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DATA SPOTLIGHT

MEDICARE ADVANTAGE 2012 DATA SPOTLIGHT: ENROLLMENT MARKET UPDATE

Prepared by Marsha Gold[i]; and Gretchen Jacobson, Anthony Damico, and Tricia Neuman[ii]

Medicare Advantage enrollment grew by 10 percent in 2012, exceeding 13 million enrollees nationwide, or 27 percent of the total Medicare population. The average premium paid by Medicare Advantage enrollees in 2012, $35 per month, was $4 lower than in 2011 ($39).[1] The majority of Medicare Advantage enrollees are in health maintenance organizations (HMOs) in 2012, as in the past, although enrollment in local PPOs appears to be on the rise. The Medicare Advantage population is mostly comprised of beneficiaries who enrolled as individuals, but almost a fifth (18%) enrolled through group plans (mainly employer-sponsored plans). The rise in enrollment and decline in average premiums occurred even as the reductions in Medicare payments to plans were beginning to phase in, as required by the 2010 health reform law, with reductions partially offset by new quality-based bonus payments for plans.[2,3]

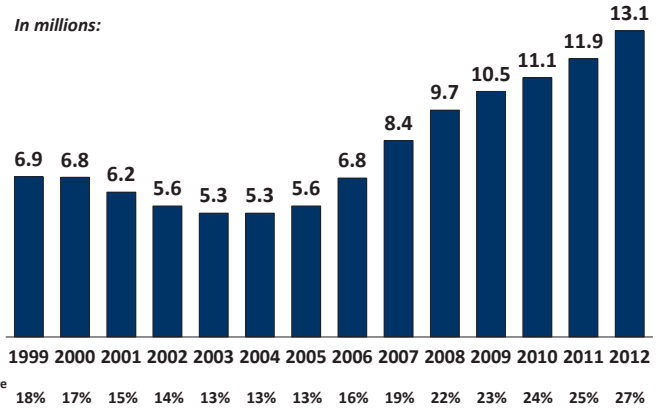
This *Data Spotlight* provides an overview of Medicare Advantage enrollment patterns in March 2012, including variations by plan type, state, and firm. It also analyzes trends in premiums paid by beneficiaries enrolled in Medicare Advantage plans, including variations by plan type, and describes the out-of-pocket limits and prescription drug coverage in the Part D "doughnut hole" provided by the plans selected by beneficiaries.

FINDINGS

Enrollment Nationwide. Over 13 million beneficiaries—27 percent of the Medicare population—was enrolled in a Medicare Advantage plan in 2012 (**Exhibit 1**; **Table A1**).[4] Total Medicare Advantage enrollment has more than doubled since 2005, a period of time concurrent with the introduction of Part D in 2006 and implementation of many other changes to Medicare Advantage authorized by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. Between 2011 and 2012, enrollment increased by 10 percent. The substantial growth in enrollment has occurred even though the average number of plans available to enrollees declined from a high of 48 in 2009 to 22 in 2012.[5]

EXHIBIT 1

Total Medicare Private Health Plan Enrollment, 1999-2012



NOTE: Includes cost and demonstration plans, and enrollees in Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2012, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 2001-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

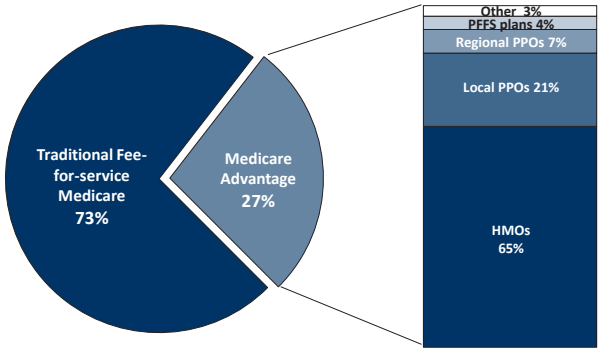
Author affiliations: [i] Mathematica Policy Research; [ii] Kaiser Family Foundation

Enrollment by Plan Type. For the most part, the distribution of enrollees by plan type remains relatively unchanged from 2011 **(Exhibit 2).** The largest share (65%) of enrollees are in health maintenance organization (HMO) plans, followed by local preferred provider organizations (PPOs) and regional PPOs (21% and 7%), and private fee-for-service (PFFS) plans (4%).

- **HMOs.** Consistent with all prior years, most Medicare Advantage enrollees in 2012 are in HMOs. Almost 8.5 million beneficiaries – almost two-thirds – are enrolled in HMOs, up from 7.7 million in 2011; however, the share of enrollees in HMOs has remained relatively steady over the past few years (**Exhibit 3**).
- **PPOs.** The number of Medicare Advantage enrollees in both local and regional PPOs has grown rapidly from 0.5 million in 2007 to 3.7 million in 2012. Three times as many enrollees are in local PPOs as in regional PPOs.
  - **Local PPOs.** In 2012, 2.8 million beneficiaries are enrolled in local PPOs, up from 2.1 million in 2011.
  - **Regional PPOs.** Enrollment in regional PPOs declined for the first time since 2006, from 1.1 million enrollees in 2011 to 0.9 million enrollees in 2012.

EXHIBIT 2

Distribution of Enrollment in Medicare Advantage Plans, by Plan Type, 2012

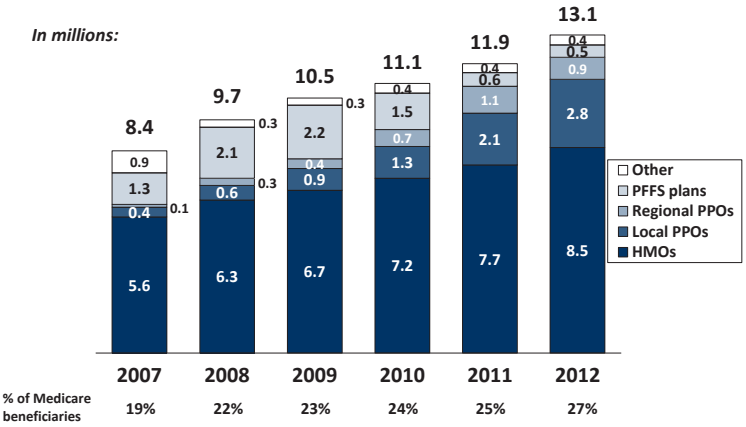


Total Medicare Advantage Enrollment, 2012 = 13.1 Million

NOTE: PFFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Other includes cost and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR / KFF analysis of the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage enrollment files, 2012.

EXHIBIT 3

Total Medicare Advantage Plan Enrollment, 2007-2012



NOTE: Other includes cost and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2012, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 2007; enrollment numbers from March of the respective year.

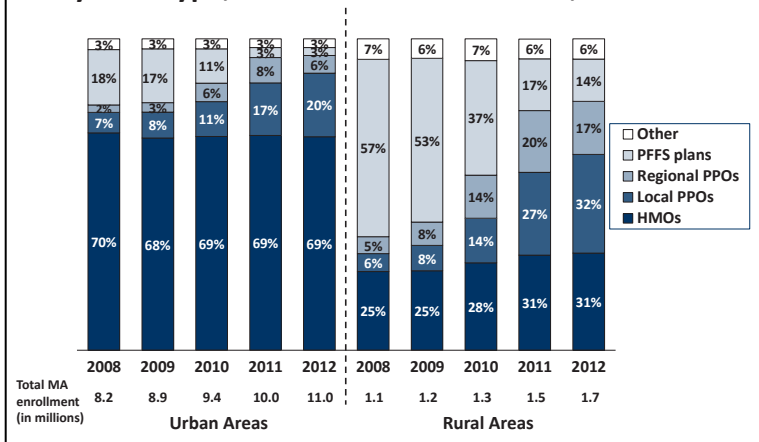
- **PFFS plans**. Enrollment in PFFS plans continued to decline in 2012, with only about half a million enrollees in PFFS plans in 2012, down about 600,000 from 2011 and 1.5 million from 2010. This decline coincides with the sharp reduction in PFFS plans in response to the addition of the requirement for PFFS plans to have networks of providers in most counties in 2011, as authorized by the Medicare Improvements for Patients and Providers (MIPPA) of 2008.[6]

Enrollment in Urban and Rural Counties. Eighty-seven percent of Medicare Advantage enrollees (11.0 million beneficiaries) are in urban counties.[7] While fewer enrollees are in rural counties (1.7 million), Medicare Advantage enrollment gains in percentage terms were no lower in rural counties as urban counties in 2012 (13% versus 10%).

- **Urban counties.** Most enrollees (69%) in urban counties are in HMOs, although the market share for PPOs, particularly local PPOs, has been growing (**Exhibit 4**).
- **Rural counties.** In 2012 for the first time, the proportion of rural Medicare Advantage enrollees in local PPOs (32%) was about equal to that of HMOs (31%). Only 14 percent of rural Medicare Advantage enrollees were in PFFS plans in 2012, down from 17 percent in 2011. The share of rural Medicare Advantage enrollees in regional PPOs also declined in 2012 (to 17%), a contrast with their steady growth in previous years. However, a larger share of rural than urban enrollees are in either regional PPOs or PFFS plans (31% of rural enrollees and 8% of urban enrollees).

EXHIBIT 4

Distribution of Medicare Advantage Enrollees by Plan Type, in Urban and Rural Areas, 2008-2012

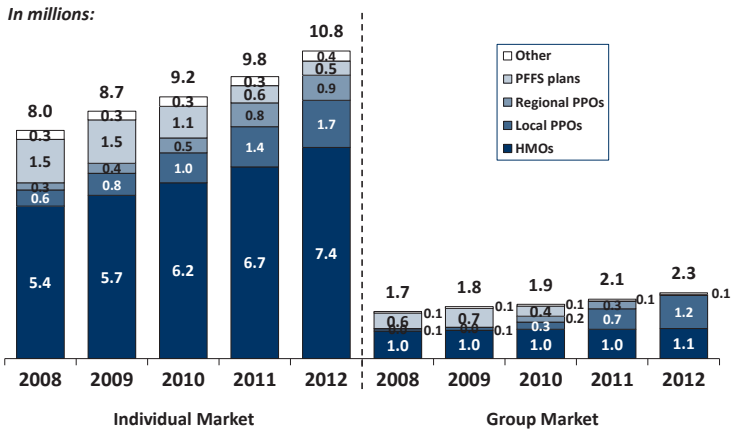


NOTE: PFFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Other includes cost and demonstration plans. Includes enrollees in SNPs and other Medicare Advantage plans. Excludes U.S. territories; numbers do not sum to total enrollment.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2012.

Enrollment in Group Plans. Between 2011 and 2012, enrollment grew at about the same rate in both the individual and the group market (around 10%); the group market consists largely of employer-sponsored Medicare Advantage plans. Alternatives to HMOs, primarily local PPOs now, have been particularly important to growth of the group market since 2008 (**Exhibit 5**). In 2012, of the 2.3 million Medicare Advantage enrollees enrolled in group plans, more than half were in local PPOs, while most of the other half were in HMOs. Local PPOs appear to be a substitute for the declining role played by PFFS plans in the group market.

EXHIBIT 5

Medicare Advantage Enrollment in the Individual and Group Markets, by Plan Type, 2008-2012



NOTE: PFFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Other includes cost and demonstration plans. Includes enrollees in SNPs as well as other Medicare Advantage plans. Numbers may not sum to total due to rounding.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2012.

Enrollment in Special Needs Plans

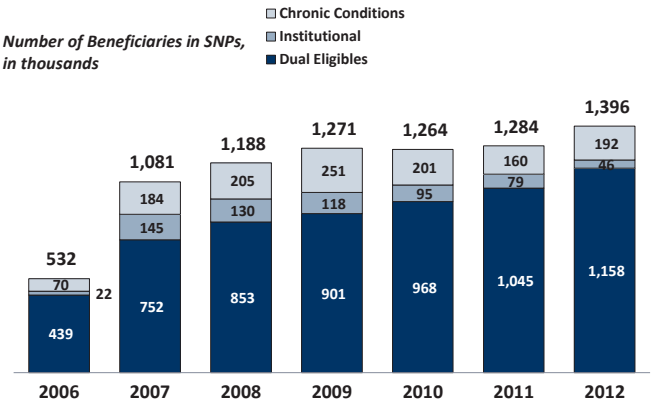
Special Needs Plans, a form of Medicare Advantage plan, were authorized in 2003 to provide a managed care option for three groups of beneficiaries with significant or relatively specialized care needs, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid (D-SNPs), beneficiaries requiring a nursing home or institutional level of care (I-SNPs), and beneficiaries with severe chronic or disabling conditions (C-SNPs).

The number of enrollees in SNPs increased slightly from 1.3 million in 2011 to 1.4 million (**Exhibit 6**). SNPs for dual eligibles (D-SNPs) account for 83 percent of all SNP enrollees, with 1.2 million in D-SNPs. Enrollment in C-SNPs increased in 2012 to about 192,000, but remains lower than in 2009, before CMS implemented rules limiting the conditions C-SNPs could cover. Among enrollees in chronic-SNPs, 90 percent are in plans related to chronic heart failure, cardiovascular disease and/or diabetes. The number of enrollees in I-SNPs continues to be a small share of SNP enrollment, accounting for less than 6 percent of enrollment in SNPs. Of the 46,000 enrolled in I-SNPs, most are in plans owned by UnitedHealthcare (62%) or SCAN Health Plan (19%).

While SNPs may be offered through HMO, local PPO, or regional PPO contracts, 88 percent of SNP enrollees are in a HMO. D-SNP penetration differs across states based on both their state characteristics and Medicaid policies. In 2012, 20 percent or more of all dual eligibles are in D-SNPs in 6 states (AZ, HI, MN, OR, PA, and UT),but there were no dual eligibles in D-SNPs in 12 states: Alaska, Kansas, Kentucky, Montana, New Hampshire, North Dakota, Oklahoma, Rhode Island, South Dakota, Vermont, West Virginia, and Wyoming (**Exhibit 7**).

EXHIBIT 6

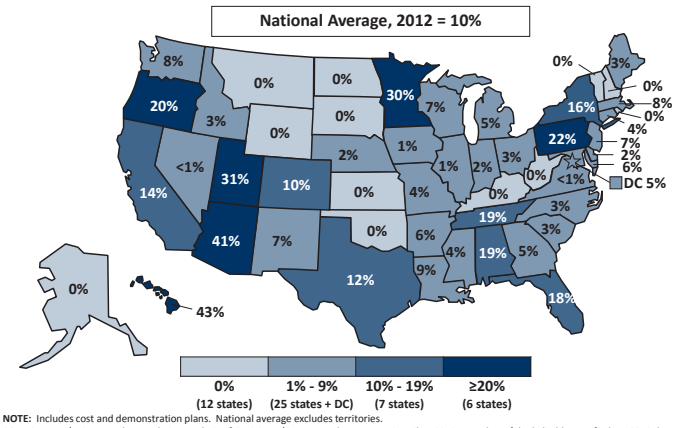
Number of Beneficiaries in Special Needs Plans, by Type, 2006 – 2012



NOTE: Numbers may not sum to the total due to rounding. Includes enrollment in Puerto Rico and other territories.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2006-2012.

EXHIBIT 7

Share of Dual Eligible Beneficiaries Enrolled in Special Needs Plans for Dual Eligibles, by State, 2012

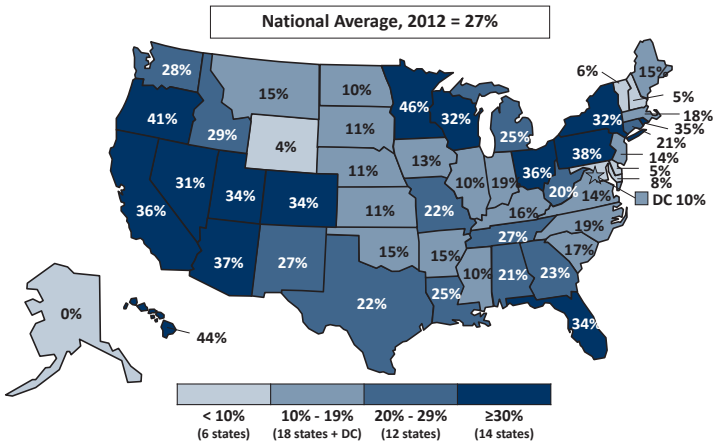


NOTE: Includes cost and demonstration plans. National average excludes territories.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2012. Number of dual eligibles as of July 1, 2010, by state from CMS 2010 Medicaid Managed Care Enrollment Report.

Geographic Variation in Enrollment. Medicare Advantage enrollment grew in every state in 2012, except Alaska and New Hampshire. Medicare Advantage penetration varies substantially by state, reflecting both the greater prevalence of Medicare Advantage plans in urban counties as well as other factors that account for variation in Medicare Advantage enrollment (**Exhibit 8, Table A2, and Table A3**).[8] In 2012, 6 states (AK, MD, DE, NH, VT, and WY) had less than 10 percent of their beneficiaries in Medicare Advantage plans. In contrast, 14 states had 30 percent or more beneficiaries enrolled in Medicare Advantage plans. Medicare Advantage penetration often varies widely across counties within the same state. For example, 55 percent of beneficiaries in Miami-Dade County in Florida are enrolled in Medicare Advantage plans, compared to 33 percent of beneficiaries in Palm Beach County.

EXHIBIT 8

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2012



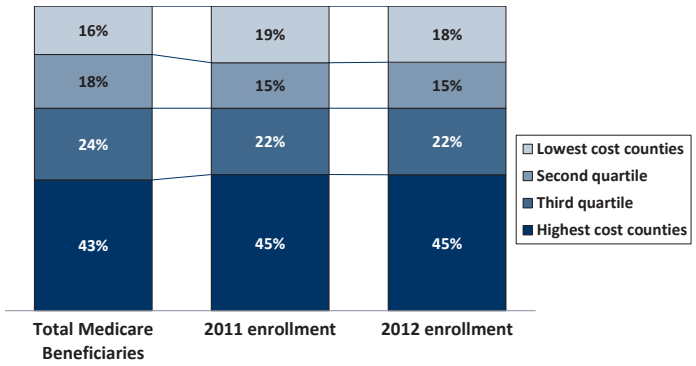
NOTE: Includes cost and demonstration plans, and enrollees in Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2012.

Enrollment by Payment Rates. Starting in 2012, Medicare payments to plans began to reflect the phase in of changes enacted in the health reform law of 2010.[9] Payments to plans depend on the relationship between their bids and the counties' Medicare fee-for-service costs, and payments also can be increased by any quality-based bonus payments the plan may receive.[10] After being frozen in 2011 at 2010 levels, benchmarks (the maximum Medicare will credit in calculating plan payments) will be adjusted down, beginning in 2012, as required by the health reform law. As a result, benchmarks are lower than they would otherwise be in all counties. Once changes are fully phased in, benchmarks will range from 95 percent of Medicare fee-for-service costs for counties in the top quartile of per capita fee-for-service spending (e.g., Miami-Dade county) to 115 percent of fee-for-service costs in the bottom quartile of per capita fee-for-service spending (e.g., Boise county). The phase in will take two years for counties with relatively small changes in benchmarks (less than $30 per month), four years for counties with relatively moderate changes in benchmarks (between $30 and $50 per month), and six years for counties with relatively larger changes in benchmarks ($50 or more per month), beginning in 2012.[11] Most Medicare Advantage enrollees (80%) reside in counties in which the benchmark changes are being phased in over 6 years to minimize disruption.[12]

As we showed in a prior analysis for 2011, most Medicare beneficiaries are in counties in the top quartile of Medicare fee-for-service costs, where benchmark payments are scheduled to drop to 95 percent of fee-for-service costs (**Exhibit 9**). Forty-five percent of Medicare Advantage enrollees live in counties in the highest quartile and another 22 percent live in the second quartile of counties. Proportionately more beneficiaries (and enrollees) are in higher than lower cost counties because many low cost counties have very few people residing there, with populations concentrated around large urban centers.

EXHIBIT 9

Share of Medicare Advantage Enrollees and Total Medicare Beneficiaries Residing in Higher Versus Lower Cost Counties, 2012

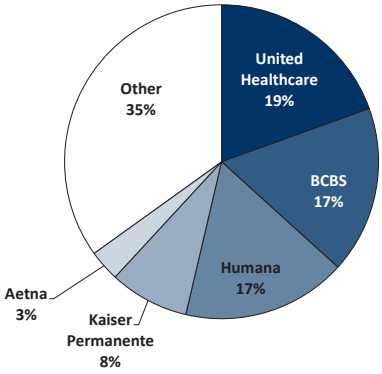


NOTE: Includes cost and demonstration plans, and enrollees in Special Needs Plans as well as other Medicare Advantage plans. Numbers may not sum to 100% due to rounding.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2011 and 2012.

Enrollment by Firm. As in 2011, Medicare Advantage enrollment tends to be highly concentrated in a small number of firms in 2012 (**Exhibit 10; Table A1**). About 65 percent of Medicare Advantage enrollment nationwide is concentrated in six firms or affiliates, roughly the same share as in 2011. These firms include United Healthcare, Humana, Blue Cross Blue Shield (BCBS) affiliates, Kaiser Permanente, Wellpoint, and Aetna. More than 1 in 3 enrollees is in a plan sponsored by United Healthcare (19%) or Humana (17%). BCBS affiliates which are multiple independent firms sharing the BCBS brand, account for 17 percent of Medicare Advantage enrollees, with about a quarter of these in Wellpoint affiliated BCBS plans. Kaiser Permanente accounts for 8 percent of the market, followed by Aetna, which accounts for 3 percent of the market. Enrollment grew in each of these firms or affiliates in 2012, as it also did in 2011. Enrollment grew particularly rapidly in 2012 in the two largest firms, with UnitedHealthcare and Humana adding 17 percent and 20 percent, respectively, to their total enrollment. For most firms, individual plans dominate plan enrollment, but group plan members account for a large share of enrollment for Kaiser Permanente and Aetna. More than two-thirds (68%) of Aetna's enrollment and 42 percent of Kaiser Permanente's enrollment is in group plans.

EXHIBIT 10

Medicare Advantage Enrollment, by Firm or Affiliate, 2012



Total Medicare Advantage Enrollment, 2012 = 13.1 Million

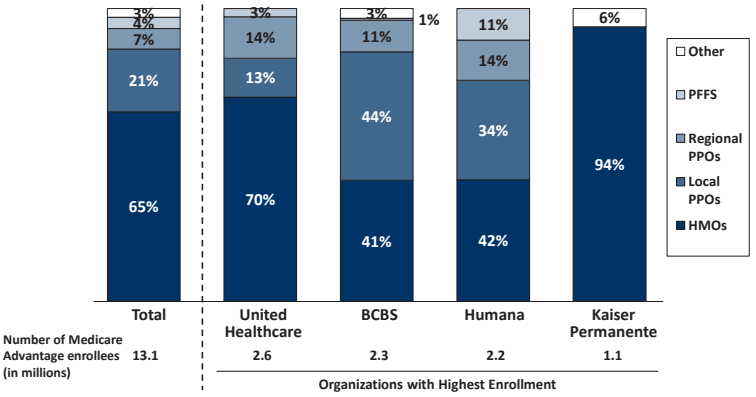
NOTE: Other includes firms with less than 3% of total enrollment. BCBS are Blue Cross/Blue Shield affiliates includes Wellpoint BCBS plans that comprise 4% of total enrollment in Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Enrollment files, 2012.

The remaining 35 percent of Medicare Advantage enrollment nationwide is distributed across other national firms (including Health Net, Coventry, Universal American, Sterling and Cigna), and more locally based firms and other kinds of Medicare Advantage sponsoring organizations, some of which are relatively large within their markets (e.g., Martin's Point Health Care in Maine).

Firms continue to differ in their reliance on different plan types **(Exhibit 11).** Almost all of Kaiser Permanente's enrollees (94%) are in HMOs and the rest are in similarly structured cost plans. For United Healthcare, a large share of enrollees (70%) are also in HMOs, roughly the same share as last year (73%) and the firm continues to have enrollees in local and regional PPOs, as well as PFFS plans. Fewer of Humana's enrollees are in HMOs (42%), while 34 percent are in local PPOs, 14 percent are in regional PPOs, and 11 percent are in PFFS plans. This distribution of Humana's enrollees by plan type represents a major shift from earlier years when a much larger share of Humana's enrollees were in PFFS plans. A similar share of enrollees in BCBS plans are in local PPOs (44%) and HMOs (41%).

EXHIBIT 11

Distribution of Medicare Advantage Enrollees in the Firms and Affiliates with the Highest Enrollment, by Plan Type, 2012

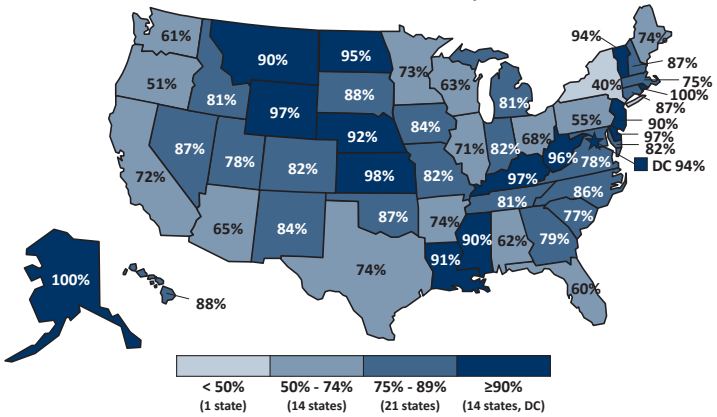


NOTE: PFFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Numbers may not sum total due to rounding. BCBS is Blue Cross/Blue Shield affiliates, which includes Wellpoint BCBS plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2012.

State Level Market Concentration. A small number of firms also dominate enrollment in most states, reflecting a mix of dominant national companies, local BCBS affiliates, and in a few states, local independent plan sponsors (**Exhibit 12; Table A4**). Enrollment in most states is concentrated within a few companies. In 35 states as well as the District of Columbia, 75 percent or more of enrollment is in plans sponsored by three companies. In 14 states plus the District of Columbia, three companies account for 90 percent or more of the state's Medicare Advantage enrollment. In 13 states plus the District of Columbia, one company has 50 percent or more of enrollment (AK, KS, KY, LA, MI, MS, NE, ND, NH, RI, VT, WV, and WY).

EXHIBIT 12

Combined Market Share of the Three Firms or Affiliates with the Largest Number of Medicare Advantage Enrollees in Each State, 2012



NOTE: Includes cost and demonstration plans, and enrollees in Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2012.

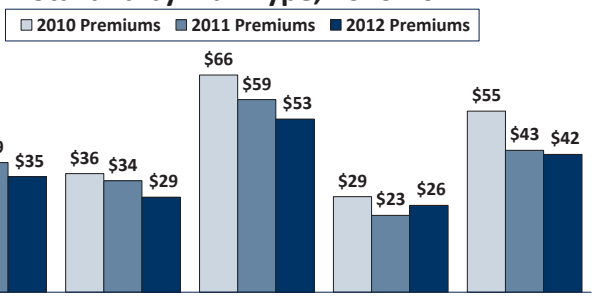
United Healthcare has the largest market share in 17 states and is among the top three firms in 18 additional states and the District of Columbia. Humana has the largest enrollment in 14 states and is among the top three in another 18 states. BCBS affiliates have the most enrollees in seven states (AL, HI, ID, MI, NJ, OR, and PA) and are among the top three firms in another six states (NC, FL, MN, RI, WV, and SC). Kaiser Permanente's presence is more geographically focused than the other major national firms and affiliates, with a heavy concentration in California, Colorado, the District of Columbia, Hawaii, Maryland, and Oregon; in California, the District of Columbia, and Maryland, Kaiser Permanente has more enrollees than any other firm. Locally dominant plans that have the top enrollment in their state include Martin's Point (ME), TAHMO (MA), Medica (MN and ND), New West Health Services (MT), Presbyterian (NM), and Group Health Cooperative (WA).

Premiums

Medicare Advantage enrollees are responsible for paying the Part B premium, in addition to any premium charged by the plan. Premiums for Medicare Advantage plans include supplemental benefits or reduced cost sharing beyond that covered by traditional Medicare, as well as any costs of Part A and Part B benefits that exceed the county benchmark, and any costs for Part D benefits that remain after the plan applies available savings (if any) between what they are paid by the government and what it costs them to deliver benefits.[13] Most (88%) of Medicare Advantage enrollees in individual plans select a Medicare Advantage plan that has a drug benefit (MA-PD).

EXHIBIT 13

Weighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, Total and by Plan Type, 2010-2012



	Total	HMOs	Local PPOs	Regional PPOs	PFFS
Percent Change, 2010 - 2012	-20%	-20%	-20%	-9%	-24%
Percent Change, 2011 - 2012	-11%	-15%	-10%	+13%	-3%

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 (not shown separately), as well as plans with zero premiums. The premiums for a subset of sanctioned plans were not available in 2011. These plans were excluded from this analysis.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2010 – 2012 and March Enrollment files for 2010-2012.

Average Premium Trends. The average enrollee in an MA-PD paid a monthly premium of $35 in 2012, down from $39 in 2011 and $44 in 2010 (**Exhibit 13**). Between 2011 and 2012, average premiums declined for each type of plan except regional PPOs which increased by $3. In the fall of 2011, we had calculated that beneficiaries who were enrolled in Medicare Advantage plans in 2011 would pay $39 per month in 2012 if they stayed in the same plan.[14] Based on actual enrollment we now show the average enrollee paying a premium of $35 per month. The difference between the $39 estimate from the fall and the $35 actual average premium reflects both changes in the beneficiaries enrolled in Medicare Advantage from 2011 to 2012 and shifts by enrollees to more attractive plans, including lower premium plans.

Zero Premium Plans. The actual premium an enrollee pays will vary by plan type and locale, as well as by decisions the enrollee makes among plans that trade off higher premiums for more comprehensive benefits (**Table 1**). Among all Medicare Advantage enrollees, 56 percent are in plans with no premiums. Among those in HMOs, who account for almost two-thirds of all Medicare Advantage enrollees, 65 percent are in plans with no premium. Zero premium plans also are common in regional PPOs (59%) but less common in local PPOs (31%) or PFFS plans (29%).

The prevalence of zero premium plans varies across firms. For example, the majority of enrollees in both Kaiser Permanente and BCBS plans pay some premium (**Table A6**). In contrast, less than one-fifth (14%) of United Healthcare enrollees are in a plan that charges a premium. Enrollees in Humana's HMOs typically pay no premium but most enrollees in Humana's local PPOs or regional PPO pay a premium. While such data do not reveal the reasons for these differences, it may be that delivery based systems (like Kaiser Permanente) or systems with historically strong local provider links (like BCBS) emphasize their networks to attract enrollees, with the assumption that enrollees may be willing to pay more (at least in premiums) for this aspect of coverage.

Enrollee Liability for Out of Pocket Costs. Individual beneficiaries enrolling in traditional Medicare for Part A and B benefits can voluntarily enroll in a stand-alone prescription drug plan for Part D and may also purchase a Medigap policy to supplement Medicare (unless they have supplemental insurance from another source, such as Medicaid or an employer plan). Medicare Advantage plans typically integrate all three types of coverage for enrollees selecting this option instead of traditional Medicare. While Medicare Advantage premiums are typically lower than premiums for Medigap policies, beneficiaries enrolling in Medicare Advantage plans also typically have more liability for out of pocket costs with the most common Medigap policies (e.g., Medigap plans C or F).[15] To gain a better sense of potential trade-offs between premiums and benefits, we examined differences among plans in two types of benefits: the limit on out of pocket costs set by the plan and the availability of expanded Part D benefits relating to the coverage gap or "doughnut hole" (**Table 1**).

Out of Pocket Limit. Although traditional Medicare does not include an annual out of pocket limit on cost sharing for Medicare Part A and B benefits, CMS now requires all Medicare Advantage plans to have a limit below $6700, and recommends a limit of $3400 or lower. In 2012, about half of all enrollees were in plans with limits below the recommended level, 27 percent had limits between $3400 and $5000, and 22 percent had higher limits, between $5000 and $6700 annually. (Most Medicare reform proposals, if they have out of pocket limits for traditional Medicare, set them at $5,500, substantially higher than the limit recommended by CMS for Medicare Advantage plans.)[16] While out-of pocket protection for cost sharing also depends on the structure of cost sharing within a plan, limits are important and also valuable in communicating to beneficiaries their potential maximum liability.[17]

Even though all plans have limits on out-of-pocket spending for covered services, the actual level varies across plans, with substantial differences, on average, across plan types. HMOs tend to have lower limits on out of pocket costs than other plan types (57% of HMO enrollees were in plans with a limit below the recommended level). Almost half (48%) of local PPOs also have such a limit. In contrast, out-of-pocket limits generally are higher in regional PPOs or PFFS plans, with 43 percent and 65 percent, respectively, having limits that exceed $5000 annually. Because of these patterns, some zero premium plans may leave beneficiaries considerably less protected from high out of pocket costs than others.

Expanded Part D Benefits. The standard Medicare Part D benefit in 2012 has a $320 deductible and 25% coinsurance up to an initial coverage limit of $2,930 in total drug costs, followed by a gap (the so called "doughnut hole") until total out of pocket spending reaches $4,700 when a "catastrophic limit" kicks in and beneficiaries pay 5 percent or specified limits per drug.[18] Medicare Advantage plans can use their rebates (obtained through payments for Part A and B benefits) to either lower cost-sharing or premiums. (Zero premium MA-PDs charge no premium for Part D or any other part of the benefit package.)

Beneficiary protection in the "coverage gap" is one way Medicare Advantage plans can enhance benefits. The health reform law gradually phases down the coverage gap until it is eliminated in 2020.[19] In 2012, the standard Medicare Part D benefit requires beneficiaries to pay 50 percent of the cost of brand drugs and 86 percent of the cost of generics in the coverage gap. In 2012, 53 percent of Medicare Advantage enrollees were in plans that provided some coverage in the gap, with enrollees split between those with coverage only for generics and those also having some coverage of brand name drugs. HMOs were more likely to provide some additional coverage than either local or regional PPOs, although the difference typically was in coverage for generic versus brand name drugs. While local PPOs may have higher premiums than HMOs, it may be that some sponsors are positioning their local PPO offering as an alternative to Medigap for beneficiaries with somewhat higher incomes who are price sensitive but want to have more flexibility in their provider choice than an HMO provides and familiar with the PPO option from their employment based coverage.

Table 1. Selected Plan Benefits and Premiums for Enrollees in Medicare Advantage Prescription Drug Plans (MA-PDs), by Plan Type, 2012

Premiums and Benefits		All Plans	HMOs	Local PPOs	Regional PPOs	PFFS Plans	Cost Plans
% of enrollees with no premium		56%	65%	31%	59%	29%	6%
Average premium, if any		$79.83	$82.75	$76.00	$64.72	$59.33	$138.97
Out-of-pocket limit	$2500 or less	5%	4%	7%	0%	0%	6%
	$2501-$3400	46%	53%	41%	10%	9%	92%
	$3401-$5000	27%	22%	41%	47%	26%	0%
	$5001-$6700	22%	21%	11%	43%	65%	3%
Part D coverage in the gap or "doughnut hole"	All generics and all brands	<1%	<1%	1%	0%	0%	0%
	Some generics and some brands	26%	25%	27%	22%	54%	21%
	Generics only	26%	32%	17%	10%	0%	5%
	No gap coverage	47%	42%	54%	68%	46%	74%

NOTE: Coverage in the Part D coverage gap in 2012 includes more than a 50% discount on brand-name drugs and additional coverage of generic drugs than required by the health reform law. Premiums weighted by March 2012 enrollment. Excludes Medicare Advantage plans that do not offer prescription drug coverage, special needs plans (SNPs), and employer group health plans. Percentages may not sum to 100% due to rounding.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment and landscape files, 2012.

DISCUSSION

Despite concerns about the effect of reductions in payments to Medicare Advantage plans that resulted from the health reform law, enrollment has continued to increase, and premiums have continued to decrease in 2012. The Medicare Advantage marketplace is robust based on plan participation and enrollment. While new quality based bonus payments may have helped to mitigate the effects of the payment reductions that are now being phased in, the trend towards growing Medicare enrollment has been persistent over time and is unlikely to be fully explained by quality bonus payments alone, but rather a combination of historical trends in payment, new quality bonuses, the continued erosion of retiree benefits, and other factors affecting beneficiary choice.

Medicare Advantage enrollees appear to be attracted to plans as a source of relatively affordable supplemental coverage, with lower premiums than beneficiaries typically pay for Medigap supplemental policies. Higher payments to plans have allowed firms to enrich their offerings at relatively limited cost to beneficiaries, though cost sharing still remains substantially higher than with Medigap plans. Historically, Medicare Advantage enrollment has been particularly attractive to beneficiaries with low to moderate incomes who do not qualify for additional assistance under Medicaid or group plans.[20] Over time, the share of beneficiaries enrolling in Medicare Advantage plans may grow as fewer retirees have access to supplemental coverage from former employers and new Medicare beneficiaries bring more experience with plan choice, particularly with preferred provider plans, as part of their previous employment based coverage. The movement of states to enroll dual eligibles in private plans, as part of a new demonstration program, could also contribute to further growth in the future.

The future of the Medicare Advantage program, and enrollment trends, remain uncertain, but will likely be influenced by numerous policy changes, some already enacted, and others to come. A key unknown rests on the effects of the phased implementation of future payment cuts in Medicare Advantage enacted as part of health reform. Under current law, federal payments to Medicare Advantage plans will be constrained which may affect the number of plans and future attractiveness of Medicare Advantage benefits. Yet, with more than one in four beneficiaries enrolled in a Medicare Advantage plan, and with numerous firms relying on Medicare Advantage for revenue, policymakers may be pressured to limit or slow the speed of payment cuts plans to avoid disruptions in certain markets. Another unknown rests in the status and nature of any Medicare reform efforts. Several leading policy proposals, offered in the context of the deficit reduction debate, would expand, rather than reduce, the role of private plans under Medicare. Typically, such proposals also assume continued downward pressure on federal payments to plans, however, which will have its own effect on the attractiveness of Medicare to beneficiaries. Ultimately, the fate of Medicare Advantage may be affected by broader policy and budgetary decisions on how to structure and finance Medicare.[21]

REFERENCES

1 Although both we and CMS show reductions in premiums from 2011 to 2012, it is not possible to compare estimates because CMS does not provide documentation on the definition of plans included in their estimates.

2 G. Jacobson, T. Neuman, A. Damico, and J. Huang "Medicare Advantage Star Ratings and Bonus Payments in 2012," Washington DC: Kaiser Family Foundation, November 2011.

3 U.S. Government Accountability Office. "Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings" GAO-12-409R, March 21, 2012.

4 Statistics include cost and demonstration plans even though they are organized under separate authority from Medicare Advantage. Enrollment includes those in special needs plans (SNPs) as well as regular Medicare Advantage plans, and includes those enrolled individually and through groups. The analysis is based on publicly available CMS data from the contract/plan/state/county enrollment file. This file excludes enrollment counts with fewer than 11 people in a plan in a county. These small cell exclusions add up to about 300,000 people in 2012.

5 M. Gold, G. Jacobson, A. Damico, and T. Neuman "Medicare Advantage 2012 Data Spotlight: Plan Availability and Premiums." Washington DC: Kaiser Family Foundation, November 2011.

6 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 The combined urban/rural enrollment (12.7 million) is less than the total reported Medicare Advantage enrollment in 2012 (13.1 million) because the urban/rural classification excludes territories (in particular Puerto Rico which has a large Medicare Advantage enrollment) as well as a few counties whose urban/rural status is not captured in the available data.

8 See R.S. Brown and M.R. Gold, "What Drives Medicare Managed Care Growth?" Health Affairs, Nov/December 1999, 149-149.

9 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).

10 See G. Jacobson, T. Neuman, A. Damico, and J. Huang "Medicare Advantage Star Ratings and Bonus Payments in 2012," Washington DC: Kaiser Family Foundation, November 2011.

11 For additional details on changes to Medicare Advantage in the health reform law, see Kaiser Family Foundation, "Explaining Health Reform: Key Changes in the Medicare Advantage Program", May 2010.

12 See G. Jacobson, A. Damico, J. Huang, and T. Neuman "Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011," February 2011.

13 Under current law, plans also may use any savings to offset the Part B premium.

14 M. Gold, G. Jacobson, A. Damico, and T. Neuman "Medicare Advantage 2012 Data Spotlight: Plan Availability and Premiums." Washington DC: Kaiser Family Foundation, November 2011.

15 M. Gold, M. Hudson, G. Jacobson, and T. Neuman "2010 Data Spotlight: Benefits and Cost Sharing," Washington DC: Kaiser Family Foundation, February 2010.

16 Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit-Reduction Proposals," September 2011.

17 M. Gold, M. Hudson, G. Jacobson, and T. Neuman "2010 Data Spotlight: Benefits and Cost Sharing," Washington DC: Kaiser Family Foundation, February 2010.

18 Kaiser Family Foundation. "Fact Sheet: The Medicare Prescription Drug Benefit" November 2011.

19 Kaiser Family Foundation. "Fact Sheet: The Medicare Prescription Drug Benefit" November 2011.

20 AHIP Center for Policy and Research. "Low Income and Minority Beneficiaries in Medicare Advantage Plans, 2010" Washington DC: America's Health Insurance Plans, May 2012.

21 M. Gold "Perspective: Medicare Advantage: Lessons for Medicare's Future" *New England J of Medicine* Posted Online, February 22, 2012.

Table A1. Medicare Advantage Enrollment by Firm, 2011-2012

Firm or Affiliate	Total enrollment		HMOs		Local PPOs		Regional PPOs		PFFS		Cost		Other	
	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
Total Enrollment														
UnitedHealthcare	2,180,485	2,552,244	1,592,712	1,780,159	264,969	338,965	248,274	361,882	74,530	71,238		-		-
Humana	1,852,398	2,217,209	701,464	920,513	398,223	753,794	484,964	303,842	267,747	239,060		-		-
BCBS	2,080,873	2,254,770	884,404	933,177	832,511	989,006	277,002	243,013	24,942	14,511	61,933	74,866	81	197
Wellpoint BCBS	530,372	581,190	178,772	183,221	119,126	235,022	221,734	162,947	10,740	-		-		-
Other BCBS plans	1,550,501	1,673,580	705,632	749,956	713,385	753,984	55,268	80,066	14,202	14,511	61,933	74,866	81	197
Kaiser Permanente	1,008,556	1,073,556	943,568	1,006,513		-		-		-	64,988	67,043		-
Coventry	215,647	246,433	132,746	146,225	82,901	100,208		-		-		-		-
Aetna	382,728	421,628	149,427	153,149	233,301	268,479		-		-		-		-
HealthNet	230,555	240,095	185,009	192,120	45,546	47,975		-		-		-		-
Universal American	161,204	131,494	60,148	56,540	21,609	16,638		-	79,447	58,316		-		-
WellCare	117,220	147,768	117,220	147,768		-		-		-		-		-
Health Spring	327,288	-	320,271	-	7,017	-		-		-		-		-
Wellpoint (non-BCBS)	15,161	63,978	1,450	63,978		-		-	13,711	-		-		-
Sterling	34,716	75,468		45,377	1,323	1,427		-	33,393	28,664		-		-
CIGNA	36,069	399,829	36,069	390,034		9,795		-		-		-		-
Other	3,279,643	3,265,264	2,620,299	2,629,118	247,682	278,101	90,673	-	78,808	92,117	221,629	241,490	20,552	24,438
Total	**11,922,543**	**13,089,736**	**7,744,787**	**8,464,671**	**2,135,082**	**2,804,388**	**1,100,913**	**908,737**	**572,578**	**503,906**	**348,550**	**383,399**	**20,633**	**24,635**
Individual Plans														
UnitedHealthcare	1,940,363	2,262,515	1,495,008	1,686,438	122,771	143,105	248,054	361,734	74,530	71,238				
Humana	1,559,328	1,849,387	683,777	901,557	378,497	428,429	229,307	280,341	267,747	239,060				
BCBS	1,672,364	1,812,271	754,544	797,880	561,251	686,559	269,685	238,306	24,942	14,511	61,861	74,818	81	197
Wellpoint BCBS	496,585	540,689	170,385	176,130	95,684	201,612	219,776	162,947	10,740					
Other BCBS plans	1,175,779	1,271,582	584,159	621,750	465,567	484,947	49,909	75,359	14,202	14,511	61,861	74,818	81	197
Kaiser Permanente	582,548	627,430	543,068	586,221							39,480	41,209		
Coventry	200,673	232,239	119,599	133,895	81,074	98,344								
Aetna	130,016	134,249	117,438	120,986	12,578	13,263								
HealthNet	188,538	200,349	144,190	152,374	44,348	47,975								
Universal American	159,672	129,789	58,616	54,835	21,609	16,638			79,447	58,316				
WellCare	117,220	147,768	117,220	147,768										
HealthSpring	324,961	-	317,944		7,017									
Wellpoint (non-BCBS)	15,161	63,897	1,450	63,897					13,711					
Sterling	34,716	75,468		45,377	1,323	1,427			33,393	28,664				
CIGNA	34,489	395,886	34,489	386,091		9,795								
Other	2,882,316	2,854,122	2,334,822	2,330,176	180,374	204,847	90,673		65,554	81,568	190,341	213,093	20,552	24,438
Total	**9,842,365**	**10,785,370**	**6,722,165**	**7,407,495**	**1,410,842**	**1,650,382**	**837,719**	**880,381**	**559,324**	**493,357**	**291,682**	**329,120**	**20,633**	**24,635**
Group Plans														
UnitedHealthcare	240,122	289,729	97,704	93,721	142,198	195,860	220	148						
Humana	293,070	367,822	17,687	18,956	19,726	325,365	255,657	23,501						
BCBS	408,509	442,499	129,860	135,297	271,260	302,447	7,317	4,707			72	48		
Wellpoint BCBS	33,787	40,501	8,387	7,091	23,442	33,410	1,958							
Other BCBS plans	374,722	401,998	121,473	128,206	247,818	269,037	5,359	4,707			72	48		
Kaiser Permanente	426,008	446,126	400,500	420,292							25,508	25,834		
Coventry	14,974	14,194	13,147	12,330	1,827	1,864								
Aetna	252,712	287,379	31,989	32,163	220,723	255,216								
HealthNet	42,017	39,746	40,819	39,746	1,198									
Universal American	1,532	1,705	1,532	1,705										
WellCare		-												
Health Spring	2,327	-	2,327											
Wellpoint (non-BCBS)		81		81										
Sterling		-												

Table A2. Medicare Advantage Enrollment by State and Plan Type, 2012

State	Total	HMOs	Local PPOs	Regional PPOs	PFFS Plans	Cost Plans	Other	% change, 2011-2012
Alabama	186,118	119,966	52,640	11,057	2,444	-	11	8%
Alaska	18	-	18	-	-	-	-	-81%
Arizona	362,998	325,837	23,139	6,421	7,521	80	-	6%
Arkansas	84,523	35,377	12,392	13,002	23,696	-	56	16%
California	1,806,300	1,734,321	61,391	-	4,392	3,652	2,544	4%
Colorado	226,249	172,770	19,693	-	8,087	23,717	1,982	9%
Connecticut	123,430	95,584	22,126	5,720	-	-	-	14%
Delaware	7,349	5,221	2,128	-	-	-	-	46%
District of Columbia	7,912	1,629	1,002	-	-	5,281	-	5%
Florida	1,193,481	836,291	92,789	258,410	5,460	-	531	12%
Georgia	303,077	77,500	132,382	46,734	46,461	-	-	14%
Hawaii	96,277	31,728	25,899	30,510	296	7,844	-	8%
Idaho	70,391	24,020	38,424	-	7,947	-	-	11%
Illinois	186,291	106,496	63,644	7,355	7,383	1,413	-	16%
Indiana	196,247	18,654	88,312	73,890	15,391	-	-	16%
Iowa	70,930	28,641	29,124	2,818	2,591	7,667	89	11%
Kansas	49,925	17,301	21,352	741	10,304	-	227	12%
Kentucky	126,465	20,988	54,613	44,378	6,486	-	-	7%
Louisiana	179,696	155,926	7,263	10,692	5,584	-	231	10%
Maine	41,903	23,713	17,064	-	1,126	-	-	20%
Maryland	69,536	27,652	12,767	-	3,015	25,968	134	14%
Massachusetts	199,134	164,478	21,593	10,379	21	-	2,663	6%
Michigan	433,810	181,525	218,286	23,116	10,223	-	660	12%
Minnesota	379,496	121,627	35,884	13,302	2,480	206,203	-	10%
Mississippi	54,196	23,654	12,036	10,637	7,869	-	-	23%
Missouri	233,050	152,656	45,471	11,264	23,498	-	161	11%
Montana	26,615	-	14,966	832	10,817	-	-	12%
Nebraska	32,670	15,853	7,052	2,253	7,512	-	-	16%
Nevada	119,618	97,878	12,343	7,560	1,837	-	-	10%
New Hampshire	10,508	1,948	3,598	-	4,962	-	-	-27%
New Jersey	196,921	178,800	17,718	12	-	-	391	17%
New Mexico	88,918	59,921	26,220	-	2,427	-	350	10%
New York	992,557	706,693	212,848	47,145	19,727	2,270	3,874	8%
North Carolina	293,450	175,665	52,624	23,001	41,939	-	221	13%
North Dakota	11,503	-	1,408	77	2,360	7,602	56	29%
Ohio	706,425	286,896	312,185	81,809	6,901	17,960	674	11%
Oklahoma	96,403	64,615	20,318	1,336	10,060	-	74	9%
Oregon	268,798	136,305	130,804	-	785	-	904	6%
Pennsylvania	899,479	548,417	320,790	6,739	18,363	-	5,170	4%
Rhode Island	66,346	61,345	1,888	2,931	-	-	182	4%
South Carolina	143,265	25,655	50,641	40,431	26,151	-	387	17%
South Dakota	15,412	-	6,269	1,054	2,320	5,769	-	39%
Tennessee	297,537	235,885	50,347	5,525	5,485	-	295	13%
Texas	710,244	468,579	110,213	69,136	37,710	23,680	926	20%
Utah	103,301	60,019	31,978	-	11,304	-	-	8%
Vermont	7,101	169	973	1,325	4,527	-	107	34%
Virginia	171,066	39,042	50,037	16,644	50,237	14,500	606	12%
Washington	284,723	215,310	57,305	-	11,729	-	379	16%
West Virginia	76,889	5,243	55,779	8,812	7,055	-	-	7%
Wisconsin	299,815	143,875	98,939	11,602	14,856	29,793	750	10%
Wyoming	3,260	165	441	87	2,567	-	-	2%

NOTE: Territories are excluded. Blank cells indicate no plans offered.

SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment and Landscape files, 2011-2012.

Table A3. Medicare Advantage Penetration by State and Plan Type, 2012

State	Total		HMOs		Local PPOs		Regional PPOs		PFFS Plans		Cost Plans		Other		% change, 2011-2012
	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	
Alabama	20%	21%	13%	14%	6%	6%	1%	1%	<1%	<1%				<1%	1%
Alaska	<1%	<1%			<1%	<1%									<1%
Arizona	37%	37%	33%	33%	2%	2%	1%	1%	1%	1%		<1%			1%
Arkansas	14%	15%	5%	6%	2%	2%	2%	2%	5%	4%			<1%	<1%	2%
California	36%	36%	33%	35%	0%	1%	2%		<1%		<1%	<1%	<1%	<1%	<1%
Colorado	33%	34%	25%	26%	3%	3%			1%	1%	4%	4%	<1%	<1%	1%
Connecticut	19%	21%	15%	16%	2%	4%	2%	1%							2%
Delaware	3%	5%	2%	3%	1%	1%									1%
District of Columbia	10%	10%	2%	2%	1%	1%					6%	6%			<1%
Florida	31%	34%	22%	24%	2%	3%	7%	7%	<1%	<1%			<1%	<1%	2%
Georgia	21%	23%	5%	6%	8%	10%	4%	4%	4%	4%					2%
Hawaii	42%	44%	13%	15%	9%	12%	13%	14%	<1%	<1%	7%	4%			2%
Idaho	27%	29%	10%	10%	13%	16%			4%	3%					2%
Illinois	9%	10%	5%	6%	2%	3%	1%	<1%	<1%	<1%	<1%	<1%			1%
Indiana	17%	19%	1%	2%	7%	8%	6%	7%	2%	1%	<1%				2%
Iowa	12%	13%	5%	5%	5%	5%	1%	1%	1%	<1%	1%	1%	<1%	<1%	1%
Kansas	10%	11%	3%	4%	4%	5%	1%	<1%	2%	2%			<1%	<1%	1%
Kentucky	15%	16%	3%	3%	3%	7%	8%	6%	1%	1%	<1%				<1%
Louisiana	23%	25%	20%	22%	1%	1%	1%	1%	1%	1%			<1%	<1%	2%
Maine	13%	15%	7%	9%	6%	6%			1%	<1%					2%
Maryland	8%	8%	3%	3%	1%	2%			<1%	<1%	3%	3%	<1%	<1%	1%
Massachusetts	18%	18%	15%	15%	2%	2%	1%	1%	<1%	<1%			<1%	<1%	<1%
Michigan	23%	25%	10%	11%	12%	13%	1%	1%	1%	1%			<1%	<1%	2%
Minnesota	44%	46%	15%	15%	4%	4%	2%	2%	<1%	<1%	23%	25%			3%
Mississippi	9%	10%	4%	5%	2%	2%	1%	2%	2%	2%					2%
Missouri	21%	22%	13%	15%	4%	4%	1%	1%	3%	2%			<1%	<1%	2%
Montana	14%	15%			7%	8%	<1%		7%	6%			<1%		1%
Nebraska	10%	11%	5%	6%	2%	2%	1%	1%	3%	3%					1%
Nevada	30%	31%	26%	26%	2%	3%	2%	2%	<1%	<1%					1%
New Hampshire	6%	5%	<1%	1%	1%	2%			6%	2%					-2%
New Jersey	13%	14%	11%	13%	1%	1%		<1%					<1%	<1%	2%
New Mexico	25%	27%	17%	18%	7%	8%			1%	1%			<1%	<1%	1%
New York	30%	32%	22%	23%	6%	7%	1%	2%	1%	1%	<1%	<1%	<1%	<1%	2%
North Carolina	17%	19%	10%	11%	3%	3%	1%	1%	4%	3%			<1%	<1%	2%
North Dakota	8%	10%			1%	1%	<1%	<1%	3%	2%	4%	7%	<1%	<1%	2%
Ohio	33%	36%	14%	15%	8%	16%	10%	4%	<1%	<1%	1%	1%	<1%	<1%	2%
Oklahoma	15%	15%	10%	10%	3%	3%	<1%	<1%	2%	2%			<1%	<1%	1%
Oregon	41%	41%	21%	21%	19%	20%			<1%	<1%			<1%	<1%	1%
Pennsylvania	38%	38%	24%	23%	12%	14%	<1%	<1%	1%	1%			<1%	<1%	1%
Rhode Island	35%	35%	27%	33%	1%	1%	6%	2%					<1%	<1%	<1%
South Carolina	16%	17%	2%	3%	5%	6%	5%	5%	3%	3%			<1%	<1%	2%
South Dakota	8%	11%			3%	4%	1%	1%	3%	2%	1%	4%			3%
Tennessee	25%	27%	19%	21%	4%	5%	1%	<1%	1%	<1%			<1%	<1%	2%
Texas	19%	22%	14%	15%	1%	3%	2%	2%	1%	1%	1%	1%	<1%	<1%	3%
Utah	34%	34%	16%	20%	13%	11%			4%	4%					1%
Vermont	5%	6%	<1%		1%	1%	2%	1%	2%	4%			<1%	<1%	1%
Virginia	13%	14%	2%	3%	4%	4%	1%	1%	5%	4%	1%	1%	<1%	<1%	1%
Washington	25%	28%	19%	21%	5%	6%			1%	1%			<1%	<1%	3%
West Virginia	19%	20%	1%	1%	6%	14%	10%	2%	2%	2%					1%
Wisconsin	30%	32%	14%	15%	8%	10%	2%	1%	2%	2%	3%	3%	<1%	<1%	2%
Wyoming	4%	4%	<1%	<1%	1%	1%	<1%	<1%	3%	3%	<1%				<1%

NOTE: Territories are excluded. Blank cells indicate no plans offered.

SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment and Landscape files, 2011-2012.

Table A4. Marketshare of the Top Three Medicare Advantage Firms, by State, 2012

State	Total		Firm 1		Firm 2		Firm 3		Other Firms
	Enrollment	Share for 3 Firms	Name	Share	Name	Share	Name	Share	Share
Alabama	186,118	67%	BlueCross BlueShield of Alabama	22%	UnitedHealth Group, Inc.	20%	UAB Health System	20%	38%
Alaska	18	100%	Aetna Inc.	100%		N/A		N/A	0%
Arizona	362,998	65%	UnitedHealth Group, Inc.	41%	Health Net, Inc.	12%	Humana Inc.	12%	35%
Arkansas	84,523	66%	Humana Inc.	38%	UnitedHealth Group, Inc.	20%	USAble Mutual Insurance Company	16%	26%
California	1,806,300	70%	Kaiser Foundation Health Plan, Inc.	46%	UnitedHealth Group, Inc.	18%	Health Net, Inc.	8%	28%
Colorado	226,249	83%	UnitedHealth Group, Inc.	37%	Kaiser Foundation Health Plan, Inc.	34%	Humana Inc.	12%	18%
Connecticut	123,430	91%	UnitedHealth Group, Inc.	46%	EmblemHealth, Inc.	32%	Aetna Inc.	9%	13%
Delaware	7,349	98%	CIGNA	45%	Aetna Inc.	43%	UnitedHealth Group, Inc.	9%	3%
District of Columbia	7,912	95%	Kaiser Foundation Health Plan, Inc.	67%	CIGNA	18%	UnitedHealth Group, Inc.	9%	6%
Florida	1,193,481	60%	Humana Inc.	33%	UnitedHealth Group, Inc.	20%	Blue Cross and Blue Shield of Florida	7%	40%
Georgia	303,077	72%	UnitedHealth Group, Inc.	49%	Humana Inc.	22%	Universal Health Care Group, Inc.	8%	21%
Hawaii	96,277	90%	Hawaii Medical Service Association	40%	Kaiser Foundation Health Plan, Inc.	27%	UnitedHealth Group, Inc.	20%	12%
Idaho	70,391	86%	Blue Cross of Idaho Health Services, Inc.	44%	Humana Inc.	20%	UnitedHealth Group, Inc.	17%	19%
Illinois	186,291	72%	Humana Inc.	43%	UnitedHealth Group, Inc.	20%	Coventry Health Care Inc.	9%	29%
Indiana	196,247	80%	WellPoint, Inc.	36%	Humana Inc.	28%	UnitedHealth Group, Inc.	19%	18%
Iowa	70,930	82%	UnitedHealth Group, Inc.	37%	Humana Inc.	32%	Coventry Health Care Inc.	15%	16%
Kansas	49,925	98%	Humana Inc.	52%	Coventry Health Care Inc.	34%	UnitedHealth Group, Inc.	12%	2%
Kentucky	126,465	94%	Humana Inc.	57%	WellPoint, Inc.	36%	UnitedHealth Group, Inc.	4%	3%
Louisiana	179,696	90%	Humana Inc.	59%	PH Holdings, LLC	28%	Vantage Health Plan, Inc.	5%	9%
Maine	41,903	75%	Martin's Point Health Care, Inc.	37%	WellPoint, Inc.	22%	Arcadian Management Services Inc.	15%	26%
Maryland	69,536	85%	Kaiser Foundation Health Plan, Inc.	37%	CIGNA	28%	Aetna Inc.	17%	18%
Massachusetts	199,134	79%	TAHMO, Inc.	45%	Fallon Community Health Plan	16%	UnitedHealth Group, Inc.	14%	25%
Michigan	433,810	81%	Blue Cross Blue Shield of Michigan	54%	Spectrum Health System	15%	Humana Inc.	11%	19%
Minnesota	379,496	72%	Medica Holding Company	29%	UCare Minnesota	24%	Blue Cross and Blue Shield of Minnesota	20%	27%
Mississippi	54,196	89%	Humana Inc.	52%	Munich American Holding Corporation	28%	CIGNA	10%	10%
Missouri	233,050	78%	UnitedHealth Group, Inc.	30%	Coventry Health Care Inc.	29%	Humana Inc.	23%	18%
Montana	26,615	89%	New West Health Services	40%	Humana Inc.	33%	Munich American Holding Corporation	17%	10%
Nebraska	32,670	88%	UnitedHealth Group, Inc.	54%	Humana Inc.	20%	Coventry Health Care Inc.	18%	8%
Nevada	119,618	90%	UnitedHealth Group, Inc.	49%	Humana Inc.	30%	Renown Health	8%	13%
New Hampshire	10,508	94%	UnitedHealth Group, Inc.	59%	Arcadian Management Services Inc.	18%	WellPoint, Inc.	10%	13%
New Jersey	196,921	91%	Horizon Blue Cross Blue Shield of New Jersey, Inc.	33%	UnitedHealth Group, Inc.	33%	Aetna Inc.	24%	10%
New Mexico	88,918	86%	Presbyterian Healthcare Services	37%	Ardent Health Services.	34%	Humana Inc.	13%	16%
New York	992,557	40%	UnitedHealth Group, Inc.	14%	EmblemHealth, Inc.	13%	WellPoint, Inc.	13%	60%
North Carolina	293,450	83%	UnitedHealth Group, Inc.	35%	Blue Cross and Blue Shield of North Carolina	28%	Humana Inc.	23%	14%
North Dakota	11,503	92%	Medica Holding Company	63%	Humana Inc.	28%	Heart of America Health Plan	4%	5%
Ohio	706,425	67%	Humana Inc.	27%	WellPoint, Inc.	26%	Aetna Inc.	15%	32%
Oklahoma	96,403	84%	UnitedHealth Group, Inc.	35%	CommunityCare Managed Healthcare Plans of OK, Inc.	29%	Humana Inc.	22%	13%
Oregon	268,798	52%	Cambia Health Solutions, Inc.	20%	Kaiser Foundation Health Plan, Inc.	16%	Providence Health & Services	15%	49%
Pennsylvania	899,479	56%	Highmark Inc.	33%	University of Pittsburgh Medical Center	12%	Aetna Inc.	10%	45%
Rhode Island	66,346	100%	UnitedHealth Group, Inc.	51%	Blue Cross & Blue Shield of Rhode Island	48%	PACE Organization of Rhode Island	<1%	<1%
South Carolina	143,265	70%	Humana Inc.	34%	UnitedHealth Group, Inc.	27%	BlueCross BlueShield of South Carolina (BCBSSC)	16%	23%
South Dakota	15,412	80%	Humana Inc.	42%	Medica Holding Company	38%	Coventry Health Care Inc.	8%	12%
Tennessee	297,537	81%	Humana Inc.	34%	CIGNA	25%	UnitedHealth Group, Inc.	22%	19%
Texas	710,244	64%	UnitedHealth Group, Inc.	36%	Humana Inc.	25%	CIGNA	13%	26%
Utah	103,301	77%	UnitedHealth Group, Inc.	39%	Humana Inc.	22%	Cambia Health Solutions, Inc.	16%	22%
Vermont	7,101	93%	UnitedHealth Group, Inc.	79%	Aetna Inc.	9%	MVP Health Care, Inc.	6%	6%
Virginia	171,066	70%	Humana Inc.	42%	UnitedHealth Group, Inc.	21%	WellPoint, Inc.	15%	22%
Washington	284,723	64%	Group Health Cooperative	27%	UnitedHealth Group, Inc.	25%	Cambia Health Solutions, Inc.	10%	39%
West Virginia	76,889	96%	Humana Inc.	72%	Highmark Inc.	17%	Health Plan of the Upper Ohio Valley	7%	4%
Wisconsin	299,815	62%	UnitedHealth Group, Inc.	27%	Humana Inc.	21%	Affinity Health System	15%	37%
Wyoming	3,260	95%	Humana Inc.	54%	UnitedHealth Group, Inc.	37%	Coventry Health Care Inc.	5%	3%

NOTE: Territories are excluded.

SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment and Landscape files, 2012.

Table A5. Premiums for Medicare Advantage Drug Plans (MA-PDs) by Firm, Weighted by Enrollment, 2011-2012

Firm or Affiliate	Total		HMOs		Local PPOs		Regional PPOs		PFFS		Cost	
	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
UnitedHealthcare	$ 10.01	$ 8.34	$ 12.02	$ 9.08	$ 5.07	$ 6.44	$ 0.00	$ 3.57	$ 10.62	$ 12.11		
Humana	$ 36.70	$ 32.63	$ 11.44	$ 9.68	$ 44.55	$ 45.82	$ 66.56	$ 64.24	$ 61.04	$ 62.46		
Wellpoint BCBS	$ 9.68	$ 12.88	$ 9.79	$ 10.20	$ 20.69	$ 21.17	$ 3.35	$ 5.44	$ 44.52			
Other BCBS plans	$ 94.34	$ 82.90	$ 96.37	$ 81.80	$ 96.47	$ 92.08	$ 62.68	$ 35.66	$ 30.50	$ 28.78	$ 121.19	$ 129.04
Kaiser Permanente	$ 50.60	$ 46.72	$ 48.26	$ 44.75							$ 85.80	$ 77.12
Coventry	$ 18.76	$ 12.86	$ 21.33	$ 15.29	$ 15.71	$ 9.94						
Aetna	$ 49.39	$ 43.67	$ 43.61	$ 39.04	$ 100.79	$ 84.41						
HealthNet	$ 18.33	$ 39.25		$ 40.86	$ 18.33	$ 35.30						
Universal American		$ 21.24		$ 0.71		$ 35.38				$ 69.64		
WellCare	$ 3.87	$ 2.96	$ 3.87	$ 2.96								
Health Spring	$ 7.11		$ 6.94		$ 11.78							
Wellpoint (non-BCBS)	$ 38.37	$ 5.22	$ 9.93	$ 5.22					$ 42.48			
Sterling	$ 46.23	$ 36.37		$ 28.92	$ 19.10	$ 58.52			$ 51.01	$ 58.52		
CIGNA	$ 0.00	$ 5.94	$ 0.00	$ 5.41		$ 21.98						
Other firms	$ 50.82	$ 48.01	$ 46.02	$ 43.34	$ 56.74	$ 53.22	$ 54.06		$ 0.15	$ 0.00	$ 151.83	$ 148.96
Average Weighted Premium	$ 39.33	$ 35.03	$ 33.85	$ 28.81	$ 58.51	$ 52.59	$ 23.32	$ 26.37	$ 43.07	$ 41.85	$ 133.58	$ 130.70

NOTE: Premiums weighted by March 2012 enrollment. Excludes Medicare Advantage plans that do not offer prescription drug coverage, special needs plans (SNPs), and employer group health plans. BCBS are Blue Cross / Blue Shield affiliates. The premiums for a subset of sanctioned plans (e.g., Universal American) were not available in 2011. These plans were excluded from this analysis. Firm affiliations reflect status in the year indicated. Because of mergers and acquisitions, some plans may be affiliated differently in 2011 than 2012. Blank cells indicate that either no plans were offered or no premium information was available.

SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment and Landscape files 2011-2012.

Table A6. Share of Total Enrollment in Medicare Advantage Prescription Drug Plans (MA-PDs) with No Premiums, 2012

Firm or Affiliate	Total	HMOs	Local PPOs	Regional PPOs	PFFS	Cost plans
UnitedHealthcare	86%	87%	82%	89%	57%	
Humana	40%	78%	1%	9%	0%	
Wellpoint BCBS	75%	78%	63%	87%		
Other BCBS plans	28%	32%	19%	50%	47%	0%
Kaiser Permanente	43%	44%				25%
Coventry	66%	67%	65%			
Aetna	50%	56%	0%			
HealthNet	53%	48%	65%			
Universal American	69%	99%	45%		0%	
WellCare	93%	93%				
Wellpoint (non-BCBS)	89%	89%				
Sterling	24%	33%	0%		0%	
CIGNA	84%	85%	50%			
Other firms	48%	50%	41%		100%	0%
All MA-PDs	56%	65%	31%	59%	29%	6%

NOTE: Premiums weighted by March 2012 enrollment. Excludes Medicare Advantage plans that do not offer prescription drug coverage, special needs plans (SNPs), and employer group health plans; includes territories. BCBS are Blue Cross / Blue Shield affiliates. Blank cells indicate that either no plans were offered or no premium information was available.

SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment and Landscape files 2012.

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THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800 Website: www.kff.org
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

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