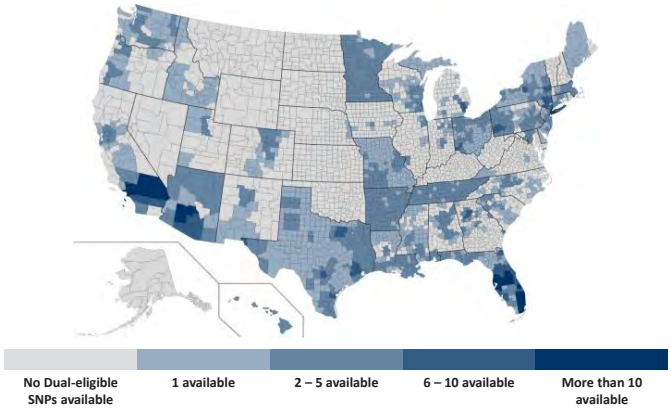
NOTE: Excludes employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites).
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2007 – 2012.

The number of SNPs will rise in 2012, reversing their recent decline **(Exhibit 4)**. In 2012, 500 SNPs of all types will be offered, up from 409 in 2011. More SNPs of every type will be offered, with dual eligible SNPs accounting for most of the growth. Between 2011 and 2012, the number of SNPs for dual eligibles will increase from 256 plans to 321 plans, while the number of chronic SNPs will increase from 92 plans to 113 plans and the institutional SNPs will increase from 61 plans to 66 plans. Of the 113 chronic care SNPs in 2012, 28 are focused on diabetes, another 47 on diabetes with some form of cardiovascular disease and/or congestive heart failure, and 15 are focused on beneficiaries with specific lung conditions.

SNPs for dual eligibles are not uniformly available across the country **(Exhibit 5)**. Dual eligibles in Los Angeles County and Miami-Dade County can choose from more than 10 dual SNPs, while no dual SNPs are available in 13 states (AK, KS, KY, MT, NV, NH, ND, OK, RI, SD, VT, WV and WY).

Exhibit 5

Number of Special Needs Plans Available for Beneficiaries Dually Eligible for Medicare and Medicaid, by County, 2012



NOTE: Excludes employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and other plans for selected populations (e.g., Mennonites).
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2012.

SNP growth does not appear concentrated in any one state, although some states with large numbers of dual eligible SNPs (such as Florida, New York and Texas) will see considerable growth in 2012 **(Table A4)**.

For more information, see M. Gold, G. Jacobson, A. Damico, and T Neuman. "Special Needs Plans: Availability and Enrollment" Data Spotlight, Washington DC: Kaiser Family Foundation Program on Medicare, September 2011.

PREMIUMS AND BENEFITS IN 2012

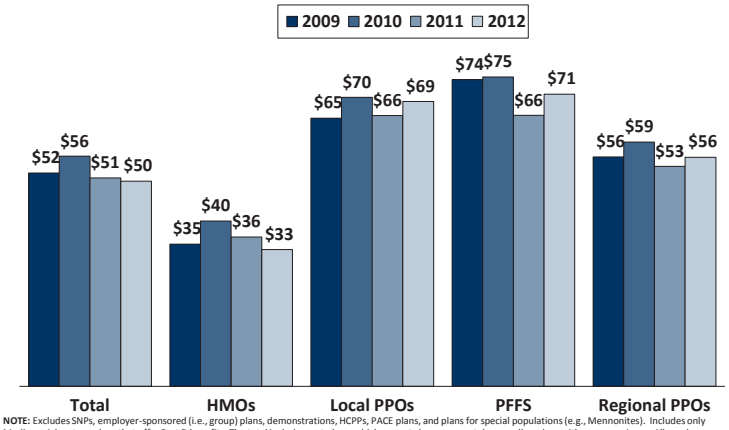
This year all Medicare beneficiaries will have the opportunity to compare and switch plans during the open enrollment period from October 15 to December 7. The dates for the open enrollment period have been moved earlier in the year to allow more time to process enrollment changes before January 1, 2012, the start of the new plan year. Premiums, benefits, cost sharing requirements, and provider networks are important plan characteristics for beneficiaries looking to determine whether to join or stay in a Medicare Advantage plan and, if so, which plan may be best for them. This analysis reviews trends in premiums, out of pocket spending limits, and Part D drug benefits, using data CMS released in September. This brief does *not* include information on cost sharing requirements for individual services, such as physician visits or hospitalizations, which could be a major factor in an enrollee's out of pocket expenses.[10]

Monthly Premiums (Unweighted). Medicare beneficiaries enrolled in Medicare Advantage plans pay the Part B premium (less any rebate provided by the Medicare Advantage plan) and any additional monthly premium charged by a Medicare Advantage plan for plan benefits and prescription drug coverage (Part D).[11] The latter is paid directly to the Medicare Advantage plan. Premiums not weighted by enrollment ("unweighted") show the change in premiums for plans available to beneficiaries, but ultimately the average premiums beneficiaries pay for the plans they select are more relevant to beneficiaries ("weighted premiums").

- In 2012, the average unweighted monthly premium for Medicare Advantage Prescription Drug plans (MA-PDs) will be $50 per month, about $1 less than in 2011, and about $6 less than in 2010 **(Exhibit 6; Table A5)**.
- Average unweighted premiums will decrease from $36 to $33, among HMOs, but increase by between $2 and $5 for other plan types.[12]

Exhibit 6

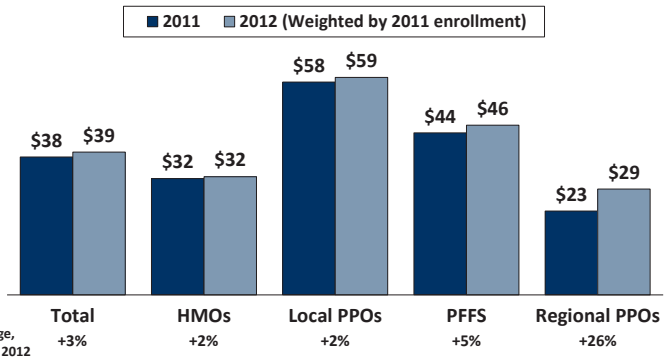
Unweighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, 2009-2012



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes only Medicare Advantage plans that offer Part D benefits. The total includes cost plans, which are not shown separately, as well as plans with zero premiums. All numbers are rounded to the nearest dollar.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2009 - 2012.

Exhibit 7

Weighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, Total and by Plan Type, 2011-2012
(2012 Weighted by 2011 Enrollment; Includes Plans Available in Both 2011 and 2012)



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes only Medicare Advantage plans that offer Part D benefits. The total includes cost plans, which are not shown separately, as well as plans with zero premiums. Weighted monthly premiums for 2012 include MA-PDs available in both 2011 and 2012, based on 2011 enrollment, and assume that enrollees remain in the same plan from one year to the next. Calculations take into account plan availability by county of residence as well as overall availability and thus reflect service area changes.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2011 – 2012, CMS's 2012 Part C and D Crosswalk file, and September 2011 Enrollment file.

Monthly Premiums for Continuing Enrollees (Weighted by Enrollment). Although the average weighted premium paid by Medicare Advantage enrollees in 2012 will not be known until after beneficiaries are actually enrolled in plans for 2012, we estimate the weighted premium based on current 2011 enrollment to estimate premiums most likely to be paid in 2012.

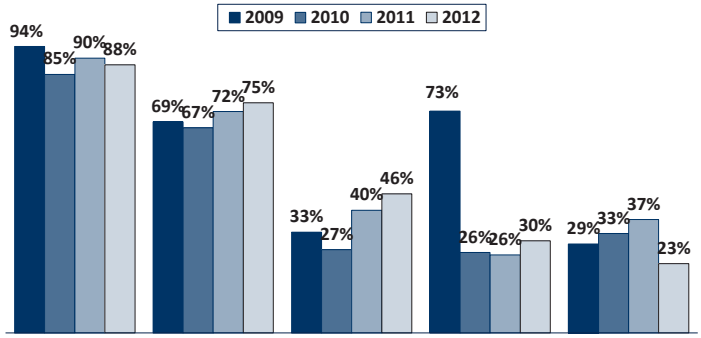
Current enrollees in a MA-PD plan that will remain available in 2012 will see their premiums rise by $1.29, on average, if they remain in the same plan. For plans available in both 2011 and 2012, the average weighted premium in 2011, $37.52 per month, will rise to $38.81 in 2012 – a 3 percent increase **(Exhibit 7)**. Enrollees in HMOs will see a smaller premium increase than those in other plan types **(Table A6)**.

Availability of "Zero Premium" MA-PDs. The vast majority (88%) of beneficiaries nationwide will have access to a MA-PD for no additional premium, other than the monthly Part B premium (i.e., "zero premium plans"). In 2011, about half of Medicare Advantage enrollees were enrolled in a MA-PD with no additional premium. If Medicare Advantage enrollees who are able to stay in the same plan choose to do so in 2012, over half (53%) will be in a plan that charges no premium.

- Three-fourths of all beneficiaries will have access to a zero premium HMO with prescription drug coverage (**Exhibit 8**).
- Nearly half (46%) of all beneficiaries will have access to a local PPO plan for no additional premium (up from 40% in 2011), while less than one-quarter (23%) will have access to a zero premium regional PPO plan with prescription drug coverage (down from 37% in 2011).
- Beneficiaries in urban areas are more likely to have access to a zero premium plan than beneficiaries in rural areas (92% compared to 73%; data not shown).
- A smaller share of beneficiaries in the lowest cost counties will have access to a zero premium plan than beneficiaries in the highest cost counties (31% compared to 69%, respectively; data not shown). These differences are unlikely to be attributable to payment changes because similar patterns were seen in 2011.

Exhibit 8

Share of Beneficiaries with Access to Medicare Advantage Prescription Drug Plans with No Additional Premium, Total and by Plan Type, 2009-2012



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes only Medicare Advantage plans that offer Part D benefits. The total includes cost plans, which are not shown separately. Calculations take into account plan availability by county of residence as well as overall availability and thus reflect service area changes.
SOURCE: MPR/KFF analysis of CMS's Landscape and Penetration Files for 2009 – 2012.

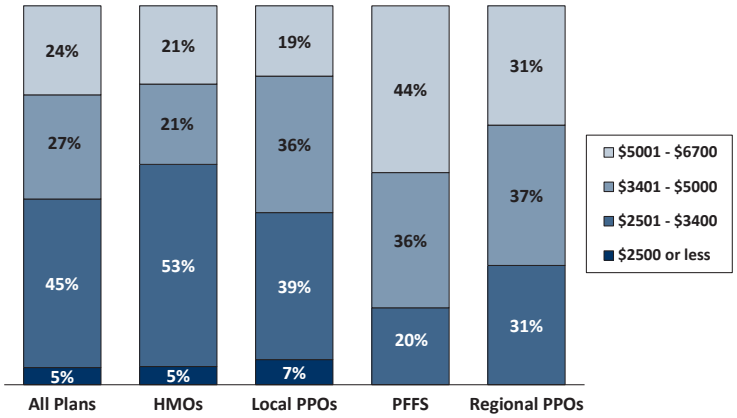
LIMITS ON OUT-OF-POCKET SPENDING

The fee-for-service Medicare program does not include a limit on out-of-pocket spending for services covered under Parts A and B. When HMOs were first offered under the risk contracting program, they covered most of Medicare's cost sharing requirements, making limits essentially unnecessary. However, cost sharing requirements have increased over time in Medicare Advantage plans, reflecting cost growth and broader societal trends.[13] In 2006, when they were first authorized, regional PPOs were required to have a limit on out-of-pocket spending for benefits under Parts A and B. Beginning in the 2011 plan year, CMS required all local Medicare Advantage plans to limit enrollees' out-of-pocket expenses to no more than $6,700, and *encouraged* plans to limit enrollees' out-of-pocket expenses to no more than $3,400.

- In 2012, 49 percent of all Medicare Advantage plans have a limit of $3,400 or less, while 24 percent have an annual limit of more than $5,000 **(Exhibit 9)**.
- Out-of-pocket limits for HMOs, on average, are lower than those among PFFS plans and regional PPOs. Nearly one-third of regional PPOs and 44 percent of PFFS plans have limits above $5,000.
- Across all plans, the distribution of limits in 2012 is fairly similar to 2011 (data not shown).

Exhibit 9

Distribution of Medicare Advantage Plans' Out-of-Pocket Spending Limits, by Plan Type, 2012



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, MSAs, and plans for special populations (e.g., Mennonites). Percentages are unweighted by enrollment. Totals may not add to 100% due to rounding. All Medicare Advantage plans have been required to limit out-of-pocket expenses to no more than $6,700 since 2011.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2012.

PRESCRIPTION DRUG COVERAGE

Until 2006, Medicare did not offer a prescription drug benefit, and Medicare Advantage plans were an important source of prescription drug coverage for people on Medicare. Many plans offered some coverage for prescription drugs, which they often financed in part with the net difference between Medicare Advantage payments for Part A and B benefits and the plan's cost for such benefits. Beginning in 2006, all beneficiaries had access to a prescription drug benefit either through free-standing prescription drug plans (PDPs) or a Medicare Advantage plan that included Part D (MA-PDs). In 2012, manufacturers will discount the prices for their brand-name drugs by 50 percent for all beneficiaries in Medicare. Today, 81 percent of all Medicare Advantage plans offer prescription drug coverage. Many of those that do not are designed for beneficiaries who may have access to other sources of prescription drug coverage, such as former employers or the Department of Veterans Affairs (VA).

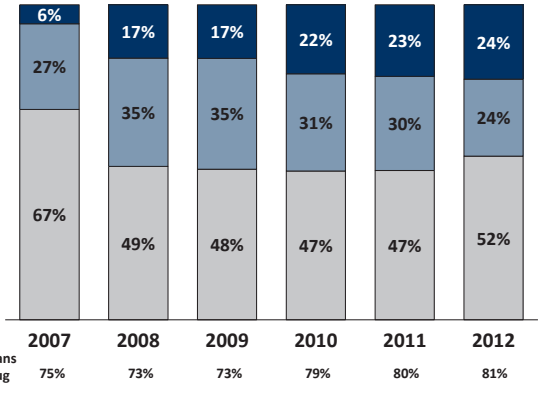
Medicare Advantage Prescription Drug Plans (MA-PDs). More than one-third (37%) of all Medicare beneficiaries enrolled in Part D in late 2011 were in a MA-PD plan, with the remaining 63 percent in PDPs.[14] Many MA-PDs provide prescription drug coverage and other supplemental benefits available for no additional premium (see prior discussion of available "zero premium MA-PD plans").[15]

- After holding steady for several years, a slightly larger share of MA-PDs (52%) will offer no coverage in the Part D coverage gap, also known as the Part D "doughnut hole" in 2012, other than the 50 percent discount on brand-name drugs required by the health reform law **(Exhibit 10)**.
- In 2012, 24 percent of MA-PDs will limit their gap coverage solely to generics and the other 24 percent offer some limited brand-name coverage as well.

HMOs and local PPOs are more likely to offer gap coverage than PFFS plans and regional PPOs **(Exhibit 11)**. The majority of regional PPOs (71%), PFFS plans (60%), and local PPOs (54%) have no gap coverage, while more than half (52%) of HMOs offer some coverage in the gap. MA-PDs are more likely than PDPs to offer coverage in the gap in 2012, as in previous years.[16] One reason for this is that the MA-PD structure allows them to offset Part D costs (as well as other features of plan design) by any savings in Part A and B payments. These savings will likely be lower in future years because the health reform law gradually decreases the Medicare Advantage payment benchmarks.

Exhibit 10

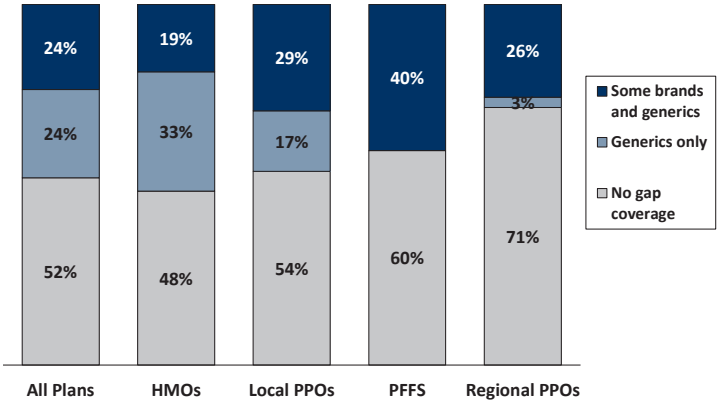
Share of Medicare Advantage Prescription Drug Plans with Gap Coverage, 2007-2012



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, MSAs, and plans for special populations (e.g., Mennonites). Includes only Medicare Advantage plans that offer Part D benefits. Percentages are unweighted by enrollment. Totals may not add to 100% due to rounding. All plans that cover brand name drugs in the coverage gap also cover generic drugs in the gap. Less than 1% of plans in 2010, 2011, and 2012 cover all brands and generics in the gap.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2007-2012.

Exhibit 11

Share of Medicare Advantage Prescription Drug Plans with Gap Coverage, by Plan Type, 2012



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes only Medicare Advantage plans that offer Part D benefits. Percentages are unweighted by enrollment. Totals may not add to 100% due to rounding. All plans that cover brand name drugs in the coverage gap also cover generic drugs in the gap.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2012.

DISCUSSION

The Medicare Advantage market has been affected by many policy changes over the years, and Medicare beneficiaries have seen annual changes in premiums, benefits, and plan offerings. In contrast to previous year to year changes, the offerings in 2012 are remarkably similar to those in 2011.[17] This analysis did not examine changes in extra benefits or cost-sharing for specific services, and we do not know whether plan benefits became more or less generous (or stayed the same) between 2011 and 2012. The gradual decrease in Medicare Advantage payments from the health reform law will not be fully implemented in most counties until 2017. Ongoing monitoring efforts are needed to assess the implication of payment changes on plan availability, premiums and benefits.

REFERENCES

[1] Data for individual plans offered are contained in "2012 MA and SNP Landscape Source Files" https://www.cms.gov/PrescriptionDrugCovGenIn/

[2] Hereinafter, the health reform law refers to the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148; PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

[3] For more information, see "Explaining Health Reform: Key Changes in the Medicare Advantage Program" Kaiser Family Foundation, May 2010.

[4] Jacobson G, Neuman T, Damico A, and Huang J, "Medicare Advantage Plan Star Ratings and Bonus Payments in 2012," November 2011. See also Jacobson G, Damico A, Huang J, and Neuman T, "Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011" Kaiser Family Foundation, February 2011.

[5] Plan counts exclude group plans and SNPs since they are not available to all beneficiaries for individual enrollment. They also exclude plans with special eligibility or other requirements, including Health care Prepayment Plans (HCPP), Program for All Inclusive Care for the Elderly (PACE) plans, demonstrations, and plans offered by selected groups, such as Mennonites.

[6] For 2011 data, see M. Gold, G. Jacobson, A. Damico, and T. Neuman "Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums" Washington DC: Kaiser Family Foundation, October 2010.

[7] This is even more the case when it comes to enrollment. See, M.Gold, G. Jacobson, A. Damico and T. Neuman "Medicare Advantage 2011 Data Spotlight: Medicare Advantage Enrollment Market Update," Washington DC: Kaiser Family Foundation, September 2011.

[8] When we analyzed PFFS plans in 2011, the first year the network requirements went into effect, we found that many of those offered had networks. That is, PFFS plans are not necessarily just offered in counties where network requirements are lacking. See M.Gold, G. Jacobson, A. Damico, and T. Neuman "Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums" Washington DC: Kaiser Family Foundation, October 2010.

[9] These data are based on September 2011 enrollment.

[10] Those seeking such information for individual plans can find it at www.medicare.gov on the "Compare Drug and Health Plan" database. However, this database shows individual plans by zip code and does not include summary statistics on the characteristics of plans available nationwide or in particular locales.

[11] Medicare Advantage plans are required to cover all Part A and B Medicare benefits on an actuarially equivalent basis. While they are not precluded from charging beneficiaries an extra premium for those benefits if the plan's costs exceed what Medicare pays for such benefits, this is not a very likely option in the current environment given the current level of benchmarks used to set Medicare Advantage rates and the importance of premiums in competing for enrollment.

[12] This analysis shows a smaller decline in premiums for 2012 than that shown by CMS (a decline of 1.6% versus 4%). We speculate that the variation between estimates is explained by slightly different criteria used for including plans in these calculations. Note 5 summarizes our exclusions and the rationale for them. When making premium comparisons, we also exclude Medicare Advantage plans that do not offer prescription drug coverage to provide a consistent comparison across plan types and years. CMS did not release the methodology for their estimates. See CMS, "2012 Medicare Advantage premiums fall and projected enrollment rises," press release, September 15, 2011.

[13] M. Gold "Medicare+Choice: An Interim Report Card" *Health Affair*s 20:4120-138; July 2001. See also M. Gold, M. Hudson, G. Jacobson, and T. Neuman, "Medicare Advantage 2010 Data Spotlight: Benefits and Cost-sharing," February 2010.

[14] CMS Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report: Monthly Summary Report (Data as of October 2011). Most beneficiaries opting out of Part D do so because they receive benefits at least equal in value from a group retiree plan or Medicaid. About 10% of Medicare beneficiaries opt not to receive drug coverage.

[15] In contrast, all free standing PDPs have some associated premium, with the average monthly PDP premium in 2011 being $38 per month (weighted by enrollment) in 2012, monthly PDP premiums for those able to stay in the same plan will be $39 per month. J. Hoadley, J. Cubanski, E. Hargrave, L. Summer, and J. Huang, "Medicare Part D: A First Look at Part D Plan Offerings in 2012" Data Spotlight, Washington DC: Kaiser Family Foundation, October 2011.

[16] J. Hoadley, et al., "Medicare Part D: A First Look at Part D Plan Offerings in 2012" Data Spotlight, Washington DC: Kaiser Family Foundation, October 2011.

[17] M. Gold, G. Jacobson, and T. Neuman, "Firm Perspectives on the Medicare Advantage Market," Washington DC: Kaiser Family Foundation, September 2011.

Table A1. Average Number of Plans Available to Beneficiaries by County of Residence, 2009-2012

	2009	2010	2011	2012
National Average	48	33	24	20
Urban counties	51	35	26	22
Rural counties	36	24	16	13
Fee-for-Service Costs, by Quartile				
Lowest cost counties	45	28	18	17
Second quartile	46	31	20	17
Third quartile	44	30	20	17
Highest cost counties	53	37	30	24

NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites).
SOURCE: MPR/KFF analysis of CMS's Landscape and Penetration Files for 2009 - 2012.

Table A2. Number of Medicare Advantage Plans Available, by Plan Type and Firm, 2009-2012

	All				HMOs				Local PPOs				PFFS Plans				Regional PPOs				Cost Plans			
	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012
Number of Plans - Total	**2830**	**2314**	**2011**	**1974**	**1451**	**1218**	**1104**	**1114**	**525**	**522**	**512**	**504**	**696**	**413**	**220**	**201**	**51**	**59**	**59**	**54**	**100**	**99**	**111**	**96**
United HealthCare	220	173	152	159	170	136	125	132	21	16	16	16	21	13	3	3	8	8	8	8	0	0	0	0
Humana	358	396	422	426	80	84	119	146	74	125	148	142	173	149	118	104	31	38	37	34	0	0	0	0
BCBS - Total	316	267	236	236	108	97	96	94	129	116	107	116	64	34	13	8	6	10	8	6	9	10	8	8
Wellpoint BCBS	54	60	53	50	25	25	23	18	12	19	20	28	12	8	4	0	5	8	6	4	0	0	0	0
Other BCBS plans	262	207	183	186	83	72	73	76	117	97	87	88	52	26	9	8	1	2	2	2	9	10	8	8
Kaiser Permanente	32	39	43	46	21	28	30	31	0	0	0	0	0	0	0	0	0	0	0	0	11	11	13	15
Coventry	105	67	59	71	53	41	35	44	32	26	24	27	17	0	0	0	0	0	0	0	0	0	0	0
Aetna	208	116	74	69	120	71	52	51	63	39	22	18	20	6	0	0	5	0	0	0	0	0	0	0
Health Net	117	48	39	37	40	39	28	26	7	9	11	11	69	0	0	0	1	0	0	0	0	0	0	0
Universal American	169	178	79	100	16	14	14	10	43	48	20	22	110	116	45	68	0	0	0	0	0	0	0	0
WellCare	154	0	41	35	91	0	41	35	1	0	0	0	62	0	0	0	0	0	0	0	0	0	0	0
HealthSpring	40	40	28	44	37	35	25	39	3	5	3	5	0	0	0	0	0	0	0	0	0	0	0	0
WellPoint (non-BCBS)	6	8	4	15	0	0	0	15	0	0	0	0	6	8	4	0	0	0	0	0	0	0	0	0
Sterling	6	21	42	18	0	0	0	0	0	16	36	13	6	5	6	5	0	0	0	0	0	0	0	0
Cigna	50	31	1	2	1	1	1	2	0	0	0	0	49	30	0	0	0	0	0	0	0	0	0	0
Other	1049	930	791	716	714	672	538	489	152	122	125	134	99	52	31	13	0	3	6	6	80	78	90	73

Note: Excludes SNPs, demonstrations, HCPPs, PACE plans, employer-sponsored (i.e., group) plans, and plans for special populations (e.g., Mennonites). BCBS are BlueCross BlueShield affiliates, which includes Wellpoint BCBS plans. Total for 2012 includes 5 MSAs. HealthSpring's plans for 2012 include plans offered by Bravo for 2012; for 2009 - 2011, plans offered by Bravo are included with other firms. In 2011, Cigna announced plans to acquire Healthspring, pending regulatory approval.

Source: MPR/KFF analysis of CMS's Landscape Files for 2009 - 2012.

Table A3. Share of Medicare Beneficiaries with Access to Firms' Medicare Advantage Plan Offerings, by Plan Type and Firm, 2009-2012.

Firm	Any Plan				HMOs				Local PPOs				PFFS Plans				Regional PPOs				Cost Plans			
	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012
UnitedHealthcare	81%	73%	65%	61%	46%	45%	50%	48%	11%	7%	7%	6%	53%	35%	5%	4%	19%	19%	19%	19%	0%	0%	0%	0%
Humana	84%	83%	74%	78%	17%	22%	29%	39%	27%	37%	46%	45%	84%	78%	52%	49%	60%	60%	60%	60%	0%	0%	0%	0%
BCBS - Total	78%	75%	72%	69%	38%	37%	38%	38%	40%	42%	42%	54%	44%	37%	3%	1%	22%	29%	29%	19%	2%	2%	2%	2%
Wellpoint BCBS plans	32%	32%	30%	26%	18%	16%	17%	17%	12%	11%	12%	24%	17%	17%	2%	0%	18%	18%	18%	8%	0%	0%	0%	0%
Other BCBS plans	53%	48%	48%	52%	25%	25%	26%	26%	28%	31%	30%	30%	28%	20%	1%	1%	5%	12%	11%	11%	2%	2%	2%	2%
Kaiser Permanente	15%	15%	15%	15%	12%	12%	12%	12%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	3%	3%	3%
Coventry	85%	16%	17%	17%	10%	11%	11%	12%	11%	10%	11%	12%	85%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Aetna	51%	35%	30%	30%	33%	31%	30%	30%	27%	19%	18%	18%	28%	7%	0%	0%	5%	0%	0%	0%	0%	0%	0%	0%
Health Net	31%	12%	11%	11%	11%	11%	10%	11%	2%	2%	3%	3%	23%	0%	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%
Universal American	97%	97%	30%	28%	3%	4%	4%	3%	5%	11%	11%	11%	97%	97%	28%	26%	0%	0%	0%	0%	0%	0%	0%	0%
Wellcare	76%	0%	20%	21%	21%	0%	20%	21%	1%	0%	0%	0%	65%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
HealthSpring	10%	9%	9%	15%	9%	7%	7%	14%	1%	2%	2%	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
WellPoint (non-BCBS)	48%	48%	2%	7%	0%	0%	0%	7%	0%	0%	0%	0%	48%	48%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Sterling	73%	48%	14%	14%	0%	0%	0%	0%	0%	2%	3%	6%	73%	48%	13%	11%	0%	0%	0%	0%	0%	0%	0%	0%
Cigna	54%	54%	1%	1%	1%	1%	1%	1%	0%	0%	0%	0%	54%	52%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Others	79%	82%	80%	81%	64%	67%	67%	65%	32%	34%	44%	42%	49%	44%	23%	28%	0%	14%	14%	14%	5%	5%	5%	5%

Note: Excludes SNPs, demonstrations, HCPPs, PACE plans, employer-sponsored (i.e., group) plans, and plans for special populations (e.g., Mennonites). BCBS are BlueCross BlueShield affiliates, which includes Wellpoint BCBS plans. Total for 2012 includes 5 MSAs. HealthSpring's plans for 2012 include plans offered by Bravo for 2012; for 2009 - 2011, plans offered by Bravo are included with other firms. In 2011, Cigna announced plans to acquire Healthspring, pending regulatory approval.

Source: MPR/KFF analysis of CMS's Landscape Files for 2009 - 2012.

Table A4. Number and Type of Special Needs Plans, by State, 2011 and 2012

State	2011				2012			
	Overall	Dual eligibles	Institutional	Chronic conditions	Overall	Dual eligibles	Institutional	Chronic conditions
Alabama	5	4	0	1	5	4	0	1
Alaska	0	0	0	0	0	0	0	0
Arizona	24	13	3	8	24	14	3	7
Arkansas	8	4	0	4	11	5	0	6
California	57	33	6	18	58	32	6	20
Colorado	7	5	1	1	5	4	1	0
Connecticut	3	2	1	0	2	2	0	0
Delaware	3	0	2	1	5	1	2	2
District of Columbia	4	1	2	1	5	2	2	1
Florida	58	36	2	20	79	52	4	23
Georgia	8	5	1	2	17	11	1	5
Hawaii	3	3	0	0	4	4	0	0
Idaho	1	1	0	0	1	1	0	0
Illinois	7	4	1	2	6	3	1	2
Indiana	3	1	1	1	6	3	1	2
Iowa	1	1	0	0	4	2	0	2
Kansas	2	0	1	1	1	0	1	0
Kentucky	1	1	0	0	0	0	0	0
Louisiana	7	7	0	0	10	10	0	0
Maine	2	2	0	0	2	2	0	0
Maryland	7	1	3	3	6	2	2	2
Massachusetts	7	4	2	1	5	4	1	0
Michigan	7	2	4	1	13	8	5	0
Minnesota	15	12	0	3	14	11	0	3
Mississippi	5	4	0	1	5	4	0	1
Missouri	7	4	0	3	9	5	0	4
Montana	0	0	0	0	0	0	0	0
Nebraska	1	1	0	0	1	1	0	0
Nevada	6	0	1	5	7	0	1	6
New Hampshire	0	0	0	0	0	0	0	0
New Jersey	10	4	4	2	8	5	2	1
New Mexico	3	2	1	0	6	3	1	2
New York	42	30	10	2	48	36	9	3
North Carolina	6	2	4	0	10	4	5	1
North Dakota	0	0	0	0	0	0	0	0
Ohio	5	3	2	0	8	7	1	0
Oklahoma	3	2	1	0	1	0	1	0
Oregon	11	7	3	1	10	7	3	0
Pennsylvania	16	9	3	4	14	8	3	3
Puerto Rico	12	8	1	3	14	10	1	3
Rhode Island	1	0	1	0	1	0	1	0
South Carolina	5	2	0	3	10	5	0	5
South Dakota	0	0	0	0	0	0	0	0
Tennessee	9	6	1	2	10	6	1	3
Texas	32	18	5	9	41	25	8	8
Utah	2	2	0	0	2	2	0	0
Vermont	0	0	0	0	0	0	0	0
Virginia	4	1	2	1	3	2	1	0
Washington	7	3	1	3	6	4	1	1
West Virginia	0	0	0	0	1	0	1	0
Wisconsin	13	12	1	0	17	14	1	2
Wyoming	0	0	0	0	0	0	0	0
Total, U.S.	**409**	**256**	**61**	**92**	**500**	**321**	**66**	**113**

Source: MPR/KFF analysis of CMS's Landscape Files for 2011-2012.

Table A5. Unweighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, by Plan Type and Firm, 2012.

	All	HMOs	Local PPOs	PFFS Plans	Regional PPOs	Cost Plans
All Plans Combined	$49.80	$33.20	$69.14	$70.96	$55.64	$137.06
UnitedHealthCare	$14.54	$15.27	$12.47	$14.00	$4.00	N/A
Humana	$44.25	$11.46	$54.48	$77.76	$77.85	N/A
BCBS - Total	$77.93	$66.13	$88.72	$51.38	$25.48	$113.27
Wellpoint BCBS	$29.52	$17.12	$38.68	N/A	$14.33	N/A
Other BCBS plans	$91.29	$78.03	$103.63	$51.38	$42.20	$113.27
Kaiser Permanente	$47.05	$46.65	N/A	N/A	N/A	$49.15
Coventry	$11.43	$9.39	$14.61	N/A	N/A	N/A
Aetna	$52.50	$39.83	$84.89	N/A	N/A	N/A
Health Net	$63.81	$64.26	$62.67	N/A	N/A	N/A
Universal American	$79.76	$24.00	$68.17	$97.38	N/A	N/A
WellCare	$6.19	$6.19	N/A	N/A	N/A	N/A
HealthSpring	$21.91	$21.00	$28.50	N/A	N/A	N/A
WellPoint (non-BCBS)	$6.53	$6.53	N/A	N/A	N/A	N/A
Sterling	$54.83	N/A	$57.31	$54.05	N/A	N/A
CIGNA	$12.50	$12.50	N/A	N/A	N/A	N/A
Other	$56.39	$41.45	$88.55	$0.00	$48.60	$153.70

Note: Excludes SNPs, demonstrations, HCPPs, PACE plans, employer-sponsored (i.e., group) plans, and plans for special populations (e.g., Mennonites). BCBS are BlueCross BlueShield affiliates, which includes Wellpoint BCBS plans. Total for 2012 includes 5 MSAs. HealthSpring's plans for 2012 include plans offered by Bravo for 2012; for 2009 - 2011, plans offered by Bravo are included with other firms. Premiums include plans with premiums as well as plans with no premiums. N/A indicates plan not available. Historical data included in Kaiser Family Foundation, *Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums* , October 2010.

Source: MPR/KFF analysis of CMS's Landscape Files for 2009 - 2012 and September 2011 Enrollment file.

Table A6. Average Monthly Premiums for Medicare Advantage Prescription Drug plans, Weighted by 2011 Enrollment, 2011-2012.

	All plans	HMO	Local PPO	PFFS	Regional PPO	Cost
Number of new plans	251	151	74	16	1	9
Number of staying plans	1,348	809	360	109	34	36
Number of staying plans' enrollees	7,795,786	5,397,278	1,302,598	362,316	598,338	135,256
Number of leaving plans' enrollees	167,697	16,405	26,229	13,243	111,699	121
Average premiums, weighted by 2011 enrollment						
Premiums for all plans, 2011	$37.52	$31.63	$57.86	$44.06	$22.79	$132.26
Departing plans, 2011	$19.77	$29.67	$82.36	$49.78	$0.00	$75.28
Remaining plans, 2011	$37.90	$31.64	$57.36	$43.85	$27.04	$132.32
2012 Premiums for remaining 2011 plans	$38.81	$32.11	$59.17	$46.14	$28.77	$134.43
Change in premiums for plans available in both 2011 and 2012	$0.91	$0.48	$1.81	$2.29	$1.73	$2.12
Share of enrollees plans with no premiums, among plans available in both 2011 and 2012						
2011	53%	63%	24%	24%	57%	5%
2012	53%	63%	25%	24%	54%	5%
Change in share of plans with no premiums	0%	0%	1%	0%	-4%	0%
Average premiums paid per enrollee, among plans with premiums (excluding zero premium plans) and available in both 2011 and 2012						
2011	$81.12	$85.74	$75.45	$57.64	$63.34	$138.59
2012	$83.32	$87.83	$79.00	$60.65	$62.17	$140.81

NOTE: Excludes Special Needs Plans (SNPs), demonstrations, Health Care Prepayment Plans (HCPPs), Program of All Inclusive Care for the Elderly (PACE) plans, employer-sponsored (i.e., group) plans, plans for special populations (e.g., Mennonites) and plans that do not offer Part D benefits.

SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2011 and 2012 and CMS's 2011 and 2012 Part C and D Crosswalk file and September 2011 enrollment.

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