THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE ADVANTAGE 2011 DATA SPOTLIGHT

Plan Availability and Premiums

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The Centers for Medicare and Medicaid Services (CMS) recently released information about the Medicare Advantage plans that will be available in 2011.[1] As of September 2010, 11.8 million Medicare beneficiaries, nearly one-quarter of the total Medicare population, are enrolled in a Medicare Advantage plan. This *Data Spotlight* briefly reviews recent changes made to the Medicare Advantage program and examines trends in plan participation, premiums, and certain benefits.

SUMMARY OF FINDINGS

Overall, our analysis of the 2011 Medicare Advantage market finds modest changes in-store for 2011, although the experience of enrollees will vary by county and across plans. Medicare beneficiaries, on average, will be able to choose from among 24 Medicare Advantage plans offered in their county, even after a 13 percent decline in the total number of Medicare Advantage plans nationwide.[2] This includes, on average, a choice of 10 HMOs, 4 local PPOs, 4 PFFS plans, and 5 regional PPOs. The decline in the total number of plans is primarily due to a drop in the number of private fee-for-service (PFFS) plans and the relatively new CMS rules encouraging consolidation of low enrollment and duplicative plans. These rules were adopted in response to consumer concerns about the ability of beneficiaries to make informed choices when large numbers of plans were offered. Virtually all beneficiaries will continue to have access to at least one Medicare Advantage plan, and the vast majority will have access to more than 10 plans in 2011.

Average unweighted premiums for Medicare Advantage Prescription Drug (MA-PD) plans will be $51 per month in 2011 – a $5 decrease from 2010. As observed in previous years, average unweighted premiums will be higher than enrollment-weighted premiums in 2011 ($43 per month) assuming enrollees do not switch plans, because beneficiaries tend to choose lower premium plans among those offered in their area. Between 2010 and 2011, enrollment-weighted MA-PD premiums will increase by $2, on average, or about 5 percent, for plans offered in both 2010 and 2011.[3] The average increase will be less if, on balance, enrollees switch to lower premium plans. Either way, the increase in premiums for 2011 will likely be substantially smaller than the 22 percent increase in weighted MA-PD premiums between 2009 and 2010.[4]

As we have documented in prior years, monthly premiums will vary across plans, plan types, and markets and will be lower in absolute terms for HMOs than other plan types. Because enrollees can shift plans in open enrollment, historically average enrollment weighted premiums drop once these effects are factored in.

In 2011, all Medicare Advantage plans will be required to limit beneficiaries' out-of-pocket expenses for the first time, although in many plans, the limits are quite high. As in previous years, about half of all MA-PDs will offer some coverage in the coverage gap, also known as the "doughnut hole." This year, however, enrollees in plans with a gap in drug coverage will receive a 50 percent discount from drug manufacturers on brand-name drugs in the gap due to changes made in the health reform law of 2010. Between 2011 and 2020, the doughnut hold will gradually be filled in due to changes enacted in the 2010 health reform law. Plans will continue to vary in terms of premiums, benefits and other key features presenting beneficiaries with opportunities and challenges in choosing plans for 2011.

RECENT REFORMS IN LAW AND REGULATION

The Medicare Advantage program has evolved in response to a number of changes enacted by Congress and by changes in rules and requirements established by the Administration in recent years. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, for example, requires PFFS to have networks of providers in most counties beginning in 2011. In 2009, CMS began encouraging the consolidation of low-enrollment and duplicative

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("look alike") plans, leading to a consolidation in plans available in 2010 and 2011. CMS also increased its review of how Medicare Advantage plans structured cost-sharing, with the goal of limiting features that could adversely affect high-cost beneficiaries and encouraged firms to set limits on out-of-pocket spending at $3,400 or less. In 2011, CMS established a new requirement that plans limit beneficiaries' out-of-pocket expenditures to no greater than $6,700, among other reforms.[5]

The Affordable Care Act (ACA) of 2010 included a number of provisions that are also expected to affect the Medicare Advantage marketplace, although most of these changes will not begin to take effect until 2012 or later. The ACA reduces payments to plans over time, beginning with a freeze in benchmarks (the maximum amount Medicare pays plans in a given county) for 2011 at 2010 levels. Beginning in 2012, the law phases in a reduction in benchmarks, provides new quality bonus payments to plans, and reduces the share plans are permitted to keep when bids are below the benchmark based on quality ratings.[6] Beginning in 2014, the ACA also will require plans to maintain a medical loss ratio of at least 85 percent.

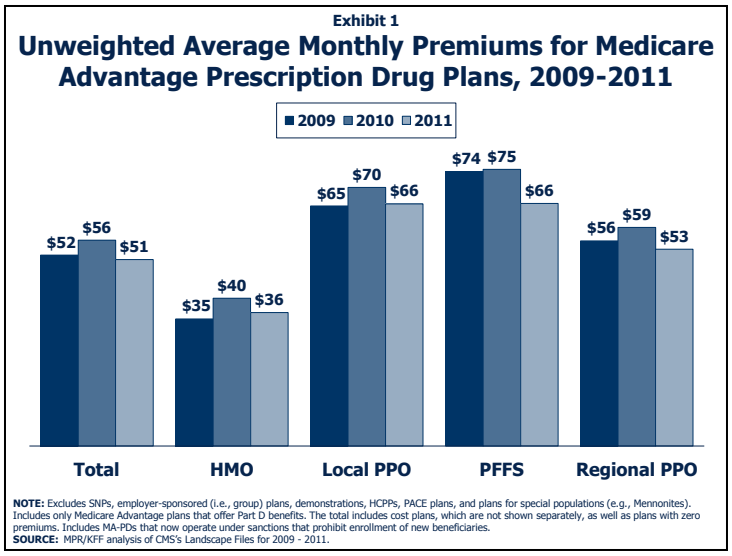
This *Data Spotlight* examines the Medicare Advantage marketplace in 2011, in the context of these changes.

FINDINGS

Premiums and Benefits. With numerous Medicare Advantage plans available to beneficiaries throughout the country in 2011, as in 2010 (see section on plan choice below), beneficiaries will have the opportunity to compare and switch plans during the open enrollment period that runs from November 15 – December 31st. Premiums, benefits and cost-sharing requirements are important plan characteristics for beneficiaries looking to get the best possible coverage, at the lowest possible cost. This analysis examines trends in premiums, the Part D drug benefit and limits on out-of-pocket spending as published by CMS in late September of 2010; it does not, however, compare cost-sharing requirements for individual services, such as daily hospital copayments, that could be a major factor in an enrollees' out-of-pocket expenses because those data for 2011 are not on the data file.

Monthly Premiums. Medicare beneficiaries enrolled in Medicare Advantage plans pay the Part B premium (less any rebate provided in the Medicare Advantage package) and often pay an additional monthly premium directly to the plan for supplemental benefits and for prescription drug coverage (Part D).

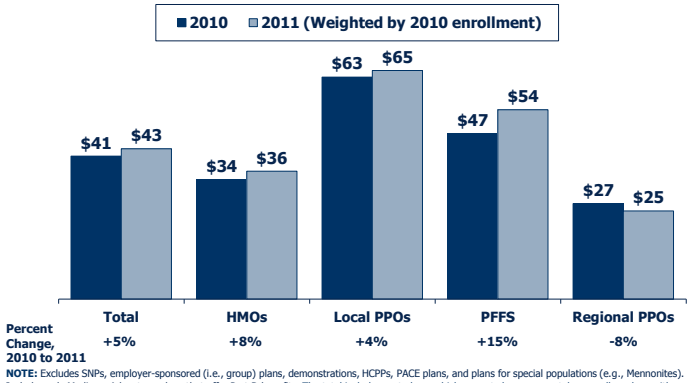
- Among MA-PDs, the average unweighted monthly plan premium, including the portion attributable to Part D, will be $51 per month in 2011.[7] Average unweighted plan premiums capture the premiums beneficiaries have available across all plans offered nationwide. Average premiums weighted for enrollment are a better indicator of the amount beneficiaries actually pay, on average, because they give greater weight to plans with higher enrollment (see below). Typically, unweighted premiums are higher than weighted ones, reflecting beneficiaries' preferences for lower premium plans. **(Exhibit 1)**



  - Overall, average unweighted MA-PD premiums will decrease by $5 per month, or 9 percent.[8] Average unweighted premiums will decline by 6 percent for local PPOs and by 12 percent for PFFS plans between 2010 and 2011.
  - Average unweighted premiums will be lower for HMOs ($36 per month) than for other plan types in 2011, as in previous years.

- In 2011, the average premium, weighted by 2010 enrollment, will be about $43 per month, up from $41 in 2010 – a 5 percent increase – for enrollees in plans available in both years. In contrast, premiums increased by 22 percent between 2009 and 2010 (enrollment-weighted). If, during the open enrollment period, beneficiaries choose to switch from their current plan to lower premium plans for 2011, enrollment-weighted premiums will likely be somewhat lower than $43 per month.[9] Average weighted premiums in 2010 for firms remaining in the market in 2011 were substantially lower than those departing. **(Exhibit 2)**

Exhibit 2
Weighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, Total and by Plan Type, 2010-2011
(2011 Weighted by 2010 Enrollment; Includes Plans Available in Both 2010 and 2011)

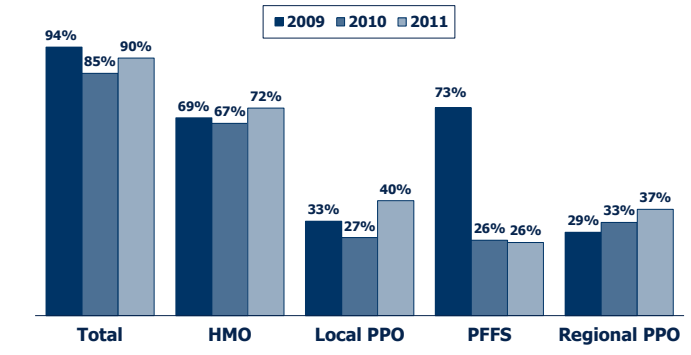


NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes only Medicare Advantage plans that offer Part D benefits. The total includes cost plans, which are not shown separately, as well as plans with zero premiums. Weighted monthly premiums for 2011 include MA-PDs available in both 2010 and 2011, based on 2010 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. Includes MA-PDs that now operate under sanctions that prohibit enrollment of new beneficiaries.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2010 – 2011, CMS's 2011 Part C and D Crosswalk file, and September 2010 Enrollment file.

  - Average MA-PD premiums, weighted for 2010 enrollment, will increase by 15 percent for beneficiaries in PFFS plans who stay in the same plan, by 8 percent for HMO enrollees, and by 4 percent for beneficiaries in local PPOs, but will decline for enrollees who remain in the same regional PPOs.
  - Average enrollment weighted premiums will vary by plan type and will be lowest for regional PPOs and HMOs, and highest for cost plans and local PPOs. **(Table A1)**
  - Relative premiums by plan type are hard to interpret in the absence of information about plans' benefit structure. For example, our analysis of 2010 plans showed that regional PPOs typically had low premiums but higher cost sharing requirements.[10]

- The share of enrollees in zero-premium plans will increase slightly from 49 percent in 2010 to 51 percent in 2011, among plans that will be offered in both years, and is much higher share among HMOs and regional PPOs enrollees (60 and 61 percent, respectively) than PFFS plan enrollees (9 percent).
  - The vast majority of Medicare beneficiaries (90 percent) have access to at least one zero-premium MA-PD, similar to previous years. More beneficiaries will have access to zero-premium HMOs (72 percent) than to zero-premium local PPOs (40 percent) and regional PPOs (37 percent). **(Exhibit 3)**
  - The share of beneficiaries with access to a zero premium PFFS plan will decrease from 73 percent in 2009 to 26 percent in 2011.

Exhibit 3
Share of Beneficiaries with Access to Medicare Advantage Prescription Drug Plans with No Additional Premium, Total and by Plan Type, 2009-2011



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. Includes MA-PDs that now operate under sanctions that prohibit enrollment of new beneficiaries. 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 – 2011.

The level of premiums and the extent to which they change from year to year reflect a number of factors, according to plans and industry observers, including how much the plans are paid by Medicare, the costs of delivering care in different areas, and how firms position their Medicare Advantage products in the market strategically, taking into account their view of beneficiaries' preferences and firm market strength.[11] CMS has partially attributed the relatively small overall change in premiums to the new authority given to the Secretary to negotiate with plans.[12] Such factors are important to consider when interpreting premiums for one type of plan relative to another, and changes from one year to the next. For example, the increase in PFFS premiums may reflect both the costs of adding networks as well as how firms are positioning the PFFS product in the market. Similarly, firms may be holding premiums down for regional PPOs to compete for price sensitive beneficiaries, and may be allowing premiums to rise

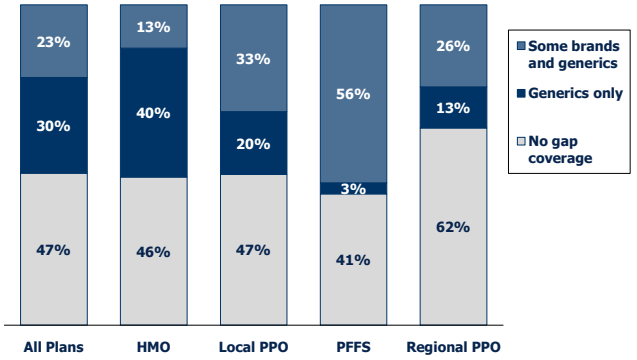
in order to offer better benefits in local PPOs to compete for the beneficiaries who want and are willing to pay more to have a greater choice in providers.

Prescription Drug Coverage. Prior to the implementation of the Medicare drug benefit in 2006, Medicare Advantage plans were attractive to beneficiaries, in part because they provided some coverage of prescription drugs which were not otherwise covered under Medicare. Today, people on Medicare can get Medicare prescription drug coverage either through a stand-alone Part D plan or a Medicare Advantage Prescription Drug (MA-PD) plan.

- Fifty-three percent of all MA-PDs will offer some coverage in the coverage gap, also known as the Medicare Part D "doughnut hole," in 2011. Thirty percent will cover generics only (no brands) and the remaining 23 percent will cover some brands and generics. Less than 1 percent of the plans offered in 2011 will cover MA-PDs will offer no coverage in the gap. **(Exhibit 4)**
- Beginning in 2011, enrollees in plans with gap in drug coverage will receive a 50 percent discount on brand-name drugs due to changes made in the ACA, and additional coverage of generics that will be phased in over time.
    - Medicare Advantage plans are somewhat more likely than stand-alone prescription drug plans (PDPs) to offer coverage in the gap. In 2011, two-thirds of all PDPs will offer no coverage in the gap.[13] One reason for this is that MA-PDs structure allows them to offset Part D costs by any savings in Part A and B beneficiaries; such savings likely will be lower in the future because the ACA limits increase in MA payment benchmarks.
- Regional PPOs and cost plans are less likely than other plan types to have any gap coverage. Nearly two-thirds of all regional PPOs have no coverage in the gap, as compared to 46 percent of HMOs and 41 percent of PFFS plans.

Exhibit 4

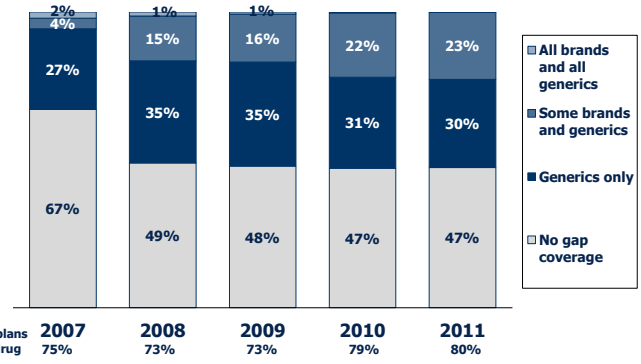
Share of Medicare Advantage Prescription Drug Plans with Gap Coverage, by Plan Type, 2011



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. Excludes MA-PDs under sanction by CMS. 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 HMOs, and 0% of local PPOs, PFFS plans, and regional PPOs, cover all brands and generics in the gap.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2011.

Exhibit 5

Share of Medicare Advantage Prescription Drug Plans with Gap Coverage, 2007-2011



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. Excludes MA-PDs under sanction by CMS in 2010. 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 and 2011 cover all brands and generics in the gap.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2007-2011.

- Since 2008, the share of all MA-PDs offering some coverage in the gap has remained fairly constant at about 50 percent. (**Exhibit 5)**

Cost Sharing and Limits on Out-of-Pocket Spending. Since the earliest days of the Medicare HMO program, private plans (now known as Medicare Advantage plans) have been required to provide Medicare benefits in a plan design that has cost-sharing that is actuarially equivalent to traditional fee-for-service Medicare. In recent years, however, there has been concern that some plans impose cost-sharing requirements that impose an excess out-of-pocket burden on high-cost beneficiaries, and in response CMS began to scrutinize more carefully cost-sharing requirements imposed by plans. The 2010 health reform law included a new provision to prohibit Medicare Advantage plans from having higher cost-sharing than traditional fee-for-service Medicare for chemotherapy, renal dialysis, and skilled nursing care.

Since 2006 when they were first authorized, regional PPOs have been required to have a limit on out-of-pocket spending on cost-sharing for benefits under Parts A and B. For 2010, CMS encouraged all Medicare Advantage plans to incorporate an overall annual out-of-pocket limit of $3,400 (the 85th percentile of beneficiary spending). In 2011, for the first time, CMS is requiring all local Medicare Advantage plans to include a limit on out-of-pocket spending that cannot exceed $6,700, a figure calculated to represent the 95th percentile in costs among beneficiaries in the traditional fee-for-service program.[14] The traditional fee-for-service Medicare program does not include a limit on out-of-pocket spending for benefits covered under Parts A and B.

- In 2011, all plans will have a limit on out-of-pocket spending, as compared to 79 percent of plans in 2010.
- About half of all plans will have limits of $3,400 or less, about the same share as in 2010 (51 percent in 2011 and 48 percent in 2010), but fewer plans will have limits of $2500 or less (5 percent versus 9 percent) and considerably more will have higher limits. **(Exhibit 6)**
- HMOs are more likely to set lower limits on out-of-pocket spending than other plan types; 59 percent of HMOs will have a limit of $3,400 or less, as compared to 41 percent of regional PPOs and 23 percent of PFFS plans. PFFS plans are more likely than other plan types to have limits in excess of $5,000 in 2011. Nearly half of all PFFS plans (46 percent) have limits between $5,001 and $6,700. **(Exhibit 7)**

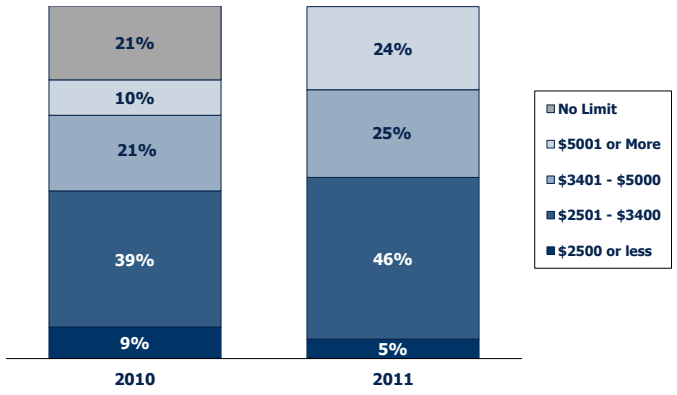
Plan Availability & Choice

Medicare Advantage Plan Availability. Nationwide 2,011 Medicare Advantage plans will be offered in 2011.[15] Of this total, 80 percent will be MA-PDs.

- Between 2009 and 2011, the number of plans offered nationwide has declined, reversing a steady increase in the number of plans that followed the enactment of the MMA in 2003 and introduction of Part D in 2006.[16] Total plans available nationwide in 2011 is down substantially from the peak of 2,830 in 2009 but down by only a small number nationwide relative to 2007 (2,011 in 2011 versus 2,098 in 2007). **(Exhibit 8)**[17]

Exhibit 6

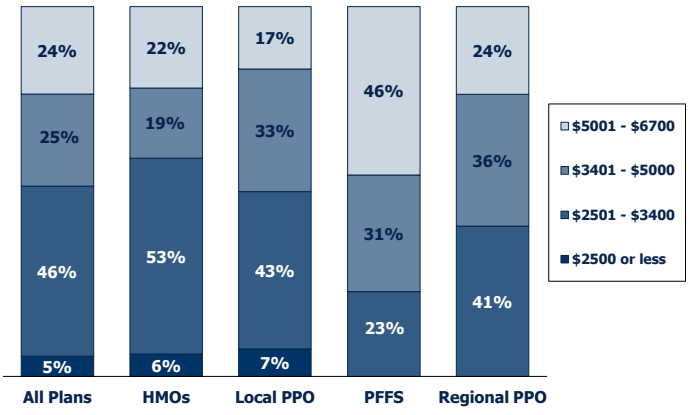
Share of Medicare Advantage Plans With Limits on Out-of-Pocket Spending, 2010-2011



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, MSAs, and plans for special populations (e.g., Mennonites). Excludes plans sanctioned by CMS. Percentages are unweighted by enrollment. Totals may not add to 100% due to rounding.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2010-2011.

Exhibit 7

Share of Medicare Advantage Plans by Limits on Out-of-Pocket Spending, by Plan Type, 2011



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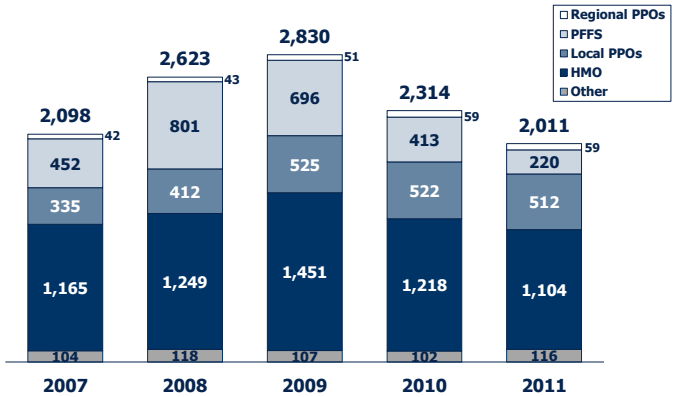
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2011.

Exhibit 8

Distribution of Medicare Advantage Plans by Plan Type, 2007-2011



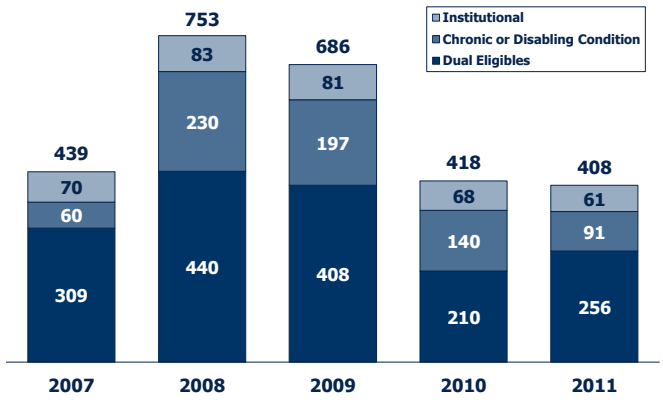
NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). HMOs include Point of Service (POS) plans. Includes MA-PDs that now operate under sanctions that prohibit enrollment of new beneficiaries.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2007 - 2011.

- The decline in the total number of Medicare Advantage plans appears to be driven in large part by the decline in the number of PFFS plans, from 801 PFFS plans at their peak in 2008 to 220 PFFS plans in 2011. Between 2010 and 2011, the total number of PFFS plans will drop nearly in half from 413 plans to 220 plans, continuing the contraction in this part of the market as firms respond to market experience and anticipate MIPPA network requirements. (See box under Market Dynamics)
- HMOs remain the most common type of plan in 2011, as in previous years, accounting for 55 percent of all Medicare Advantage plans. Fewer HMOs will be offered in 2011 than in 2010 (1,104 versus 1,218). Although HMOs' share of the total Medicare Advantage plan market has fluctuated from year to year, they have accounted for around half of all Medicare Advantage plans since 2007.[18]
- Regional PPOs continue to account for a small share of the total Medicare Advantage market, with very little change in the number of plans offered nationwide over the past several years. Less than 3 percent of all plans will be regional PPOs in 2011, as in previous years. By design, however, regional PPOs serve large areas (comprised of one or more states), so regional PPOs may have more of a presence in the market than revealed by the absolute numbers of plans (see later discussion).[19]

Special Needs Plans. Special Needs Plans (SNPs) are a type of Medicare Advantage plan that is available exclusively to beneficiaries who meet one of the following conditions: (1) are dually eligible for Medicare and Medicaid, known as "dual eligibles," (2) require institutional care, or (3) have specific chronic conditions. In 2011, as in previous years, the vast majority of SNPs are HMOs. SNPs were initially authorized in the MMA with requirements that basically mirrored those of other Medicare Advantage plans. Since then, additional SNP requirements have been introduced in ways that vary by SNP plan type.[20] Market experience and these changes have led firms to make changes that have influenced the number and type of SNPs available.

Exhibit 9

Distribution of Special Needs Plans by Plan Type, 2007-2011



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 – 2011.

- In 2011, as in previous years, the majority of SNPs offered will be for dual eligibles (63 percent), 22 percent for beneficiaries with chronic conditions (mostly diabetes, chronic heart failure, or cardiovascular disorders), and the remainder for beneficiaries requiring institutional care. Fewer institutional SNPs will be available in 2011 than in any year since 2007. **(Exhibit 9)**
- The total number of SNPs offered nationwide has declined since 2008, with the largest reduction occurring between 2009 and 2010, and only a modest decline between 2010 and 2011 (418 in 2010 versus 408 in 2011).
- Despite the overall decline in the number of SNPs, the number of SNPs for dual eligibles increased from 201 plans in 2010 to 256 plans in 2011. The number of dual SNPs was substantially higher in 2008 and 2009.
- SNPs serving dual eligibles are located in counties in many states, but there are more SNPs for dual eligibles in heavily urbanized states where Medicare Advantage is generally is more popular, like California, Arizona, Minnesota, Florida, Pennsylvania, and New York, as well as Puerto Rico (not shown). This may be due to a number of factors, including differences in state Medicaid program characteristics and requirements and differences in the market demand for plans focusing on the dual eligible population. Dual SNPs are not currently required to contract with State Medicaid agencies but will be required to do so by 2013. Contracts with states should help to improve coordination of benefits across plans and state Medicaid programs. **(Exhibit 10)**

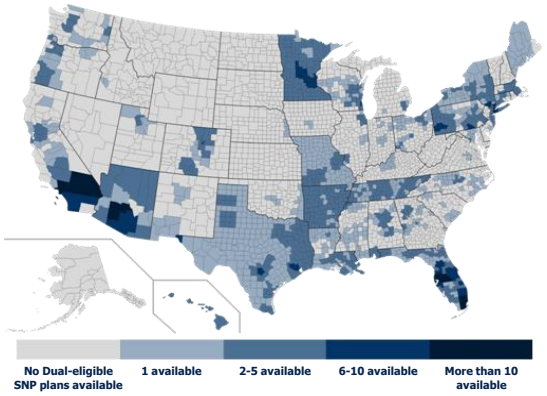
Medicare Advantage Plan Choices. Virtually all Medicare beneficiaries will have access to a Medicare Advantage plan as an alternative to the traditional fee-for-service Medicare program in 2011. This means that even if a beneficiary is in a plan that is leaving the market, there likely will be other plans available to them.[21] **(Exhibit 11)**

- 84 percent of all Medicare beneficiaries will have access to one or more HMO (93 percent of beneficiaries in urban areas and 53 percent of beneficiaries in rural areas).
- 78 percent of all Medicare beneficiaries will have access to one or more local PPOs (82 percent in urban areas and 62 percent in rural areas).
- More than 80 percent of all beneficiaries in urban and rural areas will have access to one or more regional PPOs in 2011.
- Nearly two-thirds of all beneficiaries will have access to PFFS plans in 2011, despite new requirements for these plans to have networks in most counties.

- Although the drop in overall number of Medicare Advantage plans in 2011 means beneficiaries will have fewer plans from which to choose in 2011, their choice still is extensive. In 2011, Medicare beneficiaries will be able to choose from among 24 Medicare Advantage plans, on average (26 plans in urban areas and 16 plans in rural areas). This represents a drop in the average number of plans per beneficiary from previous years, but still a considerable amount of plan choice across the country. **(Exhibit 12)**
  - The average beneficiary can choose from 10 HMOs, 4 local PPOs, 4 PFFS plans, and 5 regional PPOs in 2011 (data not shown).[22]
  - Beneficiaries in counties in which PFFS plans are not required to have networks of providers can choose from among 11 PFFS plans, on average, compared to an average of 3 plans in counties in which PFFS plans are required to have networks.
- Almost all (88 percent) beneficiaries have access to more than 10 Medicare Advantage plans in 2011 (data not shown).[23]

Exhibit 10

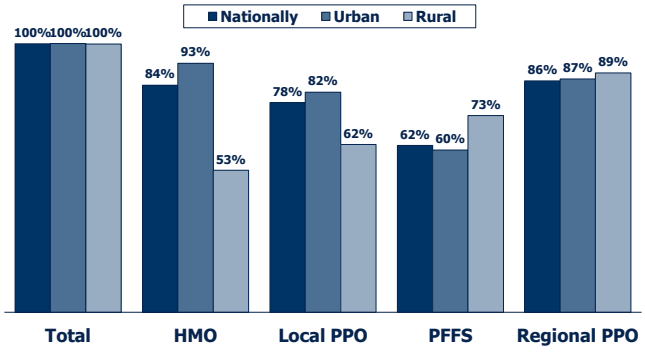
Number of Special Needs Plans Available for Beneficiaries Dually Eligible for Medicare and Medicaid, by County, 2011



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 2011.

Exhibit 11

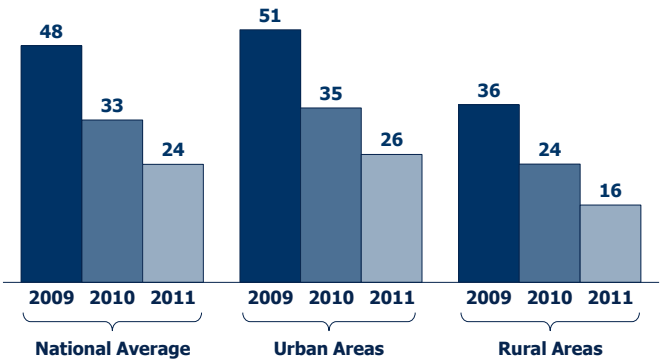
Share of Medicare Beneficiaries with Access to One or More Medicare Advantage Plans, By Plan Type, and Urban/Rural County, 2011



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. Includes MA-PDs that now operate under sanctions that prohibit enrollment of new beneficiaries.
SOURCE: MPR/KFF analysis of CMS's Landscape and Penetration Files for 2011.

Exhibit 12

Average Number of Medicare Advantage Plans Available to Beneficiaries, by Urban/Rural County, 2009-2011



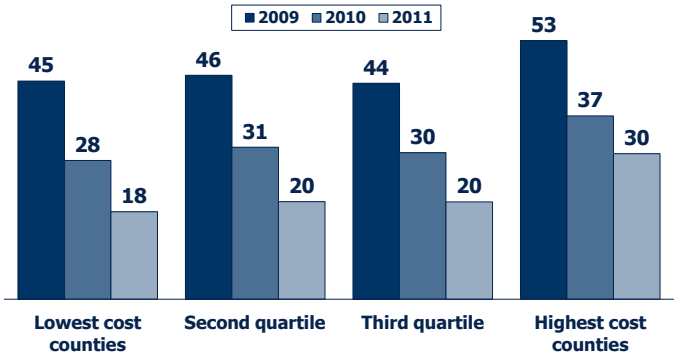
NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes MA-PDs that now operate under sanctions that prohibit enrollment of new beneficiaries.
SOURCE: MPR/KFF analysis of CMS's Landscape and Penetration Files for 2009 - 2011.

Availability of Plans in Counties, by Level of Medicare Fee-for-Service Spending. The 2010 health reform law reduces benchmarks (maximum payments to plans) beginning in 2012, based on Medicare per capita costs in the fee-for-service program; how insurers will respond to these payment reforms remains to be seen. To provide a baseline for analysis, we examined plan availability among counties in each of the four cost quartiles defined by the law.

- In 2011, consistent with other recent years, counties with the highest Medicare per capita fee-for-service costs (top quartile) have more Medicare Advantage plans available per beneficiary than counties in other quartiles. **(Exhibit 13)**
    - Counties in each quartile have seen a comparable reduction in the average number of plans available to beneficiaries living in counties since 2009, with a drop, for example, from 53 to 30 plans in counties in the top quartile of fee-for-service per capita costs and from 45 to 18 plans in the lowest per capita cost counties. These changes are unlikely to be related to changes to the Medicare Advantage program included in the ACA that take effect in 2012, but will be important trends to track as the payment reforms are fully implemented.

Exhibit 13

Average Number of Medicare Advantage Plans Available to Beneficiaries, by Quartile of Fee-for-Service per Capita Costs, 2009-2011



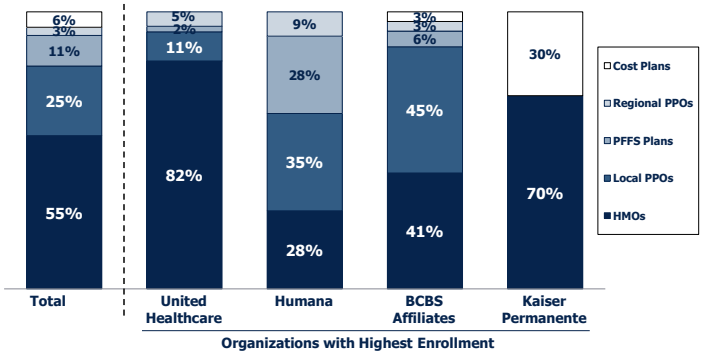
NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes MA-PDs that now operate under sanctions that prohibit enrollment of new beneficiaries.
SOURCE: MPR/KFF analysis of CMS's Landscape and Penetration Files for 2009 - 2011.

Market Dynamics

- While many firms participate in Medicare Advantage, a small number of firms have historically dominated offerings and this continues to be the case in 2011. **(Table A2)**
- Humana offers more plans nationwide (422) than any other insurer, followed by all BlueCross BlueShield (BCBS) afflilates (236 plans) and then UnitedHealthcare (152 plans). National firms such as Aetna, Universal American and Coventry also offer 50 plans or more in 2011.
- Nationwide, Humana and UnitedHealthcare plans are available to 74 percent and 65 percent of beneficiaries respectively in 2011, which compares to 83% and 73% respectively in 2010. A BCBS affiliated plan will be available to 72 percent of beneficiaries. **(Table A3)**
- Historically, firms have differed substantially in their Medicare Advantage strategy, resulting in firm differences in the types of plans offered and range of markets in which they are offered. They also have differed in how aggressively they have priced their products, over time and across markets. **(Exhibit 14; Tables A4)**

Exhibit 14

Distribution of Medicare Advantage Plans in the Firms and Affiliates with the Highest Enrollment, by Plan Type, 2011



NOTE Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, MSAs, and plans for special populations (e.g., Mennonites). Includes MA-PDs that now operate under sanctions that prohibit enrollment of new beneficiaries. Percentages are unweighted by enrollment. Totals may not add to 100% due to rounding. BCBS is Blue Cross Blue Shield affiliates and includes Wellpoint BCBS plans.
SOURCE: MPR / KFF analysis of CMS's Landscape Files for 2011.

- ***UnitedHealthcare*:** Much more so than some other firms, UnitedHealthcare relies on a mix of Medicare Advantage plan types to grow its business, including an extensive set of available HMOs and local PPOs, with more limited and geographically targeted regional PPOs. UnitedHealthcare reduced its PFFS offerings earlier than many other firms. It was thus less affected by PFFS network requirements than other firms and has now limited its PFFS offerings to only 5 percent of beneficiaries nationwide (from 35% in 2010). In 2011, UnitedHealthcare's plans will have premiums that are slightly lower than those in 2010 for most plan types (unweighted for enrollment).
- ***Humana***: Humana has competed aggressively using a broad base of PFFS plans and regional PPOs, complemented in select locales by HMOs and local PPOs. In 2010, Humana continued with a (somewhat reduced) set of PFFS offerings, maintained regional PPOs and built up its HMO and local PPO offerings in selected markets, so that their plans could attract enrollees that might be exiting from PFFS. In 2011, Humana appears to have continued with this strategy, gradually reducing its PFFS offerings while expanding other plans in an effort to maintain or grow enrollment. Medicare Advantage accounts for a larger share of revenue for Humana than for other firms.[24] Humana's average unweighted monthly PFFS premium will increase by about $10, about the same amount as its regional PPO premiums will decrease.
- ***Blue Cross / Blue Shield Affiliates:*** These plans are operated by a variety of independent companies that share the BCBS trademark. In aggregate, and probably reflecting their commercial insurance base, BCBS companies rely heavily on HMOs and increasingly local PPOs in Medicare Advantage. Collectively, they have scaled back their PFFS offerings.
- ***Kaiser Permanente:*** All of Kaiser Permanente's plans are either HMOs (70 percent) or cost plans. Over time, Kaiser Permanente has had a more stable set of plans than other national firms. While their plans are geographically concentrated, Kaiser Permanente plans tend to have many enrollees, making it the fourth largest Medicare Advantage plan in the nation by enrollment.[25]

Understanding Market Response to MIPPA's PFFS Network Requirements

MIPPA required non-employer PFFS plans to develop formal arrangements with providers (networks) by 2011 unless they operate in a county with fewer than two network-based plans, including Health Maintenance Organizations (HMOs), local Preferred Provider Organizations (PPOs), cost plans, or network-based regional PPOs or Medical Savings Account (MSA) plans. The requirement was enacted in response to concerns that the ease of establishing PFFS plans offset incentives for firms to invest in local networks and care management that could improve health outcomes.

In 2011, PFFS network requirements apply in 2,537 of the 3,138 counties nationwide. Counties without network requirements are mostly rural (461 of the 601 exempted counties in 2011). PFFS plans with networks will be available in most rural counties (78 percent) and urban counties (87 percent). All but 3.3 million Medicare beneficiaries nationwide live in a county where PFFS plans would be required to establish a network (data not shown).

When a PFFS plan converts to a network plan, CMS will roll over enrollees to the PFFS network plan, unless a beneficiary requests otherwise. Of the 220 PFFS plans offered in 2010, only 7 (including plans under sanctions) exclusively served counties exempted from 2011 network requirements (data not shown). This means that almost all firms participating in PFFS in 2011 had to develop networks in at least part of their service area.

Historically, PFFS plans have allowed firms to offer broad nationwide coverage even if they had no networks or other Medicare Advantage offerings. The only other way to achieve this was through regional PPOs with loosely interpreted network adequacy standards. As a result, many firms' geographic coverage began to diminish as they departed the PFFS market, including Coventry, Health Net and Wellcare in 2010, and Aetna, CIGNA and others in 2011. CIGNA is exiting virtually all of the individual Medicare Advantage market, with a single plan exception.

See M. Gold "Medicare's Private Plans: A Report Card on Medicare Advantage." *Health Affairs Web Exclusive,* November 24, 2008; J. Blum, R. Brown and M. Frieder "An Examination of Medicare Private Fee-for-Service Plans" Washington DC: Kaiser Family Foundation, March 2007.

DISCUSSION

The ACA of 2010 includes a number of changes to the Medicare Advantage program, but most of these changes do not begin to take effect before 2012. The Medicare Advantage marketplace in 2011 thus has predominantly been influenced by MIPPA requirements for networks in PFFS plans, expanded SNP requirements, and new plan requirements from CMS.

After the dramatic increase in plans available to beneficiaries after the MMA, the Medicare Advantage market is contracting and consolidating. Yet, Medicare beneficiaries will continue to be able to choose from among dozens of Medicare Advantage plans in 2011, having, on average, 24 Medicare Advantage plans from which to choose, as an alternative to traditional fee-for-service Medicare. Choosing among many plans is likely to continue to be challenging for beneficiaries, and efforts to support informed plan choices continue to be important given variations across plans in premiums, cost-sharing, extra benefits and provider networks.

The Medicare Advantage market is likely to remain attractive to Medicare beneficiaries in 2011, with lower monthly premiums than are generally available in the Medigap market. Enrollees who choose to stay in the same plan in 2011 will experience modest premium increases, on average, and a larger share of plans will have zero premiums. Whether due to CMS's negotiation, the desire among firms to compete aggressively (at least in the short run) to retain market share, or the limited time available to make dramatic changes between the signing of the ACA and the submission of their bids to CMS for the 2011 year, or other reasons, premiums remain essentially stable -- despite the freeze in benchmarks used to set rates for health plans in 2011. This situation is quite different from 2010 when premiums rose rapidly, though plans remained attractive to enrollees and enrollment continued to grow.

It is encouraging that all plans now have an out-of-pocket limit, unlike the traditional fee-for-service program, but many of these limits are quite high – potentially exposing enrollees to fairly high out-of-pocket costs, depending on the services they use and the benefit design of their plan. Previous research indicates that cost-sharing under Medicare Advantage plans has grown considerably.[26] Medicare Advantage generally provides a lower-premium alternative to Medigap coverage, but cost-sharing requirements are sometimes higher in Medicare Advantage plans than under traditional Medicare. Currently, Medicare Advantage plans are more likely than stand-alone Part D plans to provide some coverage in the gap, but these differences in drug coverage between MA-PD and stand-alone drug plans will narrow as gap coverage gradually phases in for all Part D plans, as required under the ACA. In 2011, enrollees in plans with gap coverage will receive a 50 percent discount on brand-name drugs from the drug manufacturers, as required by ACA.

How the Medicare Advantage market will evolve over time remains to be seen. The HHS Actuaries predict a decline in enrollment between 2011 and 2019, and an erosion of extra benefits. However, such predictions are difficult, and at the present time, Medicare Advantage appears to remain an important part of the Medicare program. Given wide variations in local market conditions and payment reforms that will vary based on average Medicare costs per county, the effects of these changes are likely to vary across the country.

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[1] See Centers for Medicare and Medicaid Services press release, "Medicare Advantage Premiums Fall, Enrollment Rises, Benefits Similar compared to 2010," September 21, 2010.

[2] The total includes plans with sanctions that are not available to new enrollees. Plan counts and premium calculations exclude SNPs, demonstrations, Health Care Prepayment Plans (HCPPs), Program of All Inclusive Care for the Elderly (PACE) plans, employer-sponsored plans and other plans for selected groups (e.g., Mennonites).

[3] CMS reports that average Medicare Advantage premiums will decrease by about $1 per month in 2011. Differences in estimates may be due to the scope of plans included (this analysis excludes plans that do not offer prescription drugs, SNPs and group plans) and different assumptions about enrollment decisions for 2011. See Centers for Medicare and Medicaid Services press release, "Medicare Advantage Premiums Fall, Enrollment Rises, Benefits Similar compared to 2010," September 21, 2010.

[4] See M. Gold, D. Phelps, G. Jacobson and T. Neuman, "Medicare Advantage 2010 Data Spotlight: Plan Enrollment Patterns and Trends." Washington, DC: Kaiser Family Foundation, June 2010.

[5] Centers for Medicare and Medicaid Services, "Medicare Program; Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Final Rule," 75 *Federal Register*19677, April 15, 2010. In addition, local PPOs are no longer

permitted to include a point-of-service-like benefit, and regional and local PPOs, PFFS plans, and medical saving accounts (MSAs) are prohibited from using prior notification to as a condition for lower cost-sharing, beginning in 2011.

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

[7] Premium calculations are based on Medicare Advantage plans that provide Part D benefits, and include zero premium plans.

[8] See Centers for Medicare and Medicaid Services press release, "Medicare Advantage Premiums Fall, Enrollment Rises, Benefits Similar compared to 2010," September 21, 2010.

[9] Enrollment is for September 2010, the most recent public data available at the time this analysis was conducted.

[10] M. Gold, M. Hudson, G. Jacobson and T. Neuman "Medicare Advantage 2010 Data Spotlight: Benefits and Cost-Sharing." Washington DC: Kaiser Family Foundation, February 2010.

[11] M. Gold, E. Fries Taylor, C. Fleming, D. Phelps, M. Cupples Hudson, and M. Loewenberg, "Looking at Medicare Advantage: What Has Happened Since the Launch? What Will Happen in the Future?" Final report submitted to the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. Washington DC: Mathematica Policy Research, November 2008.

[12] See Centers for Medicare and Medicaid Services press release, "Premiums Fall, Enrollment Rises, Benefits Similar Compared to 2010," September 21, 2010.

[13] See J. Hoadley, J.Cubanski, E. Hargrave, L. Summer, and T. Neuman, "Medicare Part D Spotlight: Part D Plan Availability in 2011 and Key Changes Since 2006", Kaiser Family Foundation, October 2010; http://www.kff.org/medicare/8107.cfm.

[14] CMS, "Medicare Program; Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Final Rule," 75 *Federal Register* 19677, April 15, 2010.

[15] 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 (HCPPs), Program for All Inclusive Care for the Eldery (PACE) plans, demonstrations, and plans offered selected groups (such as Mennonites). The total includes plans that now operate under sanctions that prohibit enrollment of new beneficiaries.

[16] MMA refers to the Medicare Prescription Drug, Improvement and Modernization Act of 2004, P.L. 108-173.

[17] Because of the implementation challenges of Part D in 2006, some plan approvals were delayed and CMS did not release the same data they have in previous years on plan availability. We therefore show data only from 2007.

[18] These counts exclude SNPs, most of which are HMOs.

[19] Other MA plans, so called "local plans" define their service areas by aggregations of counties. Though some PFFS plans have historically served large areas, most HMOs and local PPOs serve more geographically targeted areas, often defined by subsets of counties within a single state or metropolitan area.

[20] For additional information on specific SNP requirements, see http://www.cms.gov/SpecialNeedsPlans/

[21] According to CMS, the only exception is 2,300 beneficiaries in Utah and Colorado who are currently in a Medicare Advantage plan but will not have access to one in 2011. Centers for Medicare and Medicaid Service conference call, September 21, 2010.

[22] These numbers are not additive because the mix of plans differs across counties.

[23] Based on the 99th percentile.

[24] CITI Investment and Research Analysis, "Humana: It Ain't Bragging If You Can Do It – 2Q10 EPS Analysis," available at https://www.citigroupgeo.com/pdf/SNA60851.pdf

[25] M. Gold, D. Phelps, T. Neuman, and G. Jacobson, "Medicare Advantage 2010 Data Spotlight: Plans and Premiums." Washington DC: Kaiser Family Foundation, November 2009.

[26] M. Gold, L. Achman, J. Mittler, and B. Stevens. "Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage." Washington, DC: Mathematica Policy Research, August 2004.

Table A1. Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, Weighted by 2010 Enrollment, 2010-2011.

	All plans	HMOs	Local PPOs	PFFS Plans	Regional PPOs	Cost Plans
Average premiums, weighted by 2010 enrollment						
Premiums for 2010 plans - all	$41.76	$34.03	$63.72	$53.37	$27.08	$130.87
Departing Plans, 2010	$74.98	$55.91	$103.85	$78.36	N/A	$33.10
Remaining Plans, 2010	$40.57	$33.77	$63.03	$47.02	$27.08	$130.99
2011 Premiums for Remaining 2010 Plans	$42.74	$36.41	$65.44	$54.14	$25.02	$137.25
Change in premiums for plans available in both 2010 and 2011	$2.17	$2.64	$2.41	$7.12	-$2.06	$6.26
Share of plans with no premiums, among plans available in both 2010 and 2011						
2010	49%	60%	25%	12%	51%	4%
2011	51%	60%	21%	9%	61%	3%
Change in share of plans with no premiums	2%	0%	-4%	-3%	11%	-1%
Average premiums, among plans with premiums and available in both 2010 and 2011						
2010	$79.10	$84.56	$83.69	$53.27	$54.87	$135.96
2011	$86.84	$90.30	$82.95	$59.37	$64.78	$141.23

NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, plans for special populations (e.g., Mennonites) and plans that do not offer Part D benefits. All regional PPOs offered in 2010 will also be offered in 2011. Includes MA-PDs in 2011 that now operate under sanctions that prohibit enrollment of new beneficiaries.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2010 and 2011 and Enrollment file for September 2010.

Table A2. Number of Medicare Advantage Plans Available, by Plan Type and Firm, 2009-2011.

	All			HMOs			Local PPOs			PFFS Plans			Regional PPOs			Cost Plans		
	2009	2010	2011	2009	2010	2011	2009	2010	2011	2009	2010	2011	2009	2010	2011	2009	2010	2011
Number of Plans - Total	**2830**	**2314**	**2011**	**1451**	**1218**	**1104**	**525**	**522**	**512**	**696**	**413**	**220**	**51**	**59**	**59**	**100**	**99**	**111**
UnitedHealthCare	220	173	152	170	136	125	21	16	16	21	13	3	8	8	8	0	0	0
Humana	358	396	422	80	84	119	74	125	148	173	149	118	31	38	37	0	0	0
BCBS - Total	316	267	236	108	97	96	129	116	107	64	34	13	6	10	8	9	10	8
Wellpoint BCBS	54	60	53	25	25	23	12	19	20	12	8	4	5	8	6	0	0	0
Other BCBS plans	262	207	183	83	72	73	117	97	87	52	26	9	1	2	2	9	10	8
Kaiser Permanente	32	39	43	21	28	30	0	0	0	0	0	0	0	0	0	11	11	13
Coventry	105	67	59	53	41	35	32	26	24	17	0	0	0	0	0	0	0	0
Aetna	208	116	74	120	71	52	63	39	22	20	6	0	5	0	0	0	0	0
Health Net	117	48	39	40	39	28	7	9	11	69	0	0	1	0	0	0	0	0
Universal American	169	178	79	16	14	14	43	48	20	110	116	45	0	0	0	0	0	0
WellCare	154	0	41	91	0	41	1	0	0	62	0	0	0	0	0	0	0	0
HealthSpring	40	40	28	37	35	25	3	5	3	0	0	0	0	0	0	0	0	0
WellPoint (non-BCBS)	6	8	4	0	0	0	0	0	0	6	8	4	0	0	0	0	0	0
Sterling	6	21	42	0	0	0	0	16	36	6	5	6	0	0	0	0	0	0
CIGNA	50	31	1	1	1	1	0	0	0	49	30	0	0	0	0	0	0	0
Bravo	31	22	13	15	13	11	1	4	2	15	5	0	0	0	0	0	0	0
Other	1018	908	778	699	659	527	151	118	123	84	47	31	0	3	6	80	78	90

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 2011 includes 5 MSAs. Includes MA-PDs in 2011 that now operate under sanctions that prohibit enrollment of new beneficiaries.

SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2009 – 2011 and CMS's 2011 Part C and D Crosswalk file.

Table A3. Share of Medicare Beneficiaries with Access to Firms' Medicare Advantage Plan Offerings, by Plan Type and Firm, 2009-2011.

Firm	Any Plan			HMOs			Local PPOs			PFFS Plans			Regional PPOs			Cost Plans		
	2009	2010	2011	2009	2010	2011	2009	2010	2011	2009	2010	2011	2009	2010	2011	2009	2010	2011
UnitedHealthcare	81%	73%	65%	46%	45%	50%	11%	7%	7%	53%	35%	5%	19%	19%	19%	0%	0%	0%
Humana	84%	83%	74%	17%	22%	29%	27%	37%	46%	84%	78%	52%	60%	60%	60%	0%	0%	0%
BCBS - Total	78%	75%	72%	38%	37%	38%	40%	42%	42%	44%	37%	3%	22%	29%	29%	2%	2%	2%
Wellpoint BCBS plans	32%	32%	30%	18%	16%	17%	12%	11%	12%	17%	17%	2%	18%	18%	18%	0%	0%	0%
Other BCBS plans	53%	48%	48%	25%	25%	26%	28%	31%	30%	28%	20%	1%	5%	12%	11%	2%	2%	2%
Kaiser Permanente	15%	15%	15%	12%	12%	12%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	3%	3%
Coventry	85%	16%	17%	10%	11%	11%	11%	10%	11%	85%	0%	0%	0%	0%	0%	0%	0%	0%
Aetna	51%	35%	30%	33%	31%	30%	27%	19%	18%	28%	7%	0%	5%	0%	0%	0%	0%	0%
Health Net	31%	12%	11%	11%	11%	10%	2%	2%	3%	23%	0%	0%	2%	0%	0%	0%	0%	0%
Universal American	97%	97%	30%	3%	4%	4%	5%	11%	11%	97%	97%	28%	0%	0%	0%	0%	0%	0%
Wellcare	76%	0%	20%	21%	0%	20%	1%	0%	0%	65%	0%	0%	0%	0%	0%	0%	0%	0%
HealthSpring	10%	9%	9%	9%	7%	7%	1%	2%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%
WellPoint (non-BCBS)	48%	48%	2%	0%	0%	0%	0%	0%	0%	48%	48%	2%	0%	0%	0%	0%	0%	0%
Sterling	73%	48%	14%	0%	0%	0%	0%	2%	3%	73%	48%	13%	0%	0%	0%	0%	0%	0%
CIGNA	54%	54%	1%	1%	1%	1%	0%	0%	0%	54%	52%	0%	0%	0%	0%	0%	0%	0%
Bravo	9%	8%	8%	6%	7%	8%	1%	5%	2%	6%	4%	0%	0%	0%	0%	0%	0%	0%
Others	78%	82%	79%	62%	67%	64%	32%	32%	44%	48%	44%	23%	0%	14%	14%	5%	5%	5%

NOTE: Excludes SNPs, demonstrations, HCPPs, PACE plans, employer-sponsored (i.e., group) plans, plans for special populations (e.g., Mennonites), and plans that do not offer Part D benefits. BCBS are Blue Cross / Blue Shield affiliates, which includes Wellpoint BCBS plans. Includes MA-PDs in 2011 that now operate under sanctions that prohibit enrollment of new beneficiaries.

SOURCE: MPR/KFF analysis of CMS's Landscape and Penetration Files for 2009-2011.

Table A4. Unweighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, by Plan Type and Firm, 2009-2011.

	All			HMOs			Local PPOs			PFFS Plans			Regional PPOs			Cost Plans		
	2009	2010	2011	2009	2010	2011	2009	2010	2011	2009	2010	2011	2009	2010	2011	2009	2010	2011
All Plans Combined	$51.81	$55.86	$50.61	$34.52	$40.11	$36.24	$65.12	$70.17	$65.72	$74.46	$75.09	$65.79	$55.68	$59.29	$53.38	$128.53	$129.64	$131.18
UnitedHealthCare	$18.08	$17.78	$15.36	$20.41	$19.55	$17.27	$11.91	$7.67	$7.67	$6.50	$20.57	$10.00	$0.00	$2.48	$0.00	N/A	N/A	N/A
Humana	$58.66	$51.62	$45.55	$12.45	$11.18	$11.80	$42.94	$48.63	$46.18	$82.16	$68.89	$79.36	$54.18	$84.58	$73.74	N/A	N/A	N/A
BCBS - Total	$64.46	$81.44	$81.56	$49.00	$67.36	$66.88	$64.12	$88.94	$97.41	$89.96	$106.05	$49.74	$32.43	$26.16	$28.88	$86.73	$86.30	$111.47
Wellpoint BCBS	$22.09	$33.77	$27.13	$18.67	$23.05	$19.20	$31.58	$47.67	$37.11	$10.83	$51.38	$46.50	$27.20	$17.83	$9.75	N/A	N/A	N/A
Other BCBS plans	$72.70	$94.42	$96.14	$58.24	$82.62	$81.32	$68.11	$97.78	$110.00	$98.75	$113.59	$50.82	$58.60	$51.15	$67.15	$86.73	$86.30	$111.47
Kaiser Permanente	$57.49	$56.48	$49.25	$58.38	$56.61	$48.37	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$53.76	$55.76	$53.65
Coventry	$26.63	$13.63	$12.88	$24.99	$13.38	$10.75	$31.98	$14.00	$15.90	$13.86	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Aetna	$71.63	$70.97	$57.46	$46.01	$48.96	$42.52	$100.89	$109.37	$92.77	$96.20	$48.67	N/A	$164.25	N/A	N/A	N/A	N/A	N/A
Health Net	$70.48	$81.61	$71.59	$73.04	$84.56	$74.00	$55.40	$67.29	$64.89	$70.91	N/A	N/A	$65.00	N/A	N/A	N/A	N/A	N/A
Universal American	$53.42	$68.92	$63.57	$11.88	$23.56	$26.33	$32.31	$60.60	$59.38	$72.50	$82.86	$80.33	N/A	N/A	N/A	N/A	N/A	N/A
WellCare	$11.47	N/A	$7.75	$5.99	N/A	$7.75	$0.00	N/A	N/A	$42.43	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HealthSpring	$17.04	$29.21	$19.61	$16.92	$29.46	$20.89	$18.80	$27.50	$8.75	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
WellPoint (non-BCBS)	$11.67	$45.25	$38.50	N/A	N/A	N/A	N/A	N/A	N/A	$11.67	$45.25	$38.50	N/A	N/A	N/A	N/A	N/A	N/A
Sterling	$61.00	$112.27	$42.84	N/A	N/A	N/A	N/A	$99.13	$33.48	$61.00	$127.29	$59.70	N/A	N/A	N/A	N/A	N/A	N/A
CIGNA	$76.69	$79.00	$0.00	$0.00	$0.00	$0.00	N/A	N/A	N/A	$79.16	$84.64	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Bravo	$40.55	$36.53	$31.53	$23.79	$25.25	$30.94	$41.00	$51.25	$34.50	$65.63	$62.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other	$54.48	$55.53	$55.04	$40.01	$42.90	$42.16	$89.38	$91.12	$82.33	$64.16	$59.91	$18.55	N/A	$40.00	$42.54	$141.73	$143.55	$142.11

NOTE: Excludes SNPs, demonstrations, HCPPs, PACE plans, employer-sponsored (i.e., group) plans, plans for special populations (e.g., Mennonites), and plans that do not offer Part D benefits. BCBS are Blue Cross / Blue Shield affiliates, which includes Wellpoint BCBS plans. Premiums include plans with premiums as well as plans with no premiums. Includes MA-PDs in 2011 that now operate under sanctions that prohibit enrollment of new beneficiaries. N/A indicates plan not available.
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2009 – 2011 and September 2009 and 2010 Enrollment files.

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