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Medicare Advantage 2015 Spotlight: Enrollment Market Update

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Despite concerns that reductions in payments to Medicare Advantage plans enacted in the Affordable Care Act of 2010 (ACA) would lead to reductions in Medicare Advantage enrollment, the number and share of Medicare beneficiaries enrolling in Medicare Advantage plans has continued to climb.¹ Since the enactment of the ACA, Medicare Advantage enrollment has increased by 5.6 million, or by 50 percent. The ACA payment reductions aimed to reduce historical overpayments to Medicare Advantage plans, relative to traditional Medicare.

This Data Spotlight reviews national and state-level enrollment trends as of March 2015 and examines variation in enrollment by plan type and firm. It analyzes the most recent data on premiums, out-of-pocket limits, Part D cost sharing, and plans' quality ratings for Medicare Advantage enrollees. Key findings include:

- Medicare Advantage enrollment has continued to grow and increased in virtually all states in 2015. Almost one in three (31 percent) people on Medicare (16.8 million beneficiaries) were enrolled in a Medicare Advantage plan in March 2015 – up by more than one million beneficiaries from 2014.
- Medicare Advantage enrollment continues to be highly concentrated among large firms, both nationally and in local markets. Together, UnitedHealthcare and Humana account for 39 percent of all Medicare Advantage enrollment, and three other firms and BCBS affiliates account for another 33 percent of enrollment in 2015. In 15 states and the District of Columbia, more than half of all enrollees are in plans offered by one company – an indicator that these markets that may not be very competitive.
- Despite the growth in enrollment in new plan types, most enrollees continue to be in HMOs (64% in 2015). As in prior years, enrollees in HMOs, on average, pay lower premiums and have lower limits on total out of pocket expenses than enrollees in other plan types.
- The share of enrollees in plans with 4 or more stars rose from 37 percent in 2013 to 61 percent in 2015.
- While growth in premiums has been relatively modest, Medicare Advantage plans provide less financial protection to Medicare enrollees than they have in the past. While average monthly premiums for MAPDs (weighted by enrollment) remain relatively flat (\$38 per month in 2015, an increase of \$3 per month from 2014), they vary across plan types and states.
- Average out-of-pocket spending limits have continued to rise, exposing enrollees with significant medical needs to higher costs, and in 2015, the average out-of-pocket limit is \$5,041. All plans have been required to limit enrollees' out-of-pocket expenses to no more than \$6,700 since 2011, and are encouraged have lower limits. The growth in out-of-pocket limits makes it increasingly critical that beneficiaries receive good information to help them choose effectively among the complex array of choices they face.

Overall Trends in Enrollment

NATIONWIDE ENROLLMENT

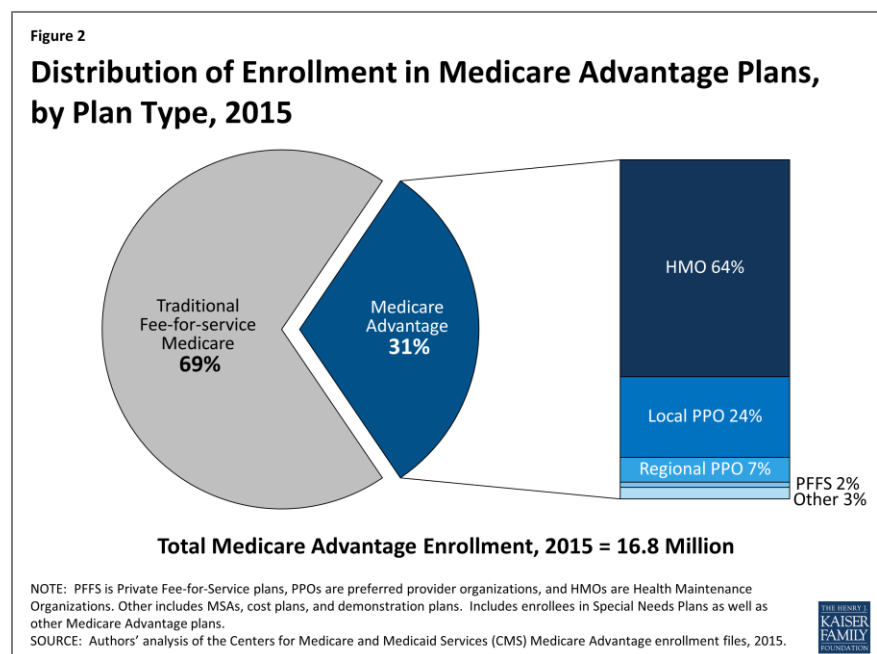
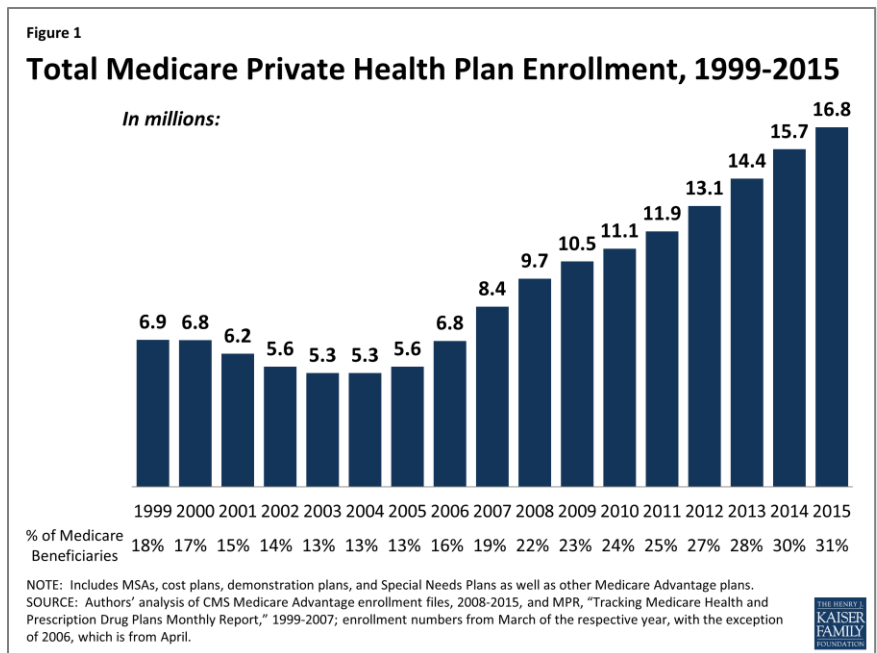
There are 16.8 million beneficiaries – 31 percent of the Medicare population – are enrolled in Medicare Advantage plans in 2015 (**Figure 1**). Total Medicare Advantage enrollment grew by more than 1 million beneficiaries, or 7 percent, between 2014 and 2015. This pattern continues the rapid growth in enrollment that occurred concurrently with the introduction of Part D (prescription drug coverage) in 2006 and other changes in the Medicare Advantage program authorized by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. While some of the growth in Medicare advantage

enrollment reflects the influence of the baby boomers newly eligible for Medicare, recent evidence has indicated that enrollment growth also reflects small shifts in the larger pool of current beneficiaries switching from traditional Medicare to Medicare Advantage plans.² Medicare enrollment has continued to grow despite the fact that the average number of plans available to enrollees nationwide declined from a high of 48 plans in 2009 to 20 plans in 2012 and to 18 in 2014 and 2015, as firms made changes to plans offered under their Medicare Advantage contracts.³

TRENDS IN ENROLLMENT BY PLAN TYPE

Similar to each year since 2007, about two-thirds (64%) of Medicare Advantage enrollees are enrolled in HMOs in 2015 (**Figure 2**). Almost one-third of enrollees are in either local PPOs (24%) or regional PPOs (7%), 2 percent are in PFFS plans, and 3 percent are in other types of plans, including cost plans and Medicare Medical Savings Accounts (MSAs).

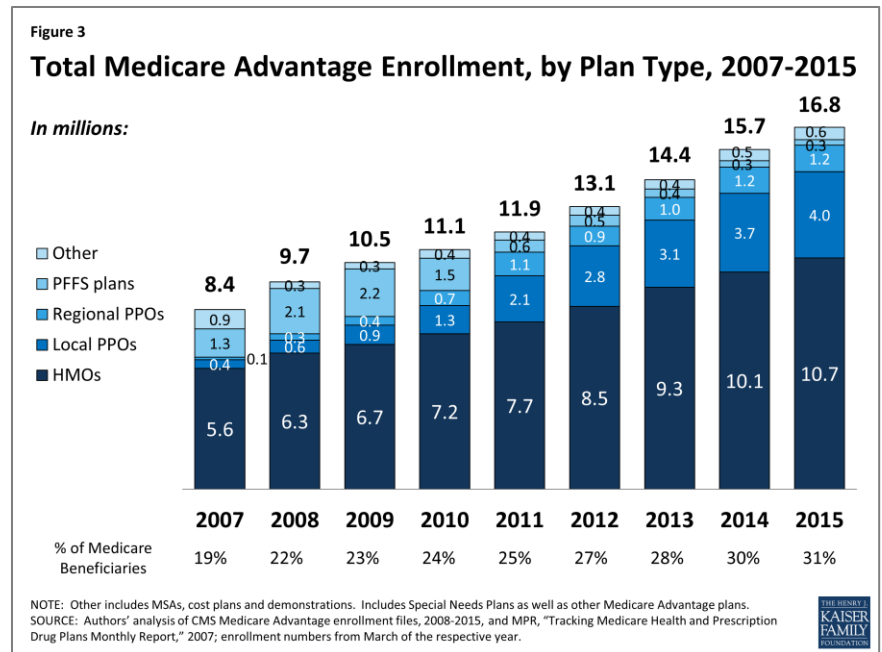
PFFS plans were the primary alternative to HMOs from 2007 through 2009 but their role in the Medicare Advantage market has now been more than eclipsed



by that of PPOs (especially local PPOs) since the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 required PFFS plans (with some county-specific exceptions) to have networks of providers by 2011.⁴

- **HMOs.** In absolute numbers, enrollment in HMOs grew more than other plan types. Enrollment in HMOs increased by 0.7 million to 10.7 million beneficiaries in 2015, a seven percent increase (**Figure 3**).

- **PPOs.** Enrollment in local PPOs increased by 0.3 million to 4.0 million beneficiaries in 2015, a nine percent increase. In contrast, enrollment in regional PPOs (1.2 million) remained flat between 2014 and 2015. Between 2007 and 2015, total PPO enrollment increased ten-fold from about 500,000 to 5.2 million, with most of the growth in local PPOs. Regional PPOs have had limited traction nationwide, although they account for a not insignificant share of the market in a small number of states (**Table A1**).⁵



A key difference between an HMO and a PPO is that the latter provides enrollees with more flexibility to see providers outside of the plan's provider network, although cost sharing associated with out-of-network providers typically is substantially higher than for providers in a plan's network. Local PPOs, like HMOs, are open to beneficiaries who live in specified counties. Regional PPOs are required to serve areas defined by one or more states with a uniform benefit package across the service area.

- **PFFS Plans.** Enrollment in PFFS plans (0.3 million) has been fairly flat since 2014, and is substantially lower in 2015 than the high of 2.2 million enrolled in 2009.⁶ Enrollment has fallen precipitously since MIPPA of 2008 required PFFS plans in most parts of the country to have networks of providers. Among PFFS plan enrollees, 29% are in counties in which PFFS plans are exempted from network requirements.

GROUP ENROLLMENT

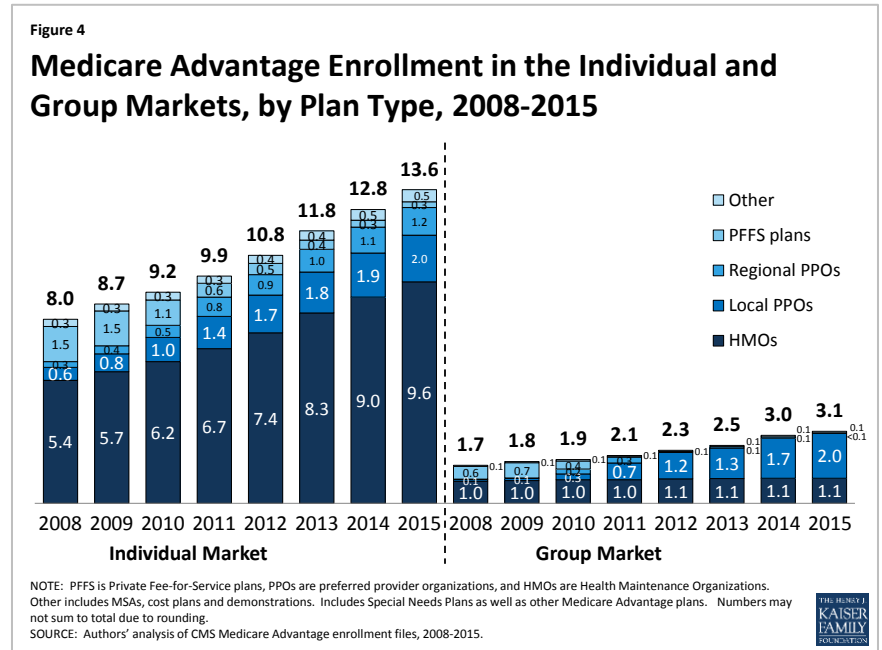
Most Medicare beneficiaries who enroll in Medicare Advantage plans do so as individuals, but a small share is enrolled through groups, comprised largely of employment-sponsored Medicare Advantage plans for retirees. Under these arrangements, employers contract with a Medicare Advantage insurer to provide its retirees supplemental benefits, and Medicare pays the plan a fixed payment per enrollee to provide benefits covered by Medicare, and the employer pays a premium for any additional benefits.⁷

In 2015, 3.1 million of the 16.8 million Medicare Advantage enrollees (19%) were in a group plan, (**Figure 4** and **Table A2**).

The share of Medicare Advantage enrollees in group plans has never been very large, but the numbers are growing, consistent with trends in the overall Medicare Advantage market. In some states, the share of Medicare Advantage enrollees in group plans is much larger than average, including West Virginia (55%), Michigan (49%), Kentucky (42%), Illinois (41%), Ohio (38%), Maryland (32%), New Hampshire (31%), and the District of Columbia (30%). Higher rates of Medicare Advantage group enrollment in these states are likely due to a higher prevalence of employers offering retiree health benefits, including public and unionized industries.⁸

Employers (and their retirees) appear to continue to favor local PPOs over HMOs, which contrasts with the individual market. Most of the enrollment growth in the group market between 2014 and 2015 was in local PPOs, with enrollment increasing to 2.0 million from 1.7 million.

According to the Medicare Payment Advisory Commission (MedPAC), group Medicare Advantage plans typically receive higher Medicare payments and have higher bids, on average, than plans offered in the individual Medicare Advantage market.⁹ Their analysis shows that the average payment to group Medicare Advantage plans is 106 percent of traditional Medicare spending whereas the average payment to all Medicare Advantage plans is 102 percent of traditional Medicare spending in 2015. MedPAC attributes the differences to incentives for firms in the group market to maximize Medicare revenue to offset employer costs by bidding at the benchmark, whereas firms in the individual Medicare Advantage market have an incentive to bid below the benchmark, in order to receive a rebate (a percent of the difference between the bid and the benchmark) with which they can provide extra benefits to individual plan enrollees.



MEDICARE ADVANTAGE ENROLLMENT GROWTH BY STATE

Enrollment increased in virtually all states in 2015, with the exception of Maryland in which enrollment declined by less than 1 percent (**Table 1**). Five states and the District of Columbia saw particularly large increases in enrollment (19% in SD, 18% in ND, 14% in DC, 14% in GA, 14% in IL, and 14% in ME). High rates of growth typically reflect small states with limited prior year enrollment whose growth rates are sensitive to small changes in enrollment; for example, South Dakota has the highest growth rate (19%) and has historically had relatively low enrollment in Medicare Advantage plans.

While HMOs are the most common type of plan nationally, they are not equally important in all states. For example, HMOs constitute 75 percent of Medicare Advantage enrollment in 11 states (AZ, CA, CO, CT, LA, MA, NJ, NV, RI, UT, and WA) but less than half of Medicare enrollment in 25 states, 6 of whom (AK, MT, ND, SD, VT, and WV) have less than 10 percent HMO enrollment (see **Table A1**). Geographic variation in the composition of Medicare Advantage plans is important since HMOs tend to perform better on certain measures of efficiency and tend to have lower premiums.¹⁰ In addition, there is more evidence on the quality of care in HMOs than in other model types.¹¹

ENROLLMENT GROWTH BY COUNTY, BASED ON MEDICARE SPENDING QUARTILES. Over the years, Congress and various Administrations have made a number of changes to payment and participation rules for Medicare Advantage plans. Many of these changes have revolved around plan payment levels, seeking to balance plan participation and plan choices for beneficiaries with parity in payments between traditional Medicare and Medicare Advantage. The ACA reduced payments to all plans, and varied payment policy with the level of traditional Medicare spending in counties, grouped evenly into four quartiles. In 2017, when payments are fully phased in, they will range from 95 percent of traditional Medicare spending for counties in the top quartile of spending to 115 percent of traditional Medicare spending in the bottom quartile of such spending, and 100 percent and 107.5 percent of traditional Medicare spending in the two middle quartiles.

As of 2015, payment reductions have been fully implemented in 78 percent of all counties nationwide; these counties account for 69 percent of all Medicare beneficiaries nationwide and 68 percent of all Medicare Advantage enrollees.

Enrollment continues to grow relatively equally across counties in each of the four quartiles of traditional Medicare spending (**Table A3**). Between 2014 and 2015, enrollment grew by 6 percent in both the highest quartile counties and in the lowest quartile counties, and by 7 percent each in the two middle quartiles. Overall penetration is also similar across the quartiles (ranging from 28% to 35%). Thus, enrollment continues to grow across counties, irrespective of changes in payments that differ according to traditional Medicare spending.

Table 1. Medicare Advantage Enrollment and Penetration Rate, by State, 2014-2015

State	2014 Total Enrollment	2015 Total Enrollment	Change in Total Enrollment, 2014-2015	Percent Change in Enrollment, 2014-2015	2014 Penetration Rate	2015 Penetration Rate
Total U.S.	15,732,081	16,761,673	1,029,592	7%	30%	31%
Alabama	220,640	238,091	17,451	8%	24%	25%
Alaska	N/A	56	N/A	N/A	N/A	<1%
Arizona	401,626	425,454	23,828	6%	38%	38%
Arkansas	107,713	114,326	6,613	6%	19%	19%
California	2,061,617	2,127,666	66,049	3%	38%	38%
Colorado	263,788	281,467	17,679	7%	36%	37%
Connecticut	146,372	157,692	11,320	8%	24%	25%
Delaware	12,623	13,841	1,218	10%	7%	8%
District of Columbia	9,714	11,033	1,319	14%	11%	13%
Florida	1,438,325	1,570,845	132,520	9%	38%	40%
Georgia	404,628	460,670	56,042	14%	28%	31%
Hawaii	108,143	110,465	2,322	2%	46%	46%
Idaho	81,440	87,837	6,397	8%	33%	32%
Illinois	326,678	371,007	44,329	14%	16%	18%
Indiana	244,970	264,104	19,134	8%	22%	23%
Iowa	77,032	81,541	4,509	6%	14%	14%
Kansas	59,018	61,600	2,582	4%	13%	13%
Kentucky	198,052	212,948	14,896	8%	24%	25%
Louisiana	213,280	232,445	19,165	9%	28%	30%
Maine	58,234	66,307	8,073	14%	20%	22%
Maryland	76,464	76,375	-89	0%	9%	8%
Massachusetts	229,400	233,084	3,684	2%	20%	19%
Michigan	547,372	595,239	47,867	9%	30%	32%
Minnesota	448,301	480,474	32,173	7%	51%	53%
Mississippi	69,962	76,776	6,814	10%	13%	14%
Missouri	285,066	311,364	26,298	9%	26%	28%
Montana	31,125	34,758	3,633	12%	17%	18%
Nebraska	33,507	34,982	1,475	4%	13%	11%
Nevada	135,599	146,094	10,495	8%	33%	33%
New Hampshire	15,905	17,295	1,390	9%	6%	7%
New Jersey	219,494	222,846	3,352	2%	15%	15%
New Mexico	107,064	113,807	6,743	6%	30%	31%
New York	1,151,620	1,212,239	60,619	5%	35%	37%
North Carolina	475,432	512,924	37,492	8%	28%	29%
North Dakota	15,202	17,878	2,676	18%	14%	15%
Ohio	794,226	811,503	17,277	2%	38%	38%
Oklahoma	106,706	111,013	4,307	4%	16%	17%
Oregon	305,794	323,765	17,971	6%	43%	44%
Pennsylvania	971,144	1,001,864	30,720	3%	39%	40%
Rhode Island	70,627	71,009	382	1%	36%	35%
South Carolina	193,641	209,812	16,171	8%	22%	23%
South Dakota	22,242	26,400	4,158	19%	15%	17%
Tennessee	376,577	412,042	35,465	9%	32%	34%
Texas	990,399	1,098,678	108,279	11%	29%	31%
Utah	107,139	113,034	5,895	6%	34%	33%
Vermont	8,368	8,984	616	7%	7%	7%
Virginia	196,993	206,427	9,434	5%	15%	16%
Washington	329,087	348,467	19,380	6%	29%	30%
West Virginia	96,604	99,454	2,850	3%	24%	24%
Wisconsin	352,842	388,732	35,890	10%	35%	38%
Wyoming	1,997	2,071	74	4%	3%	2%

NOTE: Includes employer-sponsored plans, special needs plans, and other private plans. N/A indicates too few (less than 50) enrollees to report. Total U.S. includes Puerto Rico.

SOURCE: Authors' analysis of CMS Medicare Advantage enrollment and Landscape files, 2014-2015.

MEDICARE ADVANTAGE PENETRATION

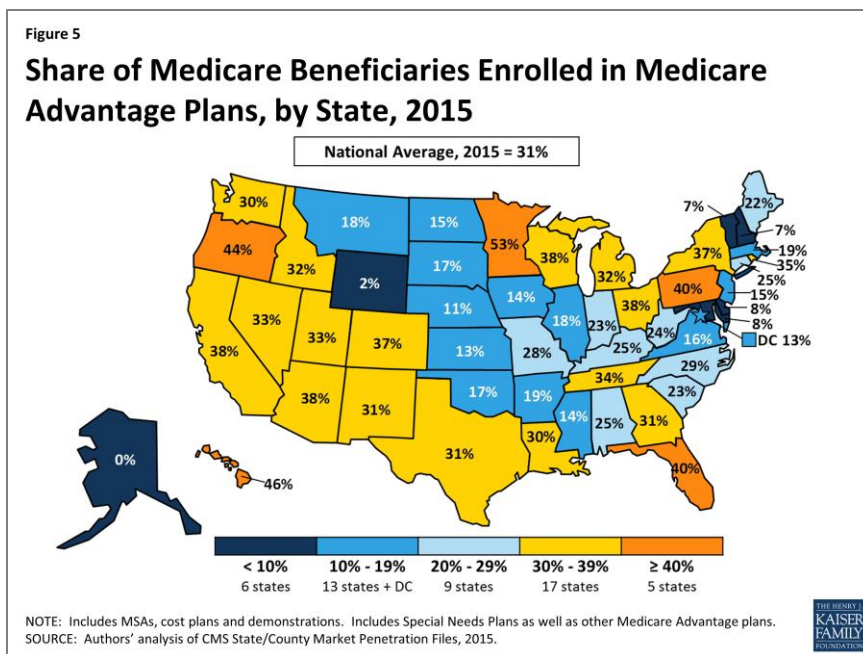
While Medicare Advantage enrollment is increasing in many states, in 6 states (AK, DE, MD, NH, VT and WY) less than 10% of beneficiaries are enrolled in Medicare Advantage plans in 2015, which was also the case in at least the prior three years (**Figure 5**). In contrast, in 22 states (versus 18 states in 2014 and 15 states in 2013) more than 30 percent of beneficiaries are enrolled in Medicare Advantage plans in 2015. Additionally, in 5 states (FL, HI, MN, OR, and PA) more than 40 percent of beneficiaries are enrolled in Medicare Advantage plans, and Medicare Advantage enrollment these states account for 6% of all

Medicare beneficiaries and 21% of all Medicare Advantage enrollees. This variation reflects the urban origins of health maintenance organizations (HMOs) in Medicare Advantage and other factors, such as the history of managed care in the state and the prevalence of employer sponsored insurance for retirees. Within states, Medicare Advantage penetration varies across counties. For example, 43 percent of beneficiaries in Los Angeles County, California are enrolled in Medicare Advantage plans compared to only 8 percent of beneficiaries in Santa Cruz County, California.

Premiums

Medicare Advantage enrollees are responsible for paying the Part B premium, in addition to any premium charged by the plan. The Medicare Advantage premium paid by enrollees reflects the difference between the plan's costs of providing Part A and B benefits and any supplemental benefits offered, and the federal payment to the plan for the benefits. Plans receive a percentage of the difference between their bid and the maximum federal payment (known as a rebate) and are required to use this amount to offer extra benefits, reduce cost sharing, or reduce the Part B premium. If the plan offers the Part D drug benefit, as most plans do, the plan may also use the rebate to reduce the Part D premium.

This brief analyzes premiums for Medicare Advantage plans that offer prescription drug benefits (MA-PDs) because the vast majority (88%) of Medicare Advantage enrollees is in MA-PDs.

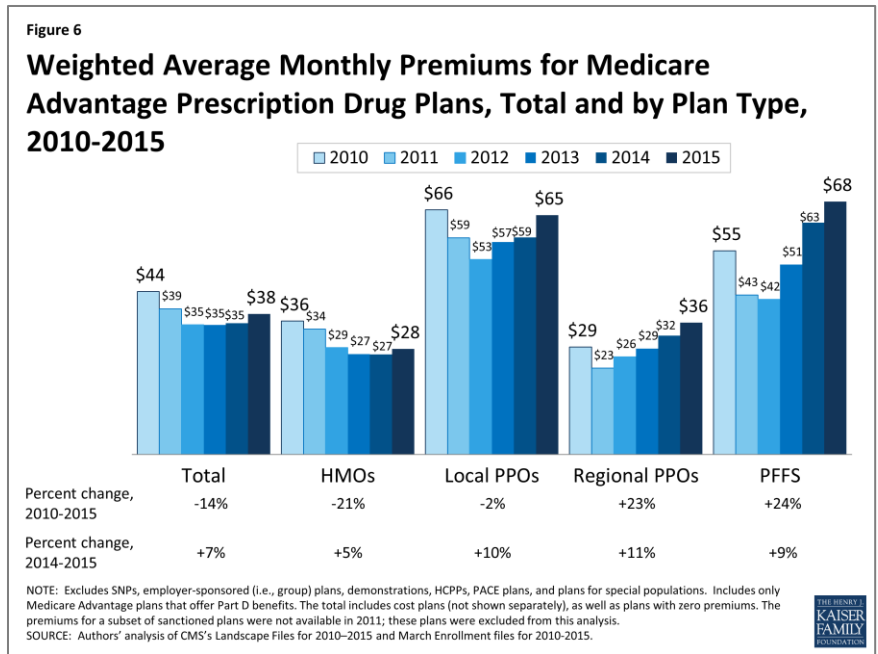


AVERAGE PREMIUM TRENDS

The average MA-PD enrollee pays a monthly premium of about \$38 in 2015, a \$3 per month (7%) increase from 2014 (Figure 6). Actual premiums paid by enrollees vary by plan type, locale, and characteristics, such as relative breadth of the provider network and/or benefits.¹²

Average premiums range from \$28 per month (for HMO enrollees) to \$68 per month (for PFFS plan enrollees).

Average premium increases were lower for HMO enrollees (\$1 per month) than for local PPO enrollees (\$6 per month), regional PPO enrollees (\$4 per month), and PFFS plan enrollees (\$5 per month).

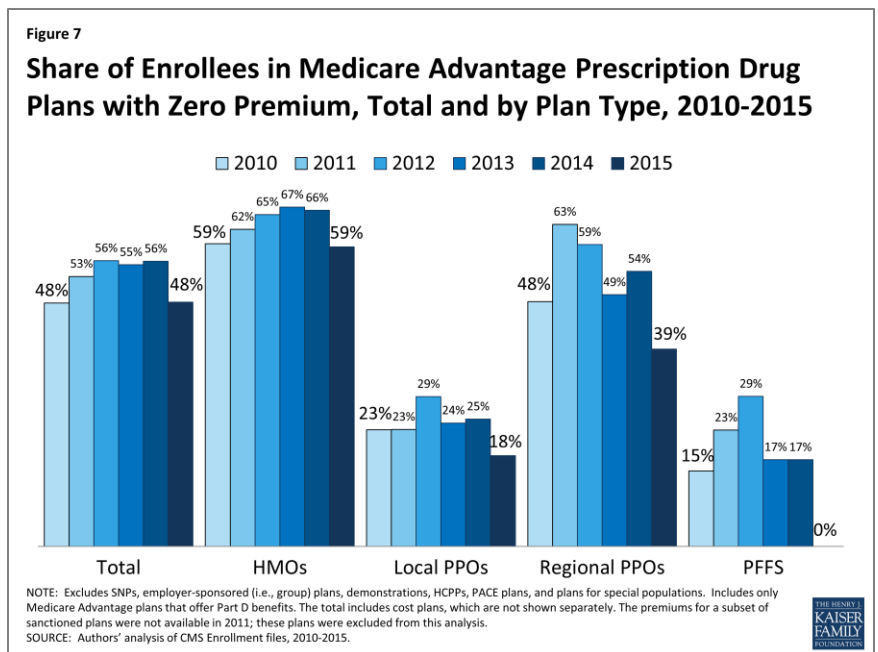


Average Medicare Advantage premiums for HMO enrollees and local PPO enrollees are lower in 2015 than in 2010, prior to the ACA payment changes; premiums are higher in 2015 than in 2010 for regional PPOs and PFFS plans.

ZERO PREMIUM PLANS

As in prior years, most Medicare beneficiaries (78%) had a choice of at least one MA-PD that charged no additional premium for coverage, other than the monthly Part B premium, also known as “zero premium plans”.¹³

Between 2014 and 2015, the share of enrollees in zero premium MA-PDs declined from 56 percent to 48 percent, which is about the same share as in 2010 (Figure 7). Similar to prior years, a larger share of enrollees in HMOs was enrolled in zero-premium plans (59%) than enrollees in regional PPOs (39%) or local PPOs (18%). No zero premium PFFS plans are offered in 2015.

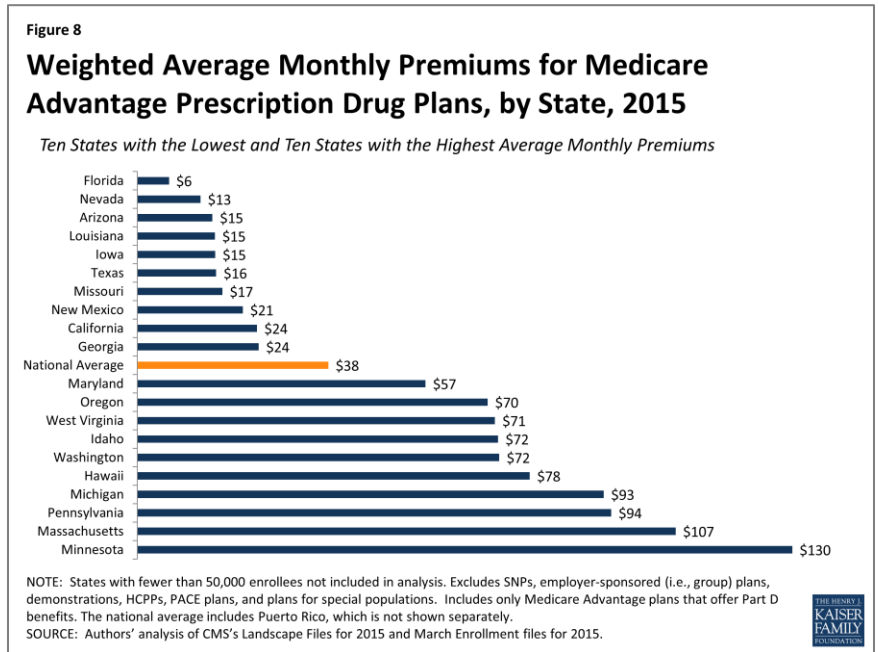


PREMIUM VARIATION ACROSS STATES

Comparing premiums across states is complicated by the fact that premiums reflect many factors, including the underlying costs of care in a given county relative to the national average, the level of payments to Medicare Advantage plans in the area, and firms' strategy about whether to use plans' rebates to offer extra benefits, reduce cost-sharing, or lower premiums. Additionally, as previously discussed, premiums vary across plan types, with HMOs having the lowest average premiums, and enrollment by plan type varying across states.

Average monthly premiums paid by enrollees vary across states (**Figure 8**). While the average premium nationwide is \$38 per month, in four states (MA, MI, MN, and PA,) average monthly premiums exceed \$90 in 2015.¹⁴ In contrast, average monthly premiums are less than \$20 in seven states (AZ, IA, FL, LA, MO, NV, and TX). (States with fewer than 50,000 Medicare Advantage enrollees are not displayed in the exhibit).

Premiums also vary greatly within a state since plans and federal payments to plans vary by county. For example, in Los Angeles County, California, Medicare Advantage enrollees pay an average of \$2 per month for an MA-PD. In contrast, in San Francisco County, California, enrollees pay an average of \$65 per month for an MA-PD. Similarly, in New York County, New York, enrollees pay an average of \$18 per month for an MA-PD whereas in Albany County, New York, enrollees pay an average of \$73 per month for an MA-PD.



Structuring Cost Sharing in the Medicare Benefit

Medicare Advantage plans are required to provide all Medicare covered services. In addition, plans are required to limit enrollees' out-of-pocket expenditures for Part A and Part B covered services and may provide additional benefits that are not covered by traditional Medicare. Out-of-pocket limits define ultimate financial liability for Medicare benefits for in-network Medicare-covered benefits and are especially important for people with relatively high health expenses. Actual financial liability will vary with a beneficiary's health status and use of medical care.

OUT-OF-POCKET LIMITS

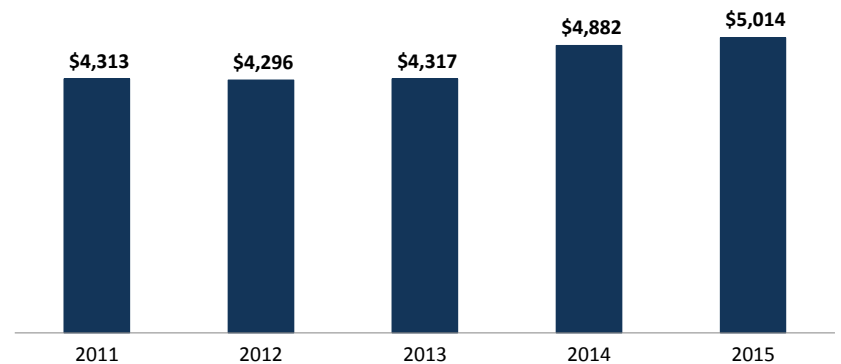
Although traditional Medicare does not include an annual out of pocket limit on cost sharing for Medicare A and B benefits, the CMS began requiring all Medicare Advantage plans to have a limit no higher than \$6,700 annually, and recommended a limit of \$3,400 or lower, for in-network services, as of 2011.¹⁵

In 2015, the average out-of-pocket limit for Medicare Advantage enrollees is \$5,041 (Figure 9). Nearly half of all enrollees (46%) are in plans with limits above \$5,000 in 2015, roughly the same share as in 2014. Between 2011 and 2015, the share of enrollees in plans with a limit above \$5,000 nearly doubled, from 24 percent in 2011 to 46 percent in 2015. Concurrently, the share of beneficiaries in plans with limits below \$3,400 has declined from 51 percent in 2011 to 27 percent in 2015.

HMOs have generally had lower out-of-pocket limits than local PPOs or regional PPOs, and this remains the case in 2015 (Figure 10). Virtually all regional PPO enrollees (99%) and more than half of local PPO enrollees (53%), compared to more than one-third of HMO enrollees (39%), are in plans with limits above \$5,000 in 2015. Less than one-third (29%) of HMO enrollees are in plans with limits below \$3,400 in 2015, a decline from 59 percent of HMO enrollees in 2011. About one in five (20%) local PPO enrollees and less than 1 percent of regional PPO enrollees are in plans with limits below \$3,400.

Figure 9

Average Out-of-Pocket Limit for Enrollees in Medicare Advantage Plans, 2011-2015

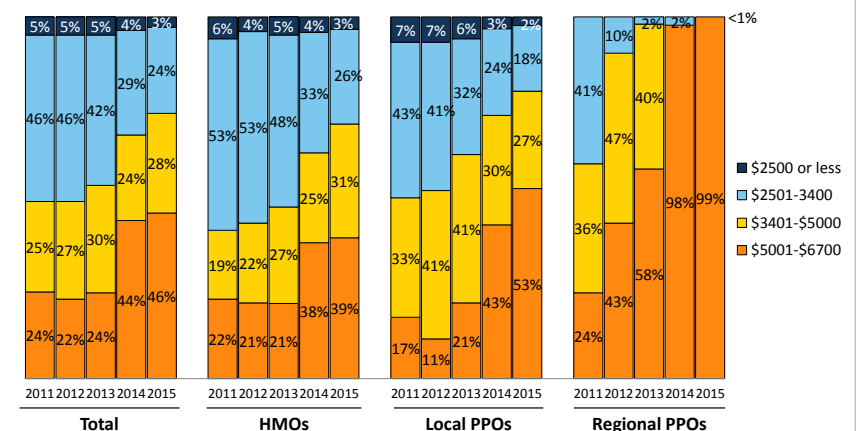


NOTE: Excludes special needs plans (SNPs) and employer group health plans. In 2015, plans with 3% of enrollees were missing information about out-of-pocket limits, including 1% of HMO enrollees, 1% of Local PPO enrollees, 13% of other plan enrollees (cost and pace), and 100% of PFFS enrollees.
SOURCE: Authors' analysis of CMS Enrollment files, 2011-2015.



Figure 10

Medicare Advantage Enrollees' Out-of-Pocket Limits, by Plan Type, 2011-2015



NOTE: Excludes special needs plans (SNPs) and employer group health plans. Percentages may not sum to 100% due to rounding. In 2015, plans with 3% of enrollees were missing information about out-of-pocket limits, including 1% of HMO enrollees, 1% of Local PPO enrollees, 13% of other plan enrollees (cost and pace), and 100% of PFFS enrollees.
SOURCE: Authors' analysis of CMS Medicare Advantage enrollment and landscape files, 2011-2015.



PART D COST SHARING

The standard Medicare Part D benefit in 2015, for both stand-alone prescription drug plans (PDPs) and MA-PDs, has a \$320 deductible and 25 percent coinsurance up to an initial coverage limit of \$2,960 in total drug costs, followed by a coverage gap (the so-called “donut hole”), until their total out of pocket Part D spending reaches \$4,700 when the catastrophic limit kicks in and beneficiaries pay 5 percent of the cost of drugs.

PART D DEDUCTIBLES

Medicare Advantage plans have the flexibility to vary the design of their Part D benefit; however, the deductible cannot exceed \$320 in 2015. In 2015, most MA-PD enrollees (58%) are in plans without a Part D deductible (**Figure 11**). Only 11 percent are in plans with the maximum deductible of \$320. Nearly one-third of MA-PD enrollees have deductibles ranging from \$160-\$319.

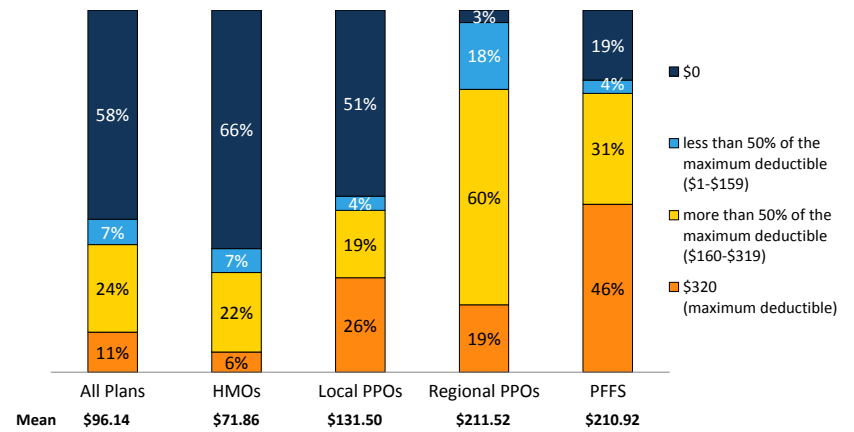
Two-thirds (66%) of MA-PD HMO enrollees and half (51%) of local PPO enrollees do not have a Part D deductible. In contrast, the preponderance of regional PPO enrollees (97%) and PFFS plan enrollees (81%) do have a Part D deductible. Six percent of HMO enrollees are in plans with the maximum deductible, compared to 26 percent of local PPO enrollees, 19 percent of regional PPO enrollees, and 46 percent of PFFS plan enrollees.

COVERAGE IN THE PART D DONUT HOLE

The ACA gradually closes the coverage gap by 2020. Plans have the option to close the gap before then, but few have. In 2015, 45 percent of enrollees are in plans that provide some additional coverage – beyond what is required by law – a decline from 51 percent in 2014 (**Figure 12**). Enrollees in plans with no additional gap coverage will pay 45 percent of the total costs of brand-name drugs and 65 percent of the total cost of generics in the gap in 2015 until they reach the catastrophic limit. A larger

Figure 11

Enrollment in Medicare Advantage Prescription Drug Plans, by Part D Deductible and Plan Type, 2015

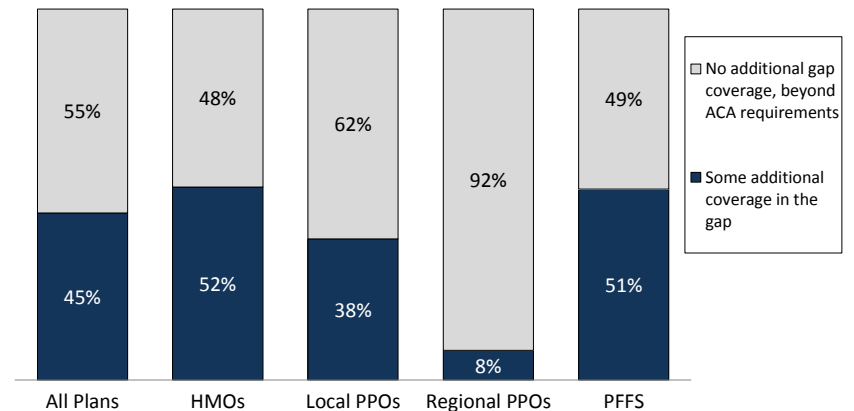


NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPs, PACE plans, and plans for special populations. Totals may not add to 100% due to rounding. All plans includes cost plans, which are not shown separately. Less than 1% of enrollment is in plans missing data on deductibles. In 2015, the maximum deductible is \$320.
SOURCE: Authors' analysis of CMS's Enrollment and Landscape Files for 2015.



Figure 12

Enrollment in Medicare Advantage Prescription Drug Plans, by Coverage in the Gap and Plan Type, 2015



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPs, PACE plans, and plans for special populations. Includes only Medicare Advantage plans that offer Part D benefits. Totals may not add to 100% due to rounding. All plans includes cost plans, which are not shown separately. Less than 1% of enrollment is in plans missing data on gap coverage.
SOURCE: Authors' analysis of CMS's Enrollment and Landscape Files for 2015.



share of enrollees in PFFS plans (51%) and HMOs (52%) are in plans that provide some coverage in the gap, than enrollees in local PPOs (38%) or regional PPOs (8%).¹⁶

Star Quality Ratings

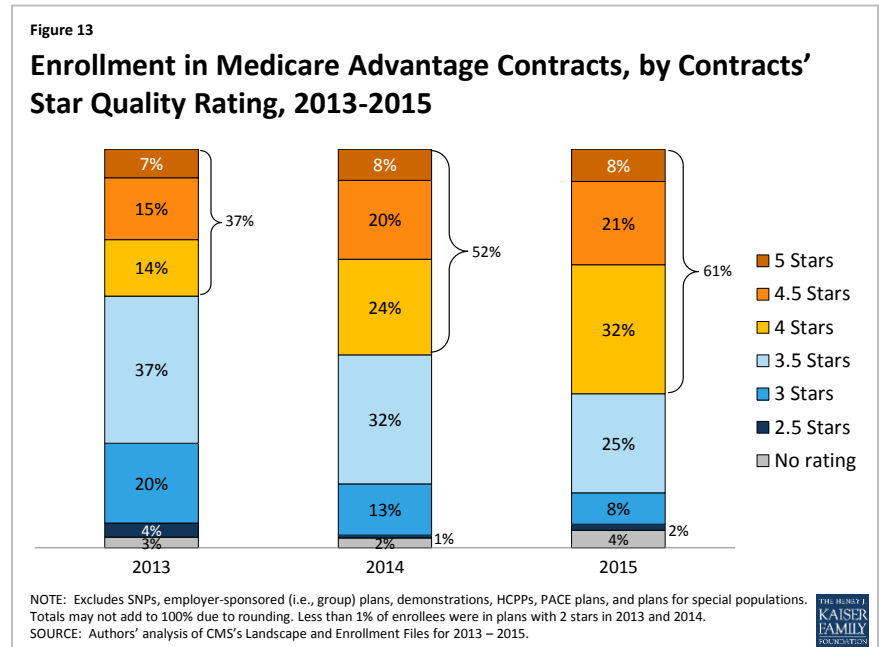
For many years, the CMS has posted quality ratings of Medicare Advantage plans to provide beneficiaries with additional information about plans offered in their area. All plans are rated on a 1 to 5 star scale, with 1 star representing poor performance, 3 stars representing average performance, and 5 stars representing excellent performance. The quality scores for Medicare Advantage plans are derived from plan and beneficiary information collected in three surveys – HEDIS®, CAHPS®, and HOS – and administrative data. CMS assigns quality ratings at the contract level, rather than for each individual plan, meaning that each plan covered under the same contract receives the same quality rating (and most contracts cover multiple plans of the same type).

In 2012, Medicare Advantage plans began receiving bonus payments based on quality ratings. These payments were initially established in the ACA and provided for bonuses to plans that receive 4 or more stars and to unrated plans beginning in 2012. In addition, CMS launched a demonstration for 2012 through 2014 that increased the size of bonuses for these plans, and also provided bonuses to plans rated as average (receiving 3 or 3.5 stars), using the same 1 to 5 star scale. CMS indicated that one goal of the demonstration was to provide an initial boost to plans in meeting the more stringent 4 star goals.¹⁷ In 2015, the bonus payments have reverted back to those that were authorized under the ACA, and plans with 3 or 3.5 stars do not receive bonus payments. Beneficiaries can enroll in a plan with 5 stars at any time during the year, not just during the annual open enrollment period.

Between 2013 and 2015, the share of enrollees in plans with 4 or more stars has steadily increased, from 37 percent in 2013 to 61 percent in 2015 (Figure 13). Much of the increase in enrollment in plans with four or more stars has occurred in the plans with 4 or 4.5 stars, while the share of enrollees in plans with 5 stars has been relatively stable.

Notably, while a larger share of beneficiaries is in plans with relatively high star ratings, seniors have said in focus groups that they do not use the star ratings to select their plan.¹⁸ Nonetheless,

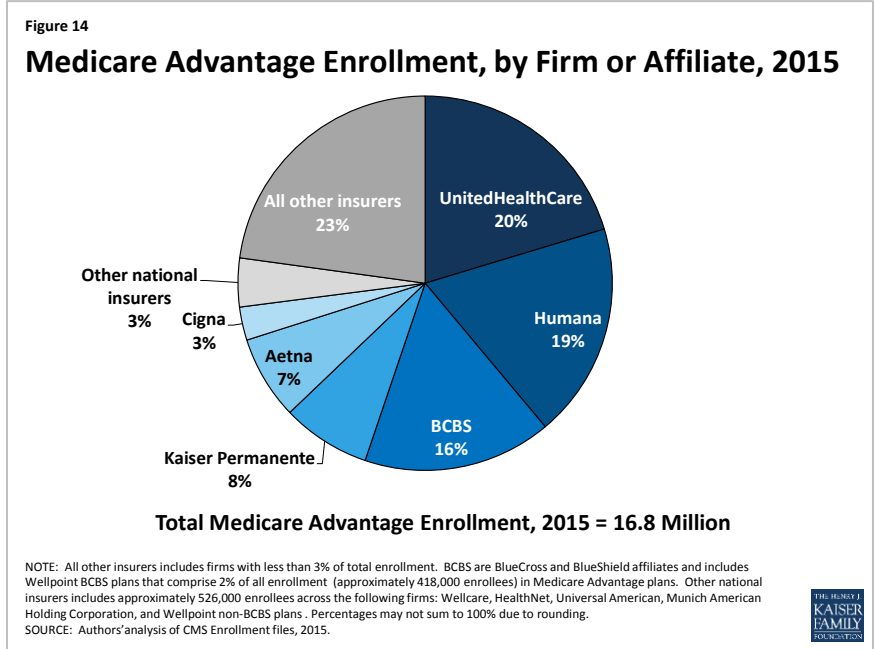
the star ratings may be correlated with factors that seniors do use to select their plan, including provider networks, and plan benefits and costs, and thus may be correlated with enrollment. It is noteworthy that the share of beneficiaries in plans with 5 stars did not materially change between 2013 and 2015. Some have argued that the measures required to achieve 5 stars are more demanding than lower level star ratings, requiring integration that some plans find more difficult to achieve.



Medicare Advantage Firms

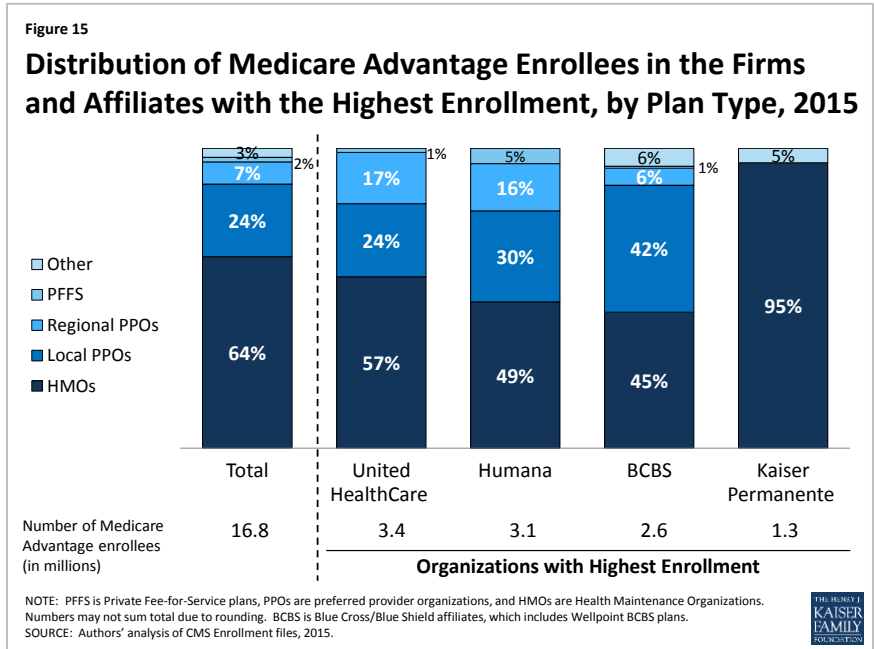
ENROLLMENT BY FIRM

As in prior years, Medicare Advantage enrollment in 2015 tends to be highly concentrated among a small number of firms (**Figure 14** and **Table A4**). In 2015, six firms or BCBS affiliates accounted for 72 percent of the market: UnitedHealthcare (20%), Humana (19%), Blue Cross Blue Shield (BCBS) affiliated plans (16%), Kaiser Permanente (8%), Aetna (7%), and Cigna (3%). Another six national firms account for 5 percent of the market, including Wellcare, HealthNet, Universal American, Munich American Holding Corporation, and Wellpoint plans not affiliated with BCBS. The remaining enrollees are in plans offered by more locally or regionally focused firms.



Enrollment in Humana’s plans in absolute numbers grew by more than 350,000 beneficiaries between 2014 and 2015 – more than any other national firm – and its national share of the Medicare Advantage market increased from 17% in 2014 to 19% in 2015. UnitedHealthcare and Aetna also had large increases in enrollment, growing by more than 250,000 and 125,000, respectively, between 2014 and 2015. Other national firms saw smaller changes in enrollment between 2014 and 2015, including Wellpoint BCBS affiliated plans, which had a net decline in enrollment.

Firms differ in how they position themselves in the market, including the plan types they offer. Almost all of Kaiser Permanente’s enrollees (95%) are in HMOs with the remainder (5%) in similarly structured cost plans (**Figure 15**). In contrast, UnitedHealthcare’s enrollment is in HMOs, local PPOs, regional PPOs, and PFFS plans, and enrollment among plan types has shifted somewhat between 2014 and 2015. A smaller share of UnitedHealthcare’s enrollees is in HMOs in 2015 than in 2014 (57% versus 62%, respectively) and a larger share are in local PPOs (24% versus 19%, respectively).



Compared to UnitedHealthcare, Humana and BCBS affiliated plans have a smaller share of their enrollment in HMOs (49% for Humana and 48% for BCBS versus 57% for United Healthcare). Humana’s distribution of enrollment across plan types continues the shift from earlier years when a much larger share of Humana’s enrollees was in PFFS plans. The share of Humana’s enrollees in HMOs increased from 45 percent in 2014 to 49 percent in 2015, while the share of Humana’s enrollees in other types of plans decreased.

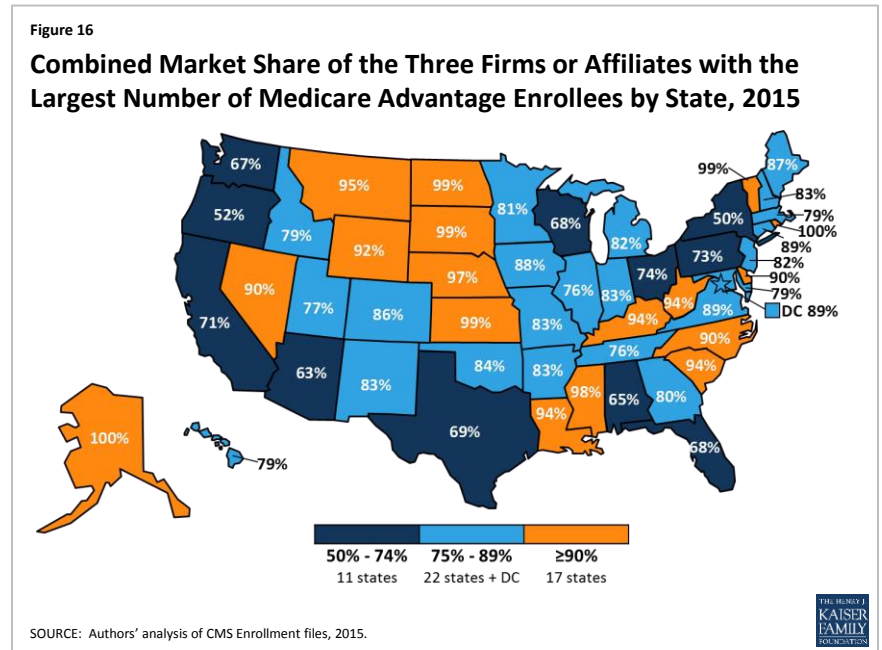
GROUP ENROLLMENT BY FIRM

Most of the growth in Medicare Advantage enrollment is in the individual market, but enrollment through group plans has been a major factor in the experience of some firms, and for UnitedHealthcare in particular (**Table A4**). Enrollment in group plans represents 20 percent of total enrollment in UnitedHealthcare plans, up from 14 percent in 2014. Similar to 2014, growth in the group market accounts for almost all of the net growth in UnitedHealthcare’s enrollment over the past year.

As in prior years, enrollment in the group market in 2015 is particularly important to Aetna (44% of enrollment, down from 47% in 2014) and Kaiser Permanente (36% of enrollment, down from 39% in 2014). Group enrollment historically has been less central to Humana’s strategy (15% of enrollment, down from 17% in 2014). Notably, all three firms saw stronger growth in their individual enrollment than group enrollment (with both Kaiser Permanente and Humana experiencing an actual decline in such enrollment). Total Medicare Advantage enrollment in Wellpoint BCBS’s plans also declined between 2014 and 2015 in part due to the large decline in group enrollment (from roughly 120,000 to 17,000). The role of individual versus group accounts in firm enrollment will vary with firm strategy, where firms are located in relation to large group accounts, and decisions made by those accounts about whether to continue retiree benefits and how to structure them (i.e., group products versus subsidies for individual purchase of products and which plans to offer or subsidize).

FIRM MARKET CONCENTRATION BY STATE

As is the case nationally, a small number of firms dominate Medicare Advantage enrollment in most states (**Figure 16**). Similar to prior years, in all but one state (NY), the three largest firms or BCBS affiliates account for more than 50 percent of enrollment. In 38 states and the District of Columbia, at least 75 percent of enrollment is in the three largest firms, including 17 states in which at least 90 percent of enrollment is in the three largest firms. Some states with highly concentrated markets (three firms accounting for at least 90 percent of enrollment) have Medicare Advantage penetration rates below the national average (AK, DE, KS, KY, MS, MT, ND, NE, SC, SD, VT, WV, WY), but several other such states do not (LA, NC, NV, RI).



In 15 states and the District of Columbia, one company has more than half of all Medicare Advantage enrollment – an indicator that these markets that may not be very competitive (**Table A5**). For the most part these large firms include large players dominant nationally, but in some cases they are local organizations that may be small nationally but having a substantial share in many states. United Healthcare has the largest share in 18 states and is among the top three firms in an additional 19 states and the District of Columbia. Humana has the largest enrollment in 11 states and is among the top 3 firms in another 19 states. Plans offered by BCBS affiliates have the most enrollees in 8 states and are among the top firms in another 18 states. Kaiser Permanente's presence is more geographically focused than other major national firms, with a heavy concentration in California, Colorado, the District of Columbia and Maryland. Kaiser Permanente has more enrollees than any other firm in California, the District of Columbia and Maryland.

Similar to prior years, locally dominant plans, that is, those with the most Medicare Advantage enrollees in their state include EmblemHealth (CT), Martin's Point Health (ME), Tufts Associated HMO (MA), New West (MT), Presbyterian Healthcare Services (NM), and Medica Holding Company (ND and SD). While these large plans do not necessarily have a large national presence, they are very important in some local markets where their enrollment may equal or exceed some national players. In 2015, local firms include a total of 3.7 million Medicare Advantage enrollees, or 23 percent of Medicare Advantage enrollment.

Discussion

Despite controversy over the reductions in payments for Medicare Advantage plans that were included in the ACA, enrollment in Medicare Advantage plans continues to grow nationally, by state, and across quartiles of traditional Medicare spending. As of 2015, the Medicare Advantage payment reductions have been fully phased in for the majority of counties.

While Medicare Advantage premiums have remained relatively flat, out-of-pocket limits have been increasing over the past few years, providing less financial protection to Medicare enrollees with significant medical needs than they have in the past. Additional work is needed to understand plans' cost-sharing and provider networks, including changes over time and variation across plans. A key concern is whether beneficiaries have the information they need to make fully informed health plan choices from one year to the next, taking into account changes in their plan's coverage and/or provider network, and changes in their own health care needs.

As in prior years, enrollment in the Medicare Advantage market is concentrated among a handful of firms. Six firms or BCBS affiliates account for almost three-quarters (72%) of the market. Two firms, UnitedHealthcare and Humana, account for almost four in ten Medicare Advantage enrollees. Enrollment is even more highly concentrated in some states, with three firms or affiliates accounting for more than 90 percent of enrollment in 17 states, and one firm accounting for more than half of enrollment in 15 states and the District of Columbia. A key, unanswered question is what this market concentration means for consumers.

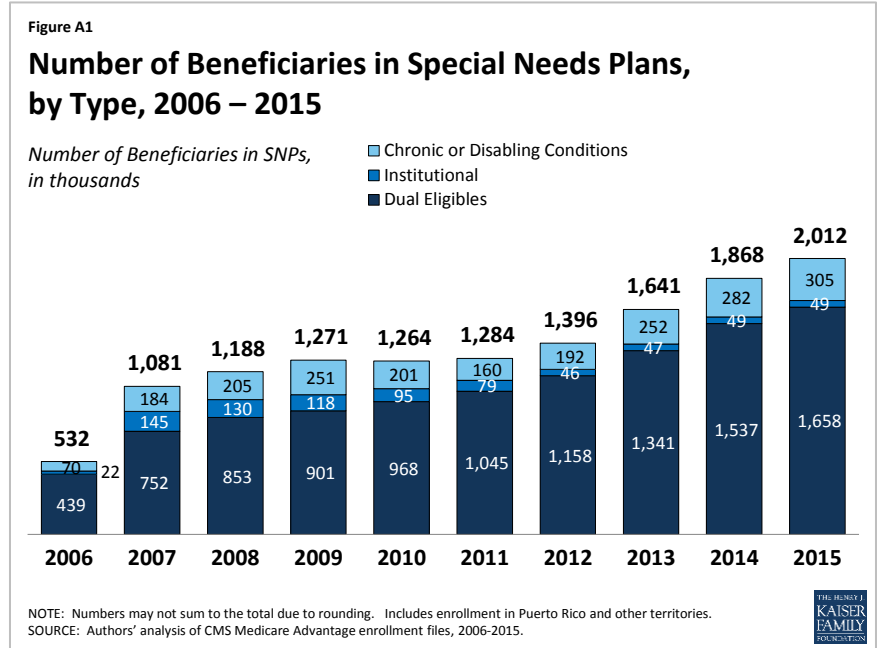
From the perspective of the Medicare program overall, it is clear that Medicare Advantage has become an increasingly important way in which Medicare beneficiaries receive their benefits and all signs suggest that this will only increase in the future. With such a large share of the program dependent on products offered from a relatively small number of private firms operating at the national and local levels, the ability of Centers for Medicare and Medicaid Services (CMS) to serve as a strong fiduciary for the program becomes increasingly important as well as challenging.

Gretchen Jacobson and Tricia Neuman are with the Kaiser Family Foundation; Anthony Damico is an independent consultant; and Marsha Gold is a Senior Fellow Emeritus with Mathematica Policy Research and independent consultant.

Appendix A: Special Needs Plans

Special Needs Plans (SNPs) restrict enrollment to specific types of beneficiaries with significant or relatively specialized care needs, including beneficiaries: (1) dually eligible for Medicare and Medicaid (D-SNPs); (2) requiring a nursing home or institutional level of care (I-SNPs); or (3) with severe chronic or disabling conditions (C-SNPs.)

Enrollment in SNPs increased modestly from 1.9 million to 2.0 million beneficiaries between 2014 and 2015 (Figure A1 and Table A6). As a share of the total Medicare Advantage population, enrollment in SNPs is relatively low, and the 2.0 million SNP enrollees in 2015 account for about 12 percent of total Medicare Advantage enrollment. Yet, in four states and the District of Columbia, enrollment in SNPs is more than one-fifth of total Medicare Advantage enrollment (31% in DC, 28% in SC, 22% in AZ, 21% in AR, and 20% in AL; data not shown).



Similar to prior years, most SNP enrollees are in HMOs (86%), with 11 percent enrolled regional PPOs and 3 percent in local PPOs. The majority of SNP enrollees (82%) are in plans serving those dually eligible for Medicare and Medicaid (D-SNPs). Enrollment of dually eligible beneficiaries in D-SNPs varies greatly by state, and is particularly prevalent in Hawaii (49%) and Arizona (41%) (Table A6).

Separately, several states (including CA, IL, MA, MI, MN, NY, OH, SC, TX, and VA) are undertaking demonstrations with CMS to improve the alignment of Medicare and Medicaid for dually eligible beneficiaries using a capitated model. These enrollees are not included in the SNP enrollment statistics provided here because they operate under unique authority and CMS classifies them as demonstrations. Minnesota is an exception because the demonstration uses its existing D-SNPs to improve the administrative alignment of Medicare and Medicaid in these dual SNPs. (Enrollment in Minnesota's demonstration is included in the SNP enrollment in Table A6.)

It is unclear how the demonstration will affect the growth in D-SNP enrollment over time in states pursuing capitated demonstrations. As of March 2015, more than 300,000 dual eligibles were enrolled in the demonstrations. Between 2014 and 2015, enrollment in D-SNPs increased or remained stable in the majority of demonstration states but enrollment in D-SNPs declined in California, Michigan, and Ohio.

Appendix B: Tables

Table A1. Medicare Advantage Enrollment by State and Plan Type, 2015							
State	Total	Distribution of Enrollment, by State and Plan Type					
		% in HMOs	% in Local PPOs	% in Regional PPOs	% in PFFS Plans	% in Cost Plans	% in Other Plans
Total U.S.	16,761,673	64%	24%	7%	2%	3%	<1%
Alabama	238,091	62%	31%	7%	<1%	0%	<1%
Alaska	56	0%	100%	0%	0%	0%	0%
Arizona	425,454	91%	7%	1%	1%	<1%	0%
Arkansas	114,326	39%	16%	26%	18%	0%	<1%
California	2,127,666	98%	2%	0%	<1%	<1%	<1%
Colorado	281,467	80%	9%	0%	1%	8%	<1%
Connecticut	157,692	85%	12%	3%	0%	0%	0%
Delaware	13,841	62%	37%	0%	0%	0%	1%
District of Columbia	11,033	16%	32%	0%	0%	52%	0%
Florida	1,570,845	70%	7%	23%	<1%	<1%	<1%
Georgia	460,670	30%	44%	24%	2%	0%	0%
Hawaii	110,465	42%	55%	3%	0%	0%	0%
Idaho	87,837	52%	47%	0%	1%	0%	0%
Illinois	371,007	44%	52%	2%	1%	<1%	0%
Indiana	264,104	15%	65%	19%	2%	0%	0%
Iowa	81,541	31%	56%	0%	2%	11%	<1%
Kansas	61,600	44%	46%	2%	7%	0%	<1%
Kentucky	212,948	18%	57%	23%	2%	0%	0%
Louisiana	232,445	86%	5%	8%	<1%	0%	<1%
Maine	66,307	64%	32%	0%	3%	0%	0%
Maryland	76,375	32%	20%	0%	0%	47%	<1%
Massachusetts	233,084	75%	17%	4%	0%	0%	1%
Michigan	595,239	39%	55%	4%	1%	0%	<1%
Minnesota	480,474	25%	8%	0%	<1%	67%	0%
Mississippi	76,776	51%	18%	28%	3%	0%	0%
Missouri	311,364	68%	19%	10%	3%	0%	<1%
Montana	34,758	2%	88%	0%	11%	0%	0%
Nebraska	34,982	53%	28%	0%	19%	0%	<1%
Nevada	146,094	89%	11%	0%	0%	0%	0%
New Hampshire	17,295	42%	35%	0%	23%	0%	0%
New Jersey	222,846	78%	21%	0%	0%	0%	1%
New Mexico	113,807	62%	36%	0%	1%	0%	<1%
New York	1,212,239	72%	18%	7%	2%	<1%	<1%
North Carolina	512,924	45%	47%	6%	3%	2%	<1%
North Dakota	17,878	0%	9%	0%	1%	89%	1%
Ohio	811,503	44%	46%	7%	1%	2%	<1%
Oklahoma	111,013	66%	27%	3%	4%	0%	<1%
Oregon	323,765	60%	40%	0%	<1%	0%	<1%
Pennsylvania	1,001,864	62%	34%	1%	1%	0%	1%
Rhode Island	71,009	93%	4%	2%	0%	0%	<1%
South Carolina	209,812	29%	20%	46%	5%	0%	<1%
South Dakota	26,400	<1%	27%	0%	2%	71%	0%
Tennessee	412,042	69%	28%	2%	0%	0%	<1%
Texas	1,098,678	59%	23%	13%	3%	2%	<1%
Utah	113,034	82%	18%	0%	0%	0%	0%
Vermont	8,984	6%	21%	45%	27%	0%	<1%
Virginia	206,427	38%	25%	12%	14%	9%	1%
Washington	348,467	83%	17%	0%	<1%	0%	<1%
West Virginia	99,454	7%	82%	5%	6%	0%	0%
Wisconsin	388,732	48%	33%	4%	3%	12%	<1%
Wyoming	2,071	9%	18%	0%	66%	0%	3%

NOTE: Total U.S. includes Puerto Rico. Includes employer-sponsored plans, special needs plans, and other private plans.

SOURCE: Authors' analysis of CMS Medicare Advantage enrollment and Landscape files, 2015.

Table A2. Medicare Advantage Enrollment in the Individual and Group Markets, by State, 2015

State	Total	Individual plans	Group plans	% enrollees in group plans
Total U.S.	16,761,673	13,634,978	3,126,695	19%
Alabama	238,091	226,722	11,369	5%
Alaska	56	0	56	100%
Arizona	425,454	380,348	45,106	11%
Arkansas	114,326	109,552	4,774	4%
California	2,127,666	1,647,253	480,413	23%
Colorado	281,467	232,166	49,301	18%
Connecticut	157,692	142,843	14,849	9%
Delaware	13,841	10,656	3,185	23%
District of Columbia	11,033	7,738	3,295	30%
Florida	1,570,845	1,465,892	104,953	7%
Georgia	460,670	333,521	127,149	28%
Hawaii	110,465	83,119	27,346	25%
Idaho	87,837	86,197	1,640	2%
Illinois	371,007	217,198	153,809	41%
Indiana	264,104	218,813	45,291	17%
Iowa	81,541	76,739	4,802	6%
Kansas	61,600	57,017	4,583	7%
Kentucky	212,948	124,342	88,606	42%
Louisiana	232,445	213,612	18,833	8%
Maine	66,307	53,713	12,594	19%
Maryland	76,375	51,724	24,651	32%
Massachusetts	233,084	196,422	36,662	16%
Michigan	595,239	302,171	293,068	49%
Minnesota	480,474	437,232	43,242	9%
Mississippi	76,776	74,762	2,014	3%
Missouri	311,364	279,712	31,652	10%
Montana	34,758	32,961	1,797	5%
Nebraska	34,982	31,769	3,213	9%
Nevada	146,094	138,940	7,154	5%
New Hampshire	17,295	12,005	5,290	31%
New Jersey	222,846	170,491	52,355	23%
New Mexico	113,807	94,595	19,212	17%
New York	1,212,239	999,021	213,218	18%
North Carolina	512,924	385,512	127,412	25%
North Dakota	17,878	17,775	103	1%
Ohio	811,503	500,372	311,131	38%
Oklahoma	111,013	100,538	10,475	9%
Oregon	323,765	272,682	51,083	16%
Pennsylvania	1,001,864	798,441	203,423	20%
Rhode Island	71,009	65,268	5,741	8%
South Carolina	209,812	195,819	13,993	7%
South Dakota	26,400	26,006	394	1%
Tennessee	412,042	389,994	22,048	5%
Texas	1,098,678	909,082	189,596	17%
Utah	113,034	109,107	3,927	3%
Vermont	8,984	7,338	1,646	18%
Virginia	206,427	179,573	26,854	13%
Washington	348,467	304,472	43,995	13%
West Virginia	99,454	44,273	55,181	55%
Wisconsin	388,732	347,663	41,069	11%
Wyoming	2,071	1,681	390	19%

NOTE: Total U.S. includes Puerto Rico.

SOURCE: Authors' analysis of CMS Medicare Advantage enrollment and Landscape files, 2015.

Table A3. Medicare Advantage enrollment and penetration rates in HMOs and other plan types, by counties' costs, 2011-2015

		2011		2012		2013		2014		2015		% change enrollment, 2011-2015	% change penetration, 2011-2015
		Enrollment	Penetration	Enrollment	Penetration	Enrollment	Penetration	Enrollment	Penetration	Enrollment	Penetration		
Total	Highest cost counties	5,327,009	26%	5,841,874	27%	6,424,806	29%	6,960,471	31%	7,405,680	32%	39%	6%
	Third quartile	2,597,314	23%	2,860,238	25%	3,153,687	26%	3,490,111	28%	3,741,407	29%	44%	6%
	Second quartile	1,780,554	21%	1,979,929	23%	2,188,981	24%	2,460,406	27%	2,634,441	28%	48%	7%
	Lowest cost counties	2,213,450	29%	2,407,614	31%	2,594,141	32%	2,821,093	34%	2,980,145	35%	35%	6%
HMOs	Highest cost counties	4,143,823	20%	4,448,435	21%	4,864,646	22%	5,171,382	23%	5,482,057	23%	32%	3%
	Third quartile	1,536,786	14%	1,683,128	14%	1,877,124	16%	2,027,660	16%	2,151,469	17%	40%	3%
	Second quartile	838,808	10%	977,524	11%	1,114,918	12%	1,243,714	13%	1,342,806	14%	60%	4%
	Lowest cost counties	1,222,611	16%	1,355,503	17%	1,493,211	18%	1,612,992	19%	1,738,779	20%	42%	4%
non-HMOs	Highest cost counties	1,183,186	6%	1,393,439	7%	1,560,160	7%	1,789,089	8%	1,923,623	8%	63%	2%
	Third quartile	1,060,528	9%	1,177,110	10%	1,276,563	11%	1,462,451	12%	1,589,938	12%	50%	3%
	Second quartile	941,746	11%	1,002,405	12%	1,074,063	12%	1,216,692	13%	1,291,635	14%	37%	2%
	Lowest cost counties	990,839	13%	1,052,111	13%	1,100,930	14%	1,208,101	15%	1,241,366	15%	25%	1%

NOTE: Includes employer-sponsored plans, special needs plans, and other private plans. Includes Puerto Rico.

SOURCE: Authors' analysis of CMS Medicare Advantage enrollment and Landscape files, 2011-2015.

Table A4. Medicare Advantage Enrollment by Firm, 2014-2015

Firm or Affiliate	Total enrollment		HMOs		Local PPOs		Regional PPOs		PFFS		Cost		Other	
	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015
Total Enrollment														
UnitedHealthcare	3,150,382	3,407,126	1,965,730	1,948,813	609,576	830,889	517,247	580,745	57,829	46,679	-	-	-	-
Humana	2,761,253	3,114,543	1,244,454	1,518,778	845,952	948,313	493,771	488,303	177,076	159,149	-	-	-	-
BCBS	2,701,395	2,624,429	1,208,696	1,187,215	1,159,793	1,106,486	194,837	152,563	18,303	17,284	118,746	159,762	1,020	1,119
Wellpoint BCBS	600,014	418,026	271,798	218,674	225,674	96,277	102,542	103,075	-	-	-	-	-	-
Other BCBS plans	2,101,404	2,206,403	936,898	968,541	934,119	1,010,209	92,295	49,488	18,303	17,284	118,746	159,762	1,020	1,119
Kaiser Permanente	1,217,830	1,285,326	1,145,690	1,223,627	-	-	-	-	-	-	72,140	61,699	-	-
Aetna	1,081,217	1,210,244	420,475	438,826	660,742	771,418	-	-	-	-	-	-	-	-
WellCare	338,978	338,767	338,978	338,767	-	-	-	-	-	-	-	-	-	-
CIGNA	450,563	481,716	444,268	476,497	6,295	5,219	-	-	-	-	-	-	-	-
Other national insurers	455,348	525,808	328,157	448,162	59,678	50,991	-	-	39,854	26,655	-	-	27,659	-
All others	3,575,092	3,773,714	2,959,300	3,134,426	309,620	278,559	-	-	6,608	3,801	280,325	315,975	19,239	40,953
Total	15,732,058	16,761,673	10,055,748	10,715,111	3,651,656	3,991,875	1,205,855	1,221,611	299,670	253,568	471,211	537,436	47,918	42,072
Individual Plans														-
UnitedHealthcare	2,708,097	2,736,927	1,877,783	1,871,701	255,349	237,933	517,136	580,614	57,829	46,679	-	-	-	-
Humana	2,299,565	2,659,149	1,220,812	1,495,305	470,023	529,679	431,654	475,016	177,076	159,149	-	-	-	-
BCBS	2,084,210	2,077,246	1,089,369	1,066,491	666,646	680,098	190,126	152,563	18,303	17,284	118,746	159,762	1,020	1,048
Wellpoint BCBS	479,940	400,312	266,877	215,965	110,521	81,272	102,542	103,075	-	-	-	-	-	-
Other BCBS plans	1,604,293	1,676,934	822,492	850,526	556,125	598,826	87,584	49,488	18,303	17,284	118,746	159,762	1,020	1,048
Kaiser Permanente	745,620	817,815	698,975	778,305	-	-	-	-	-	-	46,645	39,510	-	-
Aetna	576,105	677,870	369,461	388,228	206,644	289,642	-	-	-	-	-	-	-	-
WellCare	338,978	338,767	338,978	338,767	-	-	-	-	-	-	-	-	-	-
CIGNA	446,798	478,016	440,503	472,797	6,295	5,219	-	-	-	-	-	-	-	-
Other national insurers	416,641	492,362	289,450	414,716	59,678	50,991	-	-	39,854	26,655	-	-	27,659	-
All others	3,158,990	3,356,826	2,641,840	2,798,673	245,821	236,230	-	-	6,608	3,801	245,482	277,169	19,239	40,953
Total	12,775,004	13,634,978	8,967,171	9,624,983	1,910,456	2,029,792	1,138,916	1,208,193	299,670	253,568	410,873	476,441	47,918	42,001
Group Plans														-
UnitedHealthcare	442,285	670,199	87,947	77,112	354,227	592,956	111	131	-	-	-	-	-	-
Humana	461,688	455,394	23,642	23,473	375,929	418,634	62,117	13,287	-	-	-	-	-	-
BCBS	617,185	547,183	119,327	120,724	493,147	426,388	4,711	-	-	-	-	-	-	71
Wellpoint BCBS	120,074	17,714	4,921	2,709	115,153	15,005	-	-	-	-	-	-	-	-
Other BCBS plans	497,111	529,469	114,406	118,015	377,994	411,383	4,711	-	-	-	-	-	-	71
Kaiser Permanente	472,210	467,511	446,715	445,322	-	-	-	-	-	-	25,495	22,189	-	-
Aetna	505,112	532,374	51,014	50,598	454,098	481,776	-	-	-	-	-	-	-	-
WellCare	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CIGNA	3,765	3,700	3,765	3,700	-	-	-	-	-	-	-	-	-	-
Other national insurers	38,707	33,446	38,707	33,446	-	-	-	-	-	-	-	-	-	-
All others	416,102	416,888	317,460	335,753	63,799	42,329	-	-	-	-	34,843	38,806	-	-
Total	2,957,054	3,126,695	1,088,577	1,090,128	1,741,200	1,962,083	66,939	13,418	-	-	60,338	60,995	-	71

NOTE: BCBS is BlueCross BlueShield affiliates. Other national insurers include Health Net, Universal American, Munich American Holding Corporation, and Wellpoint non-BCBS plans. Includes Puerto Rico.

SOURCE: Authors' analysis of CMS Medicare Advantage enrollment and Landscape files, 2014-2015.

Table A5. Market Share of the Top Three Medicare Advantage Firms, by State, 2015

State	Total		Firm 1		Firm 2		Firm 3		Other Firms
	Enrollment	Share for 3 Firms	Name	Share	Name	Share	Name	Share	
Alabama	238,091	65%	BCBS	24%	CIGNA	22%	Humana Inc.	20%	35%
Alaska	56	100%	Aetna Inc.	55%	UnitedHealth Group, Inc.	45%			0%
Arizona	425,454	63%	UnitedHealth Group, Inc.	37%	Humana Inc.	14%	BCBS	11%	37%
Arkansas	114,326	83%	Humana Inc.	38%	UnitedHealth Group, Inc.	29%	BCBS	16%	17%
California	2,127,666	71%	Kaiser Foundation Health Plan, Inc.	47%	UnitedHealth Group, Inc.	16%	Health Net, Inc.	8%	29%
Colorado	281,467	86%	UnitedHealth Group, Inc.	39%	Kaiser Foundation Health Plan, Inc.	34%	Humana Inc.	14%	14%
Connecticut	157,692	89%	EmblemHealth, Inc.	38%	UnitedHealth Group, Inc.	31%	Aetna Inc.	20%	11%
Delaware	13,841	90%	Aetna Inc.	40%	CIGNA	38%	UnitedHealth Group, Inc.	12%	10%
District of Columbia	11,033	89%	Kaiser Foundation Health Plan, Inc.	52%	UnitedHealth Group, Inc.	28%	CIGNA	9%	11%
Florida	1,570,845	68%	Humana Inc.	37%	UnitedHealth Group, Inc.	22%	BCBS	9%	32%
Georgia	460,670	80%	UnitedHealth Group, Inc.	49%	Humana Inc.	22%	Aetna Inc.	9%	20%
Hawaii	110,465	79%	BCBS	33%	Kaiser Foundation Health Plan, Inc.	27%	UnitedHealth Group, Inc.	19%	21%
Idaho	87,837	79%	BCBS	46%	PacificSource Health Plans	20%	UnitedHealth Group, Inc.	13%	21%
Illinois	371,007	76%	UnitedHealth Group, Inc.	39%	Humana Inc.	26%	Aetna Inc.	11%	24%
Indiana	264,104	83%	Humana Inc.	35%	UnitedHealth Group, Inc.	25%	BCBS	23%	17%
Iowa	81,544	88%	Aetna Inc.	40%	UnitedHealth Group, Inc.	24%	Humana Inc.	24%	12%
Kansas	61,600	99%	Humana Inc.	48%	Aetna Inc.	42%	UnitedHealth Group, Inc.	8%	1%
Kentucky	212,948	94%	Humana Inc.	60%	BCBS	19%	UnitedHealth Group, Inc.	16%	6%
Louisiana	232,445	94%	Humana Inc.	65%	PH Holdings, LLC	23%	Vantage Holdings, Inc.	5%	6%
Maine	66,307	87%	Martin's Point Health Care, Inc.	48%	Aetna Inc.	26%	UnitedHealth Group, Inc.	13%	13%
Maryland	76,375	79%	Kaiser Foundation Health Plan, Inc.	47%	CIGNA	19%	UnitedHealth Group, Inc.	13%	21%
Massachusetts	233,084	79%	Tufts Associated HMO, Inc.	45%	UnitedHealth Group, Inc.	18%	BCBS	17%	21%
Michigan	595,239	82%	BCBS	56%	Spectrum Health System	16%	Humana Inc.	10%	18%
Minnesota	480,474	81%	BCBS	35%	Medica Holding Company	26%	UCare Minnesota	20%	19%
Mississippi	76,776	98%	Humana Inc.	66%	WellCare Health Plans, Inc.	21%	CIGNA	11%	2%
Missouri	311,364	83%	UnitedHealth Group, Inc.	31%	Aetna Inc.	30%	Humana Inc.	22%	17%
Montana	34,758	95%	New West Health Services	51%	BCBS	25%	Humana Inc.	20%	5%
Nebraska	34,982	97%	UnitedHealth Group, Inc.	51%	Aetna Inc.	30%	Humana Inc.	16%	3%
Nevada	146,094	90%	UnitedHealth Group, Inc.	45%	Humana Inc.	33%	Renown Health	12%	10%
New Hampshire	17,295	83%	UnitedHealth Group, Inc.	55%	Humana Inc.	17%	BCBS	12%	17%
New Jersey	222,846	82%	UnitedHealth Group, Inc.	44%	Aetna Inc.	25%	BCBS	12%	18%
New Mexico	113,807	83%	Presbyterian Healthcare Services	36%	BCBS	28%	UnitedHealth Group, Inc.	19%	17%
New York	1,212,239	50%	BCBS	22%	UnitedHealth Group, Inc.	18%	Healthfirst, Inc.	10%	50%
North Carolina	512,924	90%	UnitedHealth Group, Inc.	34%	Humana Inc.	31%	BCBS	25%	10%
North Dakota	17,878	99%	Medica Holding Company	88%	Humana Inc.	9%	Sanford Health Plan	2%	1%
Ohio	811,503	74%	Humana Inc.	29%	BCBS	24%	Aetna Inc.	21%	26%
Oklahoma	111,013	84%	UnitedHealth Group, Inc.	29%	Humana Inc.	29%	CommunityCare Managed Healthcare Plans of OK, Inc.	26%	16%
Oregon	323,765	52%	Health Net, Inc.	18%	BCBS	18%	Kaiser Foundation Health Plan, Inc.	16%	48%
Pennsylvania	1,001,864	73%	BCBS	36%	Aetna Inc.	22%	UPMC Health System	14%	27%
Rhode Island	71,009	100%	BCBS	71%	UnitedHealth Group, Inc.	28%	PACE Organization of Rhode Island	0%	0%
South Carolina	209,812	94%	UnitedHealth Group, Inc.	45%	Humana Inc.	45%	CIGNA	4%	6%
South Dakota	26,400	99%	Medica Holding Company	71%	Humana Inc.	21%	Aetna Inc.	7%	1%
Tennessee	412,042	76%	Humana Inc.	31%	BCBS	24%	CIGNA	22%	24%
Texas	1,098,678	69%	UnitedHealth Group, Inc.	33%	Humana Inc.	24%	Aetna Inc.	12%	31%
Utah	113,034	77%	UnitedHealth Group, Inc.	45%	Intermountain Health Care, Inc.	19%	BCBS	13%	23%
Vermont	8,984	99%	UnitedHealth Group, Inc.	80%	MVP Health Care, Inc.	12%	Aetna Inc.	8%	1%
Virginia	206,427	89%	Humana Inc.	62%	UnitedHealth Group, Inc.	18%	Kaiser Foundation Health Plan, Inc.	9%	11%
Washington	348,467	67%	UnitedHealth Group, Inc.	25%	Group Health Cooperative	24%	BCBS	18%	33%
West Virginia	99,454	94%	Humana Inc.	71%	Aetna Inc.	14%	BCBS	9%	6%
Wisconsin	388,732	68%	UnitedHealth Group, Inc.	33%	Humana Inc.	19%	Ministry Health Care, Inc.	16%	32%
Wyoming	2,071	92%	UnitedHealth Group, Inc.	72%	Aetna Inc.	11%	BCBS	9%	8%

NOTE: Territories are excluded. BCBS is Blue Cross and Blue Shield affiliated health plans.

SOURCE: Authors' analysis of CMS Medicare Advantage enrollment and Landscape files, 2015.

Table A6. Enrollment in Special Needs Plans (SNPs), by Plan Type and State, 2015

State	Enrollment in Special Needs Plans				Total Dual Eligibles (in 2013)	% of Dual Eligibles in D-SNPs
	Total	Dual eligibles (D-SNPs)	Institutional (I-SNPs)	Chronic or disabling conditions (C-SNPs)		
Total U.S.	2,011,505	1,657,554	48,740	305,211	10,705,500	15%
Alabama	48,409	48,391	136	-	220,060	22%
Alaska	-	-	-	-	16,520	0%
Arizona	95,008	75,703	1,746	17,559	186,160	41%
Arkansas	24,389	12,308	-	12,081	136,060	9%
California	214,208	170,334	3,645	40,229	1,358,140	13%
Colorado	12,773	10,270	2,425	78	102,800	10%
Connecticut	12,242	9,742	2,500	-	173,400	6%
Delaware	2,223	885	457	881	29,100	3%
District of Columbia	3,394	3,218	68	108	30,940	10%
Florida	266,831	205,219	3,196	58,416	787,040	26%
Georgia	87,737	44,328	2,236	41,173	317,440	14%
Hawaii	19,118	19,118	-	-	39,120	49%
Idaho	1,460	1,460	-	-	42,840	3%
Illinois	11,648	9,547	615	1,486	382,340	2%
Indiana	4,454	821	93	3,540	190,460	<1%
Iowa	585	169	-	416	90,640	<1%
Kansas	289	-	227	62	70,860	0%
Kentucky	3,977	3,505	-	472	194,180	2%
Louisiana	27,784	26,293	-	1,491	214,220	12%
Maine	1,548	1,548	-	-	102,000	2%
Maryland	11,164	4,839	2,808	3,517	139,100	3%
Massachusetts	34,195	33,794	191	210	302,300	11%
Michigan	18,966	18,664	198	104	321,400	6%
Minnesota	36,188	36,188	-	-	146,460	25%
Mississippi	13,752	12,036	-	1,716	169,580	7%
Missouri	23,756	10,871	21	12,864	200,440	5%
Montana	-	-	-	-	27,380	0%
Nebraska	364	-	-	364	45,920	0%
Nevada	8,511	15	-	8,496	54,940	0%
New Hampshire	19	19	-	-	34,240	0%
New Jersey	11,207	9,526	1,460	221	226,420	4%
New Mexico	10,950	9,991	297	662	76,080	13%
New York	192,449	177,861	14,276	312	857,220	21%
North Carolina	21,052	16,157	2,417	2,478	342,720	5%
North Dakota	-	-	-	-	17,580	0%
Ohio	13,453	11,201	1,203	1,049	369,500	3%
Oklahoma	115	-	115	-	123,600	0%
Oregon	25,460	21,675	581	3,204	118,820	18%
Pennsylvania	119,052	103,998	2,927	12,127	456,240	23%
Rhode Island	1,538	14	1,524	-	42,080	0%
South Carolina	58,005	22,242	-	35,763	162,020	14%
South Dakota	-	-	-	-	21,920	0%
Tennessee	68,356	68,356	-	-	287,800	24%
Texas	163,979	133,966	198	29,815	726,120	18%
Utah	8,155	8,155	-	-	38,100	21%
Vermont	-	-	-	-	30,900	0%
Virginia	3,817	1,329	89	2,399	201,920	1%
Washington	24,563	23,084	1,479	-	189,940	12%
West Virginia	133	133	-	-	88,180	<1%
Wisconsin	21,109	18,454	1,612	1,043	176,620	10%
Wyoming	-	-	-	-	12,160	0%

NOTE: Total U.S. includes Puerto Rico. Blank cells indicate no plans offered.

SOURCE: Authors' analysis of CMS Medicare Advantage enrollment and Landscape files, 2015. Number of dual eligibles by state is derived from the CMS Chronic Conditions Data Warehouse standard analytic files for 2013.

Endnotes

¹ In this document, the ACA 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).

² G. Jacobson, P. Neuman, and A. Damico. “At Least Half of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006-11,” *Health Affairs*, vol. 34 no. 1, p. 48-55, January 2015. Also see G. Jacobson, T. Neuman, and A. Damico. “Medigap Enrollment Among New Medicare Beneficiaries: How Many 65-Year Olds Enroll In Plans With First-Dollar Coverage?” Washington DC: Kaiser Family Foundation, April 2015. Available at: <http://kff.org/medicare/issue-brief/medigap-enrollment-among-new-medicare-beneficiaries/>, Last accessed June 5, 2015.

³ G. Jacobson, A. Damico, T. Neuman, and M. Gold. “Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes,” Washington DC: Henry J. Kaiser Family Foundation, December 2014. Available at: <http://kff.org/medicare/issue-brief/medicare-advantage-2015-data-spotlight-overview-of-plan-changes/>

⁴ M. Gold. “Medicare Advantage in 2008.” (Table 1: PFFS Contracts by Firm and Number of Counties Covered by the Contract, 2006-2008), Kaiser Family Foundation, June 2008. Available at: <http://kff.org/medicare/issue-brief/medicare-advantage-in-2008/>

⁵ M. Gold. “Medicare’s Private Plans: A Report Card on Medicare Advantage,” *Health Affairs Web Exclusive*, November 24, 2008.

⁶ M. Gold, D. Phelps, G. Jacobson, and T. Neuman. “Medicare Advantage 2010 Data Spotlight: Plan Enrollment Patterns and Trends,” Washington DC: Henry J. Kaiser Family Foundation, June 2010. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8080.pdf#page=7>

⁷ F. McArdle, T. Neuman and J. Huang. “Retiree Health Benefits at the Crossroads”. Washington DC: Henry J. Kaiser Family Foundation, April 2014. Available at: <http://kff.org/medicare/report/retiree-health-benefits-at-the-crossroads/>

⁸ Kaiser Family Foundation and Health Research and Education Trust, “Section 11. Retiree Health Benefits.” *Employer Health Benefits: 2013 Annual Survey*. Washington, DC: Kaiser Family Foundation, 2013, pp. 191-199; and P. Fronstein and N. Adams. “Employment Based Retiree Health Benefits: Trends in Access and Coverage: 1997-2010.” EBRI Education and Research Institute, 2012.

⁹ Medicare Payment Advisory Commission “Chapter 13. The Medicare Advantage Program: Status Report” in Report to Congress: Medicare Payment Policy, Washington DC, March 2015. pp 313-343.

¹⁰ Medicare Payment Advisory Commission “Chapter 13. The Medicare Advantage Program: Status Report” in Report to Congress: Medicare Payment Policy, Washington DC, March 2015. pp 313-343 and Marsha Gold and Maria Cupples Hudson. “Analysis of the Variation in Efficiency among Medicare Advantage Plans” Research Brief Washington DC: Mathematica Policy Research, April 2013.

¹¹ Marsha Gold and Giselle Casillas. “What Do We Know about Quality and Access in Medicare Advantage versus Traditional Medicare” Washington DC: Kaiser Family Foundation, November 2014. Available at: <http://kff.org/medicare/report/what-do-we-know-about-health-care-access-and-quality-in-medicare-advantage-versus-the-traditional-medicare-program/>

¹² In the fall of 2014, we calculated that beneficiaries who were enrolled in Medicare Advantage plans at that time would pay a premium of \$41 per month in 2015, compared to \$34 per month in 2014, which assumed they remained in the same plan. Among Medicare Advantage enrollees in 2015, the average premium actually paid by enrollees (\$38 per month) is slightly lower than the amount estimated in the fall, with the difference in estimates reflecting both changes in beneficiaries enrolled in Medicare Advantage plans from 2014 to 2015 and shifts by enrollees among plans and plan types.

¹³ G. Jacobson, A. Damico, T. Neuman, and M. Gold. “Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes,” Washington DC: Henry J. Kaiser Family Foundation, December 2014. Available at: <http://kff.org/medicare/issue-brief/medicare-advantage-2015-data-spotlight-overview-of-plan-changes/>

¹⁴ In Minnesota, 67% of private plan enrollment is in cost plans, which have higher average premiums than Medicare Advantage plans.

¹⁵ Limits were required for regional PPOs since they were first authorized in 2006.

¹⁶ The files used for this analysis provide limited details on the type or extent of coverage in the Part D coverage gap that plans provide, and some additional coverage may be minimal.

¹⁷ Department of Health and Human Services, Centers for Medicare and Medicaid Services, “Medicare Announces Quality Bonus Payment Demonstration for Medicare Health Plans,” November 2010.

¹⁸ G. Jacobson, C. Swoope, M. Perry, and M.C. Slosar. “How are Seniors Choosing and Changing Health Insurance Plans?” Kaiser Family Foundation, May 2014. Available at: <http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/>